The James Lloyd Murphy Foundation

For Families Impacted By Brain Tumors

The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors

Financial Assistance Program Application

The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors builds awareness and supports brain tumor patients and their families by awarding grants to help with expenses that are beyond their means. Our goal is to ease some of the financial burden that often adds to the stress of a brain tumor diagnosis and treatment. This allows patients and their caregivers to focus, with less distraction, on treatment and quality time with loved ones.

Who is eligible?

To be considered for the James Lloyd Murphy Foundation Financial Assistance Program, the patient must:

- Be diagnosed with a brain tumor
- Reside in the United States
- Not have received assistance from The James Lloyd Murphy Foundation within the last year.

What is the amount given to a qualified applicant?

The amount awarded depends upon the number of applications received by The James Lloyd Murphy Foundation and the current available funds. Financial assistance grants are awarded on a first-come, first-served basis to the extent funding remains available.

What type of bills can be covered?

Bills that the program commonly cover include the following: rent/mortgage, utility, auto/home insurance, auto payments and childcare (licensed daycares only). The program does not cover credit card bills. It also does not cover expenses without a bill, such as groceries or gasoline.

Any expense submitted for consideration must have supporting documentation.

What is needed to apply?

To be considered, applicants must complete and submit **ALL** of the following items.

- Completed application form
- Medical provider form-the patient's medical provider must complete this form.
- Proof of household income (in PDF format if applying online).
    - Two months of bank statements.
    - Three months of pay stubs, unemployment checks, social security, or public assistance.
    - Copies of bills (in PDF format if applying online).

  Copies of up to two current bills the patient requests to be paid. The account number and the vendor's name and mailing address must be included. Bills must be recent (issued within the last 60 days).

  - If the patient requests help with rent, a signed copy of the rental lease that includes the patient's name, amount of rent, account number, landlord or property manager's name, and mailing address where payments are made must be submitted.

How do I submit the application?

Please complete this application by filling out this form electronically or printing it and filling it out. If submitting this via email; please attach all documents as instructed on the form and email them to Jlmurphyfoundation@outlook.com.

If you are mailing an application, please include all documents listed in the form and mail them to:

The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors
P.O. Box 82
Portage IN 46368

When are grants awarded?

Applications must be received in their entirety no later than the 15th to be considered for that month (except December, when the deadline for receiving everything is the 5th). Submitting a completed application by the deadline does not guarantee that an applicant will receive a grant. Grants are awarded based upon the number of grant applications received by The James Lloyd Murphy Foundation and the current available grant funds.

The James Lloyd Murphy Foundation will send the applicant an email when the applicant's application is received and let that person know if they need more information. The applicant is encouraged to add jlmurphyfoundation@outlook.com to their contact list. Adding The James Lloyd Murphy Foundation email address to a contact list will help ensure that our communication does not end up in a junk mail folder, preventing the application from moving forward in the review process.

Have any other questions? Contact The James Lloyd Murphy Foundation at jlmurphyfoundation@outlook.com or call (219)331-6810.

Patient Information:

- Full legal name_____
- Phone number_____
- Email address_____
- Street address_____
- City_____
- State_____
- Zipcode_____
- Date of birth_____

- Gender

  _____Male
  _____Female
  _____Non-binary
  _____Prefer to self-identify

- The patient's tumor type_____

  Which best describes where the patient is in their treatment? (check all that apply)
  _____Newly diagnosed
  _____Exploring treatment options
  _____In treatment
  _____Watch & Wait
  _____Survivorship

_____Hospice/End of life care

- How did the patient learn about The James Lloyd Murphy Financial Assistance Program?
  _____Family/Friend
  _____Online search
  _____Referral-Healthcare professional
  _____Social media
  _____Support group

Emergency Contact Information

- Emergency contact's full name_____
- Emergency contact relationship to patient_____
- Phone number_____
- Email address_____
- Street address_____
- City_____
- State_____
- Zipcode_____

Please complete this section if the patient is a minor (age 0-17)

- Name of parent of guardian #1_____
- Phone number_____
- Email address_____
- Street address_____
- City_____
- State_____
- Zipcode_____

- Name of parent or guardian #2_____
- Phone number_____
- Email address_____
- Street address (if different than above) _____
- City_____
- State_____
- Zipcode_____

Financial Information

Income sources for all non-dependent household members

- Monthly salaries (gross): _____
- Monthly pensions: _____
- Monthly Social Security Income (SSI) : _____
- Monthly Social Security Disability Insurance (SSDI): _____
- Monthly unemployment: _____
- Monthly short-term disability: _____
- Monthly long-term disability: _____
- Monthly Public Assistance: _____
- Monthly financial assistance (e.g., charities, non-profits): _____
- Monthly support from family/friends: _____
- Monthly other income (please specify): _____
- This year's total expected gross income for everyone living in the household: _____

Household account balances (as of date of application) – Please complete this for all non-dependent household members.

- Total checking account balances: _____
- Total saving account balances: _____
- Total investment (e.g., stocks, bonds, mutual funds) account balances: _____
- Total account balances (add total balances from above): _____

Monthly household expenses-please include information for all household members, including dependents.

- Monthly rent or mortgage (including HOA fees, taxes, homeowner's insurance if applicable): _____
- Total monthly utility bills: _____
- Total monthly automobile payment: _____
- Total monthly health insurance cost: _____
- Total other insurance cost: _____
- Other monthly expenses: _____
- Total monthly expenses (add total expenses from above): _____

Current household debt (as of date of application)-Please complete this for all non-dependent household members:

- Current total loan balances: _____
- Current total medical bills: _____
- Other expenses/debts: _____
- Total current debt (list total debt balances from above) :_____

Top expenses/bills

Please list up to two bills, in order of priority, that the patient would like the grant to pay for:

1.

2.

Signature

By signing below, I attest that the information contained in this application is true and accurate. I also agree to the terms of the James Lloyd Murphy Foundation for Families Impacted by Brain Tumors financial assistance program as listed above and stated by representatives of the James Lloyd Murphy Foundation for Families Impacted by Brain Tumors. I also understand that my application will not be considered unless it is fully completed, and all required items/documents have been submitted to The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors. Further, I understand that completing this application does not guarantee that I or my loved one will receive a financial grant. Finally, if awarded a financial assistance grant, I acknowledge that my vendor(s) will be notified that the payment(s) they receive on my behalf will be made possible by The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors financial assistance program.

A signature, either in pen or electronically, is required.

X_____

- Date:_____
- Full name of person completing this application (print or type) :_____
- Relationship to patient*: _____.

* If someone other than the patient, family member, or spouse, or healthcare provider completes this application, we will need a notarized Power of Attorney specific to the state the patient resides in to discuss this patient and the grant application.

The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors does not discriminate based on race, color, national origin, age, religion, physical or mental disability, marital status, or sex (including pregnancy, sexual orientation, and gender identity). The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors determines financial needs reasonably and uniformly. Assistance is awarded without regard to the patient's provider, treatment, products, or insurer. Those who have donated to the James Lloyd Murphy Foundation for Families Impacted by Brain Tumors Financial Assistance Program, cannot exert any direct or indirect influence over the fund, fund distribution, or selection of grantees.

If awarded a grant, may we contact you I the future to request a photo and/or a personal statement about your brain tumor experience and financial hardship? This information would be used by The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors to help raise awareness. (please select):

_____ Yes

_____No

James Lloyd Murphy Foundation

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The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors Financial Assistance Program

Medical Provider Form

Your responses will make the applicant eligible for a financial assistance grant. Please complete this form in its entirety. **This form must be filled out by a Physician, Advanced Practice Provider, Registered Nurse, or Licensed Social Worker.**

The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors Assistance Program exists to help ease the financial burden caused by a Brain Tumor diagnosis. The Grant covers certain expenses and/or bills. If awarded a grant, payment will be made to the company the patient has requested to be paid for. Payments are not made payable to the patient or their loved ones.

- Patients name: _____
    - Date of diagnosis: _____
- Tumor type and grade: _____
- Hospital, medical center, or clinic name: _____
- Physician's or Advanced Practice Provider's (e.g., neuro-oncologist) name and credentials (please print): _____
- Provider's street address: _____
- Provider's city: _____
- Provider's state: _____

- Provider's zip code: _____
- Provider's phone number: _____
- Provider's email: _____
- How often does the provider see the patient? _____
- Is the patient employed?

  _____Yes

  _____No
- In the provider's opinion, is the patient able to work at this time?

  _____Yes

  _____No

Full name and credentials of person completing this application (print/type)

- Signature: _____
- Date: _____
- Phone number (if different from above): _____
- Email address (if different from above): _____

If you have any questions, please email jlmurphyfoundation@outlook.com or call 219-331-6810 or 219-771-7380.

All information provided in this form is confidential and used solely to administer a financial assistance grant to the patient identified above. This information will only be used by The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors.

You can email the form back to us at jlmurphyfoundation@outlook.com or you can mail it to:

The James Lloyd Murphy Foundation for Families Impacted by Brain Tumors
P.O. Box 82
Portage IN
46368