IRONMATT
The Matthew Larson Foundation
for Pediatric Brain Tumors

FAMILY ASSISTANCE PROGRAM APPLICATION

GUIDELINES:

- ✓ Anyone under the age of 21 who is currently receiving treatment for a brain tumor is eligible to apply for financial assistance.
- ✓ Applications must be completed in full and submitted by a hospital social worker.
- ✓ The Foundation **only** makes payments directly to third party service providers.
- ✓ **All third party bills must accompany an application.**
- ✓ The Foundation determines financial assistance based upon review of facts and circumstances surrounding the request.

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

- Rent, mortgage
- Lodging for treatments
- Car payments
- Incidentals resulting from treatments not covered by commercial insurance or Medicaid.

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

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PATIENT INFORMATION

Today's Date: _____

Patient's First and Last Name: _____ Age: ____ Sex _____ DOB: _____

Parent(s)/Caregiver First and Last Name(s): _____ Clothing size of child _____

Parent Cell Number: _____

Mailing Address: City, State, Zip _____

_____

Diagnosis of Patient: _____ Date of Diagnosis: _____

Siblings Age/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

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REQUEST

Amount of Request: _____**Please do NOT submit the application until you have all bills, mailing addresses and account numbers. You will also need to email a JPEG photo to info@ironmatt.org incomplete applications will not be considered.**

All applications with bills and photo must be submitted by the 15th of the month. The social worker will be notified by the 20th and payments will go out to the third parties on the 1st of the month.

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

ADDITIONAL INFORMATION: In the space below please provide any additional information related to the family situation that might be helpful with making the decision.

_____

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 _____

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Media Release

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: _____

THE CHILDREN'S PLACE
♥ A PLACE FOR GIVING ♥

THE CHILDREN'S PLACE PROUDLY SUPPORTS IRONKIDS AND THEIR FAMILIES

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P.O. Box 836, Franklin Lakes, NJ 07417 Fax: (201) 337-3525