The Mya Lin Terry Foundation
Post Office Box 249
Oakhurst, NJ 07755
732-517-0697 ph

GRANT APPLICATION

If you are a current or recent resident of New Jersey, diagnosed with pediatric cancer within the past 24 months, please send completed grant application via hard copy mail or via scan and email to kellylynnterry@msn.com. Note: All information submitted is deemed strictly confidential but subject to release in limited capacity if grant is approved and in accordance with signed consent.

PROCESSING:

- Application must be completed in total and include all supporting documents as identified on page 4.
- Please allow 3-4 weeks for receipt, review, and processing. If approved, payment shall follow shortly thereafter.
- A confirmation will be sent with any and all declinations with cause and/or notification of grant payment.
- Please make sure the consent form is reviewed and signed. No processing can occur until then.
- If you are requesting assistance for a specific bill, then the invoice must be included or the application will be denied.

Date: _____

PLEASE CHECK ONE: INITIAL APPLICATION: ☐ SUPPLEMENTAL APPLICATION: ☐

PATIENT INFORMATION:

First Name: _____ Last Name: _____

Street Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Website/CaringBridge/Facebook/GoFundMeSite: _____

DOB: _____ Male/Female (please circle one)

SIBLING(S) and AGES: _____

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PARENT(s) INFORMATION:

Mother's First Name: _____ Mother's Last Name: _____

Street Address (if different):_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Father's First Name: _____ Father's Last Name: _____

Street Address (if different):_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

MEDICAL INFORMATION:

Diagnosis: _____ Date of Diagnosis: _____

Currently Undergoing Active Treatment: Yes/No (please circle one)

Date of Last Active Treatment: _____

Doctor Name: _____ Primary Hospital: _____

Alternate Hospital: _____

Any additional information you would like to provide: _____

_____

Contact Information of medical/health care provider or social worker:

Name: _____ Hospital/Facility: _____

Phone Number: _____ Email: _____

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CURRENT ISSUES RESULTING IN NEED:

To help understand the big picture, please give a detailed description of daily situation, i.e. job/work, children, living circumstances, family situation, insurance, etc.): _____

_____

_____

_____

AREA(S) IN WHICH HELP IS NEEDED MOST

Please include financial amounts being as specific as possible with prioritization of your needs such as transportation, prescription/medical, utilities, rent, child care, food, etc. If a bill needs to be paid directly, please include a copy of the invoice.

ASSISTANCE REQUESTED *(e.g. electric bill, rent, family trip – please prioritize your list)*	**COST** *(e.g. $150.00)*	**PAYEE/VENDOR** *(e.g. JCP&L)*	**INVOICE INCLUDED** *(yes/no)*

Please disclose any other resources or assistance applied for/received/or receiving:

Organization Name: _____ Date(s) Received: _____

Contact Name Phone Number: _____ Email: _____

Organization Name: _____ Date(s) Received: _____

Contact Name Phone Number: _____ Email: _____

Organization Name: _____ Date (s) Received: _____

Contact Name Phone Number: _____ Email: _____

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ACKNOWLEDGEMENT

In the event that I _____(parent name), parent of _____ (patient name), residing at _____ (address) am awarded a grant from TMLTF, I certify, promise, and affirm that the information is true to the best of my knowledge, AND I will utilize such grant for the specified intended purposes provided in the grant application and for no other purpose. I understand that this promise is a material condition of being awarded a grant by TMLTF.

We hereby consent to the sharing of my info with TMLTF Sister Charities: Yes _____ No _____ (initial)

Signature: _____ Date: _____

Signed by (please print) _____

This Grant Application must be filled out completely, signed, and dated. Did you remember to include: signed and dated Grant Application; signed and dated doctor's note with diagnosis; invoices and the signed, Photo and dated Consent Form?

FOR OFFICIAL AND INTERNAL PROCESSING ONLY, APPLICANTS ARE NOT TO ANNOTATE:

Signed and dated Grant Application	_____ (Date Received)
Signed and dated doctor's note, w/diagnosis	_____ (Date Received)
Invoices	_____ (Date Received)
Signed and dated Consent Form	_____ (Date Received)
Image	_____ (Date Received)
Received By: _____ (signed)	

Received By: _____ (printed Trustee Name)