Caring 'Til It's Cured!
www.brookehealey.com
PO Box 981 New Providence, NJ 07974

Request for Family Assistance

The Brooke Healey Foundation was created to build awareness and raise funds for research in Diffuse Intrinsic Pontine Glioma (DIPG); to help families dealing with pediatric cancers, especially brain cancers and DIPG; to foster community relationships and to promote involvement through scholarships awarded to civically active high school seniors.

For more information on the foundation please visit www.BrookeHealey.com

Eligibility:

- Parents or Guardians of a child who has been diagnosed with cancer and experiencing financial hardship as a result. Parent/Guardian requesting assistance must reside with diagnosed child.
- Parent/Guardian and Child are primary residents of the United States.
- Child or family requesting assistance has not received assistance from The Brooke Healey Foundation within 18 months of application date.
- The diagnosed child must be under the age of 18. Exceptions may apply if the diagnosis is a form of pediatric cancer and child's primary residence is with the Parent/Guardian. Please email michele@brookehealey.com detailing the request and to receive an age waiver.

What to include:

- Copy of Child's Birth Certificate.
- Letter from Physician including diagnosis and indication child is currently under their care.
- 2nd and 3rd page of this application filled out completely.
- Copy of bills or itemized expenses you are requesting assistance to be paid.

How to submit your completed application and included items:

- Email to michele@brookehealey.com
- Mail to: The Brooke Healey Foundation, PO Box 981, New Providence, NJ 07974. Attention: Michele

Application for Financial Assistance

Applicant Information:

Parent/Guardian Name (First, MI, Last):_____

Street Address:_____

City:_____ State: _____ Zip Code:_____

Phone: (_____)_____-_____

Email Address:_____

Do you use Facebook, have a web page, or some other form of social media where we can follow your child's battle? ☐Yes ☐No If yes please provide URL:_____

Patient Information:

Child's Name (First, MI, Last):_____

Child's Date of Birth:_____ Date of Diagnosis:_____

Cancer Diagnosis:_____

Siblings of patient – include names and ages:_____

_____

Physician Information:

Part 1

Diagnosing Physician Name:_____

Diagnosing Physician Email:_____ Phone:_____

Diagnosing Medical Facility:_____

Street Address:_____

City:_____ State: _____ Zip Code:_____

Phone: (_____)_____-_____

Part 2 (If information is the same as above write "same" on the 1st line for name.)

Treating Physician Name:_____

Treating Physician Email:_____ Phone:_____

Treating Medical Facility:_____

Street Address:_____

City:_____ State: _____ Zip Code:_____

Phone: (_____)_____-_____

☒ I confirm that I am the parent/legal guardian of (name of child) _____.
I also confirm I reside with and am the primary caregiver for the above named child. As a result of my child's cancer diagnosis I am experiencing a financial hardship.

☐ Copies of bills needed to be paid are included. If bills cannot be provided and financial assistance from The Brooke Healey Foundation will be used for upcoming treatments, travel, lodging or other related items required for the care of the diagnosed child they are listed here:

_____
_____
_____
_____

I ☐ **authorize** ☐ **do not authorize** The Brooke Healey Foundation and its representatives to use my child's name, diagnosis, photographs, video recordings, my name and my child's story to inform its supporters, the media and the general public about The Brooke Healey Foundation and its programs, events, fundraising and services. These materials may be used in but not limited to promotional materials, social media posts, newsletters/emails and the organizations web site. If authorized above, I, for myself and my child release all claims against The Brooke Healey Foundation its representatives and volunteers with respect to copyright ownership and publication, including any claim for compensation related to the use of these materials. Authorization or non-authorization of the above mentioned is <u>not a qualifying criteria</u> to receive financial assistance.

How did you hear about us? _____

My signature below indicates:

- My authorization for The Brooke Healey Foundation and its representatives to contact the above named medical institution and physician to confirm my child's cancer diagnosis and date of diagnosis.
- My authorization for the above named medical institution and physician to release to The Brooke Healey Foundation and its representatives my child's Diagnosis, Date of Diagnosis and current treatment (if applicable) in order for The Brooke Healey Foundation to complete its application review and verify a cancer diagnosis.
- That I attest that the information in this application is true and accurate to the best of my knowledge. I acknowledge that The Brooke Healey Foundation will pursue and is entitled to restitution for any and all financial assistance released to me from The Brooke Healey Foundation if it is determined that this application contains false information.

_____ _____

Print Name of Applicant

Signature of Applicant

_____

Date