THE LOIS MERRILL FOUNDATION
for carcinoid and other rare cancers
www.TheLMF.com

2024 LMF Medical Assistance Grant Criteria and Supplemental Information Requirements

1. Grant applications will be accepted as the schedule indicates below. Applications can be prepared by patients, immediate family members, or primary caretakers of patients suffering from carcinoid or other rare cancers. The Foundation will review grant applications per the schedule posted on our website (www.TheLMF.com) under "How we can Help".

2. **Rare Cancer Qualification:** For the purpose of awarding Medical Assistance Grants, rare cancer will be defined as any cancer that has been classified as a rare cancer by U.S. governmental granting agencies. Examples include but are not limited to the National Institute of Health (NIH), the National Cancer Institute (NCI) or the American Cancer Society (ACS). Preference will be given to patients suffering from carcinoid cancer, as that is our primary focus.

    - *Does my cancer qualify as rare?* Provide us with a detailed description of your cancer type by **June 30, 2024**
    - The LMF will provide you with a determination of eligibility by **August 30, 2024**
    - Qualifying applications are due by **June 30, 2024**

3. **Information to be submitted with this application:** Please submit demonstration of diagnosis with carcinoid or another rare cancer as defined above. This can come in the form of a letter from your current doctor or treatment facility on appropriate letterhead and signed by a physician. Please also provide a photo, that we may use at a later time in our fundraising efforts *(which we will only be done with your written permission, and only using your first name).*

4. **Information to be provided later:** If a Medical Assistance Grant is awarded, additional information will be required by the Foundation prior to payment**.** ***Please do not submit this information now*****.** It will be requested if your grant is approved, and any disbursement of funds will be considered pending until this information is provided to The LMF. Information requested may include, but is not limited to:
    - Patient and/or caregiver's household income tax return for the prior year. The Foundation may consider the annual household income relative to the U.S. government's poverty standards as part of the determination of financial need. Any additional supplemental information you determine might be useful may also be provided.
    - Copies of all bills to be paid by the Medical Assistance Grant. These can be household bills or medical bills depending on your specific situation. The Foundation will make all payments directly to the provider/vendor.
    - Verification of debt outlined in this application.
    - Documentation of household expenses outlined in this application.

Grant Submission & Review Schedule:

FINAL APPLICATION DEADLINE	**JUNE 30, 2024**
Application review	July 2024
Notification of awards	August 2024

Please send application and required information to the Lois Merrill Foundation at info@theloismerrillfoundation.org or info@TheLMF.com

Medical Assistance Grant Application

Please type or clearly print the information below. In addition to the application, please provide the demonstration of carcinoid or another rare cancer diagnosis, as outlined above (Item #3 on page 1). Please note that incomplete applications may not be considered.

Due to the large number of applicants, we are currently unable to review grant needs outside the timeframes specified on page 1 of this application. Thank you for your understanding.

DATE OF APPLICATION: _____

PATIENT NAME: _____

APPLICANT INFORMATION (If filling out on behalf of patient. If patient is completing application, please skip to the below section):

Applicant Name: _____ Relation to Patient: _____

Phone Number: _____ Email Address: _____

Mailing Address: _____

City, State, Zip Code: _____

How did you hear about the Lois Merrill Foundation's Grant Program? _____

PATIENT INFORMATION:

Patient's Name: _____ Patient's Age: _____

Patient's Birth date: _____ Phone Number: _____

Email Address: _____ Confirm Email Address: _____

Mailing Address: _____

City, State, Zip Code: _____

How did you hear about the Lois Merrill Foundation's Grant Program? _____

Has patient applied previously for a grant from The Lois Merrill Foundation? _____

If answered yes to above, please provide the following information:

Date applied: _____ Dollar Value of Award Granted: $_____

Date applied: _____ Dollar Value of Award Granted: $_____

HOUSEHOLD INFORMATION:

Please list patient's spouse and any dependents, including age and relation (use the **Additional Notes** section on page 7 of this application if more room is needed). For the purpose of this application, dependents may only include spouses, children under the age of 18 and children in college:

NAME	RELATION TO PATIENT	AGE / Full-Time Student?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DIAGNOSIS INFORMATION:

Patient's type of Cancer: _____

Note: provide letter from physician/treatment facility as described in Item #3 on page 1 of this application.
Confirm letter is included by marking here with X: ____

Diagnosing physician name: _____ Diagnosis Date: _____

Diagnosing physician's office number: _____ City, State of office:_____

Current physician or medical provider (if different than above): _____

Current physician's office number: _____ City, State of office:_____

GRANT AMOUNT REQUESTED:

Total Grant Amount Requested: $_____

Provide a list of expenses to be paid by Medical Assistance Grant (if grant is awarded, copies of bills will be required prior to payment). ***Please do not attach bills at this time and do not reference attachments.***

Item/bill type	Amount	Provider
1._____	$_____	a._____
2._____	$_____	b._____
3._____	$_____	c._____
4._____	$_____	d._____

***Completion of this page is CRITICAL to our ability to evaluate your application**, please email us with any questions you may have, but please complete all lines.*

INCOME INFORMATION:

2024: Expected household gross (1) annual income for 2024 $_____

2023: Patient's annual household income for 2023 - this information should match your tax return for 2023.

Gross Income (1) $_____

Adjusted Gross Income per tax return (2) $_____

(1) Gross Income is defined as the income earned for the household BEFORE taxes are taken out. This includes income from all jobs, unemployment, social security and other fixed income sources. Do NOT deduct the cost of ANY living or medical expenses from your Gross Income.

(2) Adjusted Gross Income is defined as your adjusted gross income as shown on your tax return records. This number MUST match patient's tax returns otherwise applicant's grant may be delayed or disqualified.

If there is a change in expected annual income from the prior year please provide an explanation for the changes below:

_____

_____

_____

Patient's source of income (patient's job, social security, disability, unemployment, or if other or none, please explain):

_____

_____

_____

Other household source of income (spouse, caregiver, adult children). For example a job, social security, disability, unemployment, or if other or none, please explain:

_____

_____

_____

***Completion of this page is CRITICAL to our ability to evaluate your application**, please email us with any questions you may have, but please complete all lines.*

HOUSEHOLD EXPENSE INFORMATION:

Living Expense**:**

Does Patient own home or rent? _____

Monthly Rent (if applicable): $_____/month

Mortgage Balance (if applicable): $_____ Mortgage Payment: $_____/month

Monthly HOA Dues* (if applicable): $_____/month

Property Taxes (if applicable): $_____/year

**HOA dues are Home Owner Association Dues payable to a legally created Home Owner Association.*

Does patient own any other real estate? _____

If yes, please list other real estate assets and indicate approximate value:

_____

_____

Car Expenses:

Car #1: _____ Payment $_____/month

Car #2: _____ Payment $_____/month

Car Insurance Costs: $_____/year $_____/month

Insurance Expense:

Monthly Medical Insurance Premium $_____/month

Annual Deductible for Patient's Insurance $_____/year (patient only)

Insurance provider: _____

Insurance Source: _____

Is payment of insurance through an employer or directly deducted from paycheck? Yes or No: ____

If no, please confirm how you make monthly insurance premiums (Social Security, Disability, patient's job, spouses' job, or if other please explain)

_____

_____

Other significant household expense: Please list any other significant monthly household expenses

_____

_____

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TOTAL DEBT:

Outstanding Non-Medical Debt $_____ *

Outstanding Medical Debt + $_____ **

Total Outstanding Household Debt = $_____ ***

*This number should be the total non-medical debt accumulated by the household. This number should not include any medical debt from the patient applicant. It should include all household-related debt (i.e. credit cards, unpaid utility bills, past due taxes, etc) and medical debt associated with other members of the household (only include children under the age of 18).

****This number should be the total debt accumulated as a result of ONLY the patient's MEDICAL care**. This number should NOT include any other household-related debt (i.e. credit cards, unpaid utility bills, past due taxes, etc) nor should it include medical debt associated with any other members of the household.

*****This number should be the sum of the two numbers above.

A note from The Lois Merrill Foundation:

To all applicants, please know that you are in the thoughts of everyone at the LMF, and that we wish you and/or your loved ones the best possible care and outcomes. We only wish we could help each and every one of you, but as our requests outnumber our financial abilities, we are grateful to our donors that we are at least able to help some of you at this time.

Please use the following pages for any additional notes relevant to your application.

ADDITIONAL NOTES RELEVANT TO APPLICATION FOR LMF COMMITTEE CONSIDERATION: