FAMILY ASSISTANCE PROGRAM
APPLICATION INSTRUCTIONS

GUIDELINES:

✓ Anyone 21 and younger who is being treated for a brain tumor can apply.

✓ Applications must be completed in full and submitted by a hospital social worker.

✓ Applications, bills and photo must be received by the 20th of the month. We will be reviewing at the end of the month and payments will go out by the 1st of the following month.

✓ The Foundation **only** makes payments directly to third party service providers. NO ONLINE PAYMENTS.

✓ **All third party bills must accompany an application.**

✓ The Foundation determines financial assistance based upon review of facts and circumstances surrounding the request.

✓ **We do not pay medical bills.**

Examples of covered expenses include, but are not limited to:

- Rent, mortgage
- Lodging for treatments
- Car payments
- Utilities

IMPORTANT: ***The media release is a requirement. Please make sure that it's signed and returned with a jpeg photo of the child. The application will not be processed without these items***

All information is confidential and is intended for IronMatt's use only.

Please email questions to **info@ironmatt.org.**

Please fax, or email this application to:
Fax: 201-337-3525
Email: Info@ironmatt.org
The Matthew Larson Foundation for Pediatric Brain Tumors
P.O. Box 836, Franklin Lakes, NJ 07417

RONMATT
The Matthew Larson Foundation for Pediatric Brain Tumors

PATIENT INFORMATION

Today's Date: _____

Patient's First and Last Name:_____Age:____Sex_____DOB:_____

Parent(s)/Caregiver Full Name _____Patients Pajama size: _____

Mailing Address: City, State, Zip _____

_____

Diagnosis of Patient:_____Date of Diagnosis: _____

Siblings Age and sex _____ _____

List all adults living in the household and place of employment: _____

_____

_____

Does the patient have medical insurance? Yes____No _____

If yes, who is the provider? _____

Approximate annual household income (please circle)

Under $25,000 $25,000 - $75,000 $75,000 - $150,000 More than $150,000

How did the patient's family learn of IronMatt's Family Assistance Program? _____

Has IronMatt assisted this patient in the past? Yes____No_____

If applicable, what other organizations is the family applying for financial assistance? _____

HOSPITAL AND SOCIAL WORKER INFORMATION

Hospital Name:_____City and State_____

Oncologist First and Last Name: _____

Social Worker First and Last Name: _____

Social Worker Phone: _____

Email Address:_____Please print clearly

Amount of Request: $_____

Please do NOT submit the application until you have all bills, mailing addreses and account numbers.

You will also need to email a JPEG photo to info@ironmatt.org.

YOU MUST HAVE THE PHYSICAL MAILING ADDRESS FOR ALL BILLS. YOU CAN FIND IT WHERE YOU LOG INTO YOUR ACCOUNT ONLINE.

If submitting multiple bills, an attachment listing the bills and payment address and account numbers is extremely helpful.

WE DO NOT PAY ONLINE BILLS.

We will no longer email back and forth if we can't read the address or don't know where to mail a payment. Bills will be denied, but could be resubmitted the next month.

All applications with bills and photo must be submitted by the 20th of the month. The board meets once a month to review applications, the last week of the month. **The social workers will be notified the next day.**

Please attach copies of invoices making sure addresses and account numbers are easy to read

SIGNATURES

By signing this application, I agree to the following:

- I am an authorized representative of the referenced hospital.
- I am authorized to submit this application on behalf of the patient and family.
- A parent or guardian of the patient has given consent to provide truthful information in this application.

Social Worker Signature: _____

Social Worker Printed Name: _____

Parent's Signature:_____Date_____

_____ Parent's Printed Name:_____

_____Date _____

RONMATT
The Matthew Larson Foundation for Pediatric Brain Tumors

Signing the Media Release is a requirement. We will not be able to process an application without this.

The Matthew Larson Foundation for Pediatric Brain Tumors strives to create public awareness about pediatric brain tumors.

By signing below, I hereby grant permission to The Matthew Larson Foundation for Pediatric Brain Tumors, to take and use: photographs and/or digital images, including video, of my child for use in news releases, education and/or promotional materials. These materials might include printed or electronic publications, websites or other electronic communications and will be used for the activities related to IronMatt's mission, programs, services and events.

I agree to include IronMatt's link www.ironmatt.org on all social media related venues: including but not limited to Facebook, Twitter, www.caringbridge.org, any blogs, or any individual websites to gain awareness for the IronMatt mission.

I further consent that our names and identities may be revealed by descriptive text or commentary for some projects. I understand that there will be no financial or other remuneration for either the initial or subsequent use of these photos/videos.

I understand this authorization shall continue until terminated in writing.

Please provide a clear picture of your child before and/or after treatment in a digital format such as jpeg

Child's First and Last Name: _____

Parent/Guardian Signature: _____

_____ Printed Name: _____

_____ Age of Child: _____

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THE CHILDREN'S PLACE

THE CHILDREN'S PLACE PROUDLY SUPPORTS IRONKIDS AND THEIR FAMILIES.