The Gail Robinson Fund

APPLICATION FOR ASSISTANCE

GENERAL BACKGROUND INFORMATION

Date of Application: _____/_____/_____ (month/day/year)

Name:_____

Date of Birth _____/_____/_____ (month/day/year)

Address: _____

_____

_____

State _____ ZIP_____

Phone: (_____)_____

Email: _____

ADDITIONAL CONTACT OTHER THAN APPLICIANT:

Contact Name: _____

Relationship to Applicant _____

Phone: _____

Email: _____

MEDICAL BACKGROUND

Name of Primary Treating Physician_____

Address _____

_____

_____

_____

Phone: _____

Please provide a brief description and history of your cancer, including date of diagnosis, and treatment(s):

_____ See Attached (check here and submit additional pages if needed).

_____

_____

_____

_____

_____

_____

OTHER SUPPORT OR GRANTS RECEIVED OR APPLIED FOR

Please describe any other sources of financial assistance or grants you have received (including the amount and date received), or for which you are applying at the time of this application. (e.g. drug assistance funds, other grants or assistance from Funds or Foundations, etc.)

_____

_____

_____

_____

_____

_____

_____

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GRANT JUSTIFICATION & PERSONAL STATEMENT:

Please describe why you are applying for a grant from the Fund. Your description may include your circumstances, or family or caregiver circumstances, and should include: the amount of grant you are requesting, how the funds would be used (e.g paying bills (describe), supporting a leave of absence from work for patient or family member, paying for trip or time together, etc.) and how the grant might help your or your family's situation or why it's important. This portion of the Application may be submitted on a separate sheet(s) of paper and attached to the application.

_____ See Attached (check here and submit additional pages if needed).

SIGNATURE PAGE AND ACKNOWLEDGEMENTS

1. The information I have provided in this application is accurate to the best of my knowledge, and any failure to provide accurate information in connection with my application may result in my being ineligible for any grants from the Fund.

2. I agree that I (and the Alternative Contact if provided) may be contacted by a representative of the Gail Robinson Fund at the phone number and/or email address provided in the application for the purpose of obtaining any supplemental information for a grant decision or to verify information provided in the application. All information provided to the Gail Robinson Fund as part of the Application and in the course of the application process is confidential and will be used by the Fund only for the purpose of evaluating eligibility for a grant from the Fund.

3. I understand that by applying to the Fund a grant is not guaranteed, that grants are subject to available funding and other factors, and that the grant program at the Fund may be limited or restricted without notice.

APPLICANT'S SIGNATURE: _____

DATE _____

MAIL TO:
The Gail Robinson Fund
c/o Steve Larsen, Fund Administrator
P.O. Box 508
Kensington, Maryland 20895

Please make sure to include your Physician Verification Form, and your Referral form if you have one, with your application.