2018 GRANT APPLICATION

Cover Sheet Check List

_____Application is completed, signed and dated by Social Worker, Nurse or Physician.

_____The patient requesting the grant has signed application requesting grant distribution on Page 6.

_____Is the applicant actively receiving treatment in the Central Virginia area?

_____Is the financial hardship a direct result of the the illness?

_____Are requests related to expenses not covered by insurance or other available funds?

The Foundation does NOT cover: Payment of medical bills and or hospital bills, payments to physicians, or payment of ambulance services.

_____Does the request include the company name, address, account number and amount to be paid?
This is required as the checks will be mailed directly to the expense provider. Grant checks cannot be mailed directly to applicants or individuals.

_____Invoices to be paid are attached to the Grant Application.

Please return completed application by mail:

Good Doctors Foundation,
PO Box 1120,
Ashland, VA 23005

Email: goodmd4@gmail.com
Phone: 804-277-9358

Good Doctors
FOUNDATION

GUIDELINES & RETURN INFORMATION

Who Is Eligible? To be considered for a grant, the patient must:

- Be a patient who is currently receiving treatment in, or residing in, the Central Virginia area.
- Be able to demonstrate financial hardship clearly as a result of the illness.

What types of expenses does the Foundation cover? Healthcare related expenses not covered by insurance or other available funding sources. The following expenses are considered:

- Insurance Premiums
- Transportation (bus, cab, automobile)
- Medications
- Durable medical equipment
- Housing to receive treatment
- Support services for recovery needs

The Foundation Does NOT Cover:

- Payment of medical bills and or hospital bills, payments to physicians, or payment of ambulance services.

Applying For A Grant:

- Our grant making services are handled by the Good Doctors Foundation in Richmond. Applicants are nominated by their Social Worker, Nurse or Physician. Completed grant applications are reviewed by the Good Doctors Foundation Grant Committee. Incomplete applications are deferred pending completion of information requested.

How Much To Ask For: Currently a maximum of $750.00 may be requested.

Our Review Process:

- Completed applications will be submitted to the Foundation's review committee. They may call the nominating health care provider with questions or request additional information. As part of the general review assessment, we may also consult specialists and other agencies active in the medical specialty of the applicant's medical condition.
- The determination of the committee will be sent to the nominating health care provider.
- The applicant will be notified of the committee's determination by the nominating health care provider.
- Based on the payment information requested in the application, checks will be mailed directly to the expense provider. Grant checks cannot be mailed directly to applicants or individuals.

Please return completed application by mail, or refer any questions to:

Good Doctors Foundation, PO Box 1120, Ashland, VA 23005
Email: goodmd4@gmail.com Phone: 804-277-9358

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MEDICAL FORM

NOTE: Failure to complete and return this form will result in the denial of the patient's *The Good Doctors Foundation* Grant Application.

Applicant Name:_____ **DOB:**_____

Address:_____

ALL INFORMATION REQUESTED BELOW TO BE COMPLETED BY TREATING HEALTHCARE PROFESSIONAL: Social Worker, Physician or Nurse.

1. **DIAGNOSIS**:_____
   a) Date of Diagnosis: _____
   b) Treatment Facility: _____
   c) Is patient currently receiving treatment? Yes ( ) No ( )
   Type of Treatment:
   _____

2. **EMPLOYABILITY ASSESSMENT**:
   a) Does the diagnosis render the patient unable to work or severely limit the patient's capacity for self-support? Yes ( ) No ( )
   b) Date of onset: _____
   c) Explain restrictions on employment:
   _____

3. Has patient been financially screened by your institution? Yes ( ) No ( )
   If Yes, what is status? _____

4. Please provide any additional remarks which may be of value to us in processing this patient's request for financial assistance including what this financial assistance means to this patient.

Signature: _____

Print Name: _____

Email Address: _____

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GRANT APPLICATION

TO BE COMPLETED BY APPLICANT

Date: _____

Name: _____
First **Middle** **Last**

Street Address: _____

City: _____ **State:** _____ **Zip**_____

Home Phone: _____ **Work Phone**_____ **Cell Phone**_____

Birth Date: _____/_____/_____ **Age:** ____ **Are you Disabled?** _____ **Are you a Veteran?** _____

Other Residents in your household: Spouse ( ) Partner ( ) Children ( ) Parent[s] ( ) Roommate ( )
Total Household Residents: ( ) Number of wage earners in the household? _____

Medical Diagnosis: _____

Do you have any Insurance coverage?

Insurance	Effective date	Monthly premium	Benefit Gap amount	Deductible or Spend down Amount
Medicare Part B				
Medicare part D				
Medicaid				
Veterans Assistance				
Private insurance Plan name: _____				
Prescription coverage Plan name: _____				
Any restrictions or yearly cap?				

Applicant Referred by: _____ **Phone:** _____

Attending Physician: _____ **Phone:** _____

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MONTHLY HOUSEHOLD EXPENSES

Applicant Name: _____

PLEASE carefully review and complete the following monthly household expenses section. For expense items paid on yearly basis, divide the yearly total by 12 to determine the monthly expense.

HOUSEHOLD

Rent _____
Mortgage Payment _____
Taxes (If not included in Mortgage) _____
Home Maintenance _____
Food _____
Utilities _____

PERSONAL

Medical Expenses for other Family Members _____
Child Care _____
Monthly Credit Card & Loan Payments _____
Other Monthly Expenses _____

INSURANCE

Medical Premiums _____
Life – Premiums _____
Car Insurance Premiums _____
Other (Please Specify) _____

PATIENT'S MEDICAL EXPENSES

(After insurance reimbursement)

Physician _____
Lab Costs _____
Prescription Costs _____
Non-Prescription Costs _____
Chemotherapy _____
Radiation _____
Equipment _____
Supplies _____
Home Health Care _____
Transportation to Medical Care _____
Clinic Fees _____

TOTAL MONTHLY EXPENSES: $ _____

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MONTHLY HOUSEHOLD INCOME

Applicant Name: _____

PLEASE carefully review and complete the following monthly household income section.

Include income documentation such as W2, Social Security Benefit Statement, or tax filing.

APPLICANT'S INCOME INFORMATION:		**INCOME INFORMATION FOR OTHER RESIDENTS OF THE HOUSEHOLD:**	
Salary (After Taxes)	$_____	Salary (After Taxes)	$_____
Monthly Social Security, Retirement or Disability	$_____	Retirement or Disability Monthly Social Security,	$_____
Pension, including VA	$_____	Pension, including VA	$_____
Contributions from relatives outside of household	$_____	Alimony/child support	$_____
Other Sources (alimony, child support, etc.): Be specific	$_____		

TOTAL ALL COMBINED MONTHLY INCOME: $_____

FINANCIAL RESOURCES

1. Savings accounts, including CD's & money market accounts $_____
2. Checking Accounts $_____
3. Securities (stocks, bonds, and IRA's) $_____
4. Business ownership $_____
5. Property (other than residence) $_____

Have you received other assistance apart from this request? Yes ( ) No ( )

If Yes, please indicate: Church ( ) Drug Company ( ) CoPay Assistance ( ) Other ( )

_____

TOTAL FINANCIAL RESOURCES: $_____

Any additional comments to help us understand your need:

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Privacy Notice to all Applicants

In order to evaluate and process your application, information will be shared with *The Good Doctors Foundation* Grant Review Committee. Please note that the information collected is not part of your medical record. All information collected on this grant application is considered confidential. Personal information about applicants will be collected only to the extent necessary to provide the service or benefit desired; only appropriate information will be collected and the applicant shall understand the reason the information is collected.

Applicant Name: _____

Applicant Signature: _____

Grant Amount Requested: (Not to exceed $750.00) $_____

PLEASE carefully review and provide complete information on how you would like to have the grant funds distributed, if this application is approved. Please list request in the order you would like to have the funds distributed. ***Include copies of invoices for all amounts requested.***

NOTE: The Good Doctors Foundation is **unable** to:
1) Write checks directly to a grant applicant
2) Award grants for medical, hospital, physician bills or ambulance services.

REQUESTED GRANT DISTRIBUTION

1. Company Name: _____ Address: _____ City, State, Zip: _____ Account Number: _____	Amount to be paid: $_____
2. Company Name: _____ Address: _____ City, State, Zip: _____ Account Number: _____	Amount to be paid: $_____
3. Company Name: _____ Address: _____ City, State, Zip: _____ Account Number: _____	Amount to be paid: $_____