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

The Brooke Healey Foundation builds awareness and raises funds for research in Diffuse Intrinsic Pontine Glioma (DIPG); helps families dealing with pediatric cancers, especially brain cancers and DIPG; fosters community relationships and promotes involvement through scholarships awarded to civically active students.

Request for Family Assistance

Eligibility:

- Parent/Guardian of a child residing in the United States who has been diagnosed with, and is currently battling, brain (or spinal cord) cancer; OR parent/guardian of a child residing in the state of New Jersey who has been diagnosed with, and is currently battling, any form of cancer.
- Parent/Guardian is experiencing financial hardship because of child's diagnosis.
- Parent/Guardian resides with diagnosed child.
- Parent/Guardian and child are primary residents of the United States.
- If applicable: Parent/Guardian and child are primary residents of the state of New Jersey.
- Parent/Guardian has not received assistance from The Brooke Healey Foundation within 18 months of application date for diagnosed child.
- Diagnosed child is under the age of 18.

What to include:

- Copy of child's birth certificate.
- Letter from treating physician, including diagnosis and indication that child is currently under their care.
- 2nd and 3rd page of this application filled out in its entirety.
- Copy of bill/s or itemized expenses you are requesting assistance to be paid. (Assistance typically comes in the form of a check made out, and sent directly, to bill collectors.)

How to submit application and included paperwork:

- 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 Full Name/s:____

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 journey? ☐Yes ☐No If yes please provide info:____

Patient Information:

Child Full Name:____

Child 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: (___)_________-_____________

How did you hear about The Brooke Healey Foundation? ____

Change of income post-diagnosis, if any: ____

Additional assistance provided from other sources post-diagnosis, if any: ______________________________

____

☐ Copies of bills needed to be paid are included **OR**

☐ Copies of bills cannot be provided; financial assistance is being requested for upcoming treatments, travel, lodging or other related items required for the care of the diagnosed child and are listed here:

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I ☐**authorize** ☐**do not authorize** The Brooke Healey Foundation 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 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 organization's website. If authorized above, I- for myself and my child- release all claims against The Brooke Healey Foundation, its representatives and its 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 not qualifying criteria to receive financial assistance.)

My signature below indicates:

- I am the parent/legal guardian of (name of child) ____
- I reside with, and am the primary caregiver for, the above-named child.
- Both my child and I are primary residents of the United States.
- I give 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.
- I give 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) for The Brooke Healey Foundation to complete its application review and verify a cancer diagnosis.
- 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 all financial assistance released to me if it is determined that this application contains false information.

___________________________________	___________________________________
Print Name of Applicant	Signature of Applicant

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Date