H.O.P.E GRANT

The Michael G. Belz Foundation is named after Michael G. Belz who was diagnosed with a cancerous brain tumor at the age of 27. Michael did not know how long he would live or the quality of life he would have after diagnosis. Therefore, it was important for him to live as normal a life as possible amidst treatments, surgeries, and medical appointments. Michael lived life to the fullest while continuing to maintain *hope* for tomorrow!

Michael provided inspiration and H.O.P.E. to those around him. In his memory, the Michael G. Belz Foundation (MGBF) was established in 2009, the year of Michael's death. Consistent with its mission, the MGBF provides patient resources for those diagnosed with brain tumors so that they may live and celebrate each day and live every day to the fullest with **H.O.P.E.**

GUIDELINES

The number of grants and amount awarded per calendar year will be determined based on the needs of the applicants and available funds. For the 2014 calendar year the maximum grant amount is $1500.00. Patients and their families may reapply after one calendar year and may not be receiving assistance from another nonprofit organization at the time of application and grant award.

CRITERIA

Potential grant recipients must meet all of the following criteria to become beneficiaries of the Michael G. Belz Foundation **H.O.P.E.** Grant:

1. The recipient is diagnosed with a brain tumor, cancerous or noncancerous.
2. The recipient is currently (or recently received) treatment for a brain tumor.
3. The recipient is a resident of the state of Ohio.
4. The recipient agrees to submit copies of receipts for items purchased with grant funds.

The MGBF H.O.P.E. Grant helps those diagnosed with brain tumors live and celebrate life and offer H.O.P.E.

Requests may be made for, but not limited to:

1. Beyond Basic Needs *(e.g., premade meal programs, private pay aides, etc.)*
2. Recreational *(e.g., dinner gift cards/certificates, travel expenses for a vacation, golf or dance lessons, movie gift cards, camera, concert tickets, zoo pass, etc.)*
3. Household chores *(e.g., mowing, plowing, cleaning, etc.)*
4. Other needs may be considered *(please explain on a separate sheet of paper and attach to this application)*

GRANT SUBMISSION

H.O.P.E. Grants may be submitted for review to the foundation by mail or e-mail to the following:

Michael G. Belz Foundation
P.O. Box 347118
Parma, Ohio 44134
mgbf2009@yahoo.com

APPLICATION

Applications must be completed to its entirety to be considered. Please provide medical documentation such as a pathology report along with your application. All medical documentation will be returned once grant eligibility has been determined.

APPLICANT INFORMATION

Name: ______________________________ Phone: ______________________

Address: ______________________ City: ______________ State: _____ Zip: _______

County of residence: ________________ E-mail: ________________________

Date of birth: ______________

Marital status: married widowed single partnered divorced separated

Number of people in household including yourself: ___________

Household monthly income: _____________ Total Monthly Expenses: ______________

INSURANCE INFORMATION (circle all that apply)

Medicare Secondary Insurance (Medigap Plan) Medicare Advantage Plan

Medicaid Private Insurance Private Insurance-Cobra No Insurance

PRESCRIPTION INFORMATION

Medicare Part D/Medicare Advantage Plan Medicaid Private Prescription Plan No Prescription Plan

PERSONAL STORY: Please share your story with us including how you were diagnosed, treatment, and how your life has changed since your diagnosis. Please include how this grant will help you live and celebrate your life with H.O.P.E.

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DESCRIBE YOUR NEED: What type of assistance do you request and how will this offer you H.O.P.E. and help you and/or your family live and celebrate your life?

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GRANT BUDGET WORKSHEET

ASSISTANCE REQUEST	COST	VENDOR NAME AND ADDRESS *(Please provide a contact name if applicable)*	TOTAL
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
		TOTAL COST OF GRANT REQUEST	$

Please denote when funds are needed:

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****Please remember to make copies of all receipts and to submit to the foundation for documentation.***

APPLICATION PERMISSION

Sign and date below that the information on this application is accurate and true:

Signature: ____ Date: _________________

Signature of parent and/or guardian *(if under age 18 or if applicant is not deemed competent):*

____ Date: __________________

PUBLICITY RELEASE

A part of the mission of the Michael G. Belz Foundation is to raise awareness about brain tumors. Sharing your story and how you live your life will attribute to the success of our mission. We host and sponsor events to raise awareness and funding for patients. To make this possible, your personal information may be used on our website and future Michael G. Belz Foundation publications. By initialing and signing below, you are providing permission for the Michael G. Belz Foundation to use the following information:

______ Name *(First name only)*

______ Photograph *(please include a photo with your application)*

______ Personal story

Signature: ____ Date: _________________

Signature of parent and/or guardian *(if under age 18 or if applicant is not deemed competent):*

____ Date: _________________

______ Please do not use my personal information

MEDICAL RELEASE OF INFORMATION

I understand and grant permission to all my physicians, social workers, clinics and/or hospitals to release necessary healthcare records and information relating to my treatment and care of a brain tumor, cancerous or noncancerous to the Michael G. Belz Foundation.

The Michael G. Belz Foundation agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their permission. I understand that this authorization will automatically expire one year from the date of my signature and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above.

Patient's Signature : ____ Date: ________________

Witness: ____ Date: ________________

Signature of parent and/or guardian *(if under age 18 or if applicant is not deemed competent):*

____ Date: _________________

PRIVACY STATEMENT

The Michael G. Belz Foundation protects the privacy of our applicants. Applicants' medical history will be kept confidential and secure. It will be reviewed by Foundation members. The MGBF may find it necessary to contact the references listed below determining eligibility.

Patient's Signature : ____ Date: _________________

Signature of parent and/or guardian (if under age 18 or if applicant is not deemed competent):

____ Date: __________________

FOR PHYSICIAN ONLY

Physician's Name: ____ Phone: ______________________

Medical Facility: ____

Date of Diagnosis: _____________________ Diagnosis: ______________________________________

Currently in treatment: Yes No Date of most recent treatment: _____________________________

Type of treatment: (circle all that apply)

surgery radiation chemotherapy clinical trial other: _______________________________

Physician's signature: _______________________________________ Date: _____________________

REFERRING SOCIAL WORKER (if applicable)

Name: ____ Phone: _________________________

Medical Facility: ____ E-mail: _________________________

Signature: ____ Date: ___________________________