THOMAS MATTHEW
MILOSCIA FOUNDATION
BE A BRIGHT
SPOT

Application to Request

Financial Assistance

We Hope to be Your Bright Spot

PO Box 91 • Port Jefferson, NY 11777 • www.thomasmiloscia.com • 631-743-9555 • info@thomasmiloscia.com

Thomas Matthew Miloscia Foundations, Inc.'s Guidelines for Financial Assistance

PLEASE READ CAREFULLY

The Thomas Matthew Miloscia Foundation, Inc. is a registered 501(c)(3) charity aiming to provide financial assistance to cancer patients between the ages of 13 and 39 to pay for some expenses resulting from cancer such as but not limited to travel, lodging, food, monthly household expenses and child-care. We hope to be a bright spot to patients with cancer and their families.

Guidelines and Qualifications

To be considered for financial assistance:

1. Patient must be between the age of 13 and 39
2. Patient must be currently receiving treatment for cancer or have finished treatment within the last six months.
3. Patient must reside or be receiving treatment on Long Island, New York.
4. Patient or family must have an adjusted gross income of up to four or five times the poverty level.
5. Patient must be a U.S. citizen or a legal permanent resident of the United States.
6. All sections of the application must be accurately completed. INCOMPLETE OR UNTRUTHFUL APPLICATIONS ARE GROUNDS FOR DENIAL OR TERMINATION OF ASSISTANCE.

Please note the maximum allowable benefit is $1,000/patient per calendar year.

*****ONLY COMPLETE APPLICATIONS WILL BE CONSIDERED FOR REVIEW*****

When application is fully completed and signed, please mail all documents to:

Thomas Matthew Miloscia Foundation, Inc.
P.O. Box 91
Port Jefferson, NY 11777

Contact us if you have any questions at info@thomasmiloscia.com or 631-743-9555.

Patient Information

Please PRINT and complete all sections accurately and clearly

Patient Name____ ☐ Male ☐ Female

Permanent Address____

City______________________________________State__________________Zip Code____________

Phone_______________________________________Email_______________________________________

Temporary Address (i.e. during treatment- please specify)__________________________________

____

City______________________________________State__________________Zip Code____________

Temporary or Additional Phone (i.e. Cell Phone)____

Place of Birth (City/State/Country)____

Date of Birth_________________________

Current Working Status: ☐ Full Time ☐ Part Time ☐ Unemployed

Employer______________________________Monthly Salary (Gross)_________________________

Address____

City______________________________________State__________________Zip Code_____________

Phone_____________________________________Email____

Other Monthly Income Source_____________________________Amount____________________

Number of people living in residence with patient____

Relationship_________________________________Age_______________ ☐ Male ☐ Female

Relationship_________________________________Age_______________ ☐ Male ☐ Female

Relationship_________________________________Age_______________ ☐ Male ☐ Female

Relationship_________________________________Age_______________ ☐ Male ☐ Female

Relationship_________________________________Age_______________ ☐ Male ☐ Female

Relationship_________________________________Age_______________ ☐ Male ☐ Female

Relationship_________________________________Age_______________ ☐ Male ☐ Female

Parent/Guardian Information

If Patient is covered by Parent/Guardian Insurance

Father___________________________________

Address___________________________________

City________________State______Zip ________

Current Working Status:

☐ Full Time ☐ Part Time ☐ Unemployed

Employer_________________________________

Monthly Salary (Gross)______________________

Address___________________________________

City________________State______Zip ________

Phone______________Email _________________

Other Income Source/Amount_______________

Do you own your residence? ☐ Own ☐ Rent

Mother___________________________________

Address___________________________________

City________________State______Zip ________

Current Working Status:

☐ Full Time ☐ Part Time ☐ Unemployed

Employer_________________________________

Monthly Salary (Gross)______________________

Address___________________________________

City________________State______Zip ________

Phone______________Email _________________

Other Income Source/Amount_______________

Do you own your residence? ☐ Own ☐ Rent

Marital Status of Parents: ☐ Single ☐ Married ☐ Separated ☐ Divorced

If Separated or Divorced, who has custody?____

Expenses

List largest expenses first

<u>Expense</u>	**<u>Amount</u>**
______________________________________	___________________________________
______________________________________	___________________________________
______________________________________	___________________________________
______________________________________	___________________________________
______________________________________	___________________________________
______________________________________	___________________________________

Medical Information

Diagnosis____Date of Diagnosis______________

Treatment patient is undergoing____

____

Name of Hospital or Treatment Center____

Address____

City_______________________________________State___________________Zip Code_________

Name of Social Worker____Phone_____________

Name of Physician____Phone____________

Additional Information____

Insurance Information

Is patient covered by an insurance plan or Medicaid? ☐ Yes ☐ No

Medical benefit plan name____

Address____

City_______________________________________State___________________Zip Code_________

Phone___________________________________ Policy Holder______________________________

Name of Secondary Insurance____

Address____

City_______________________________________State___________________Zip Code_________

Phone___________________________________ Policy Holder______________________________

****IF SEEKING HELP WITH CO-PAYS AND/OR DEDUCTIBES, PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD/S WITH YOUR RETURNED APPLICATION****

Financial Assistance Information

Has money been raised on behalf of the patient? ☐ Yes ☐ No

If yes, please describe____

____

Do you receive government assistance? ☐ Yes ☐ No

If yes, please describe____

____

Have your applied or received assistance from another organizations? Please complete:

Name of Organization______________________________Contact Name______________________

Address____

City______________________________________State________________Zip Code______________

Amount Received___________________________Date Received______________________________

Name of Organization______________________________Contact Name______________________

Address____

City______________________________________State________________Zip Code______________

Amount Received___________________________Date Received______________________________

Name of Organization______________________________Contact Name______________________

Address____

City______________________________________State________________Zip Code______________

Amount Received___________________________Date Received______________________________

How Did You Hear About The Thomas Matthew Miloscia Foundation

☐ Hospital ☐ Social Worker ☐ Relative or Friend ☐ Other

Name____

Address_______________________________ City, State Zip_____________________

Phone_________________________________ Email__________________________

Request for Assistance

Please be aware that The Thomas Matthew Miloscia Foundation, Inc. does not provide checks directly to the patient or approved beneficiaries. The Thomas Matthew Miloscia Foundation pays bills directly. This will require the patient to send bills to our Port Jefferson address.

Please Check Assistance Requested

☐ Medical Insurance Premiums Monthly Disbursement_________________

☐ Transportation other than car Monthly Disbursement_________________

☐ Lodging Monthly Disbursement_________________

☐ Food Monthly Disbursement_________________

☐ Rent or Mortgage Monthly Disbursement_________________

☐ Medicine/Prescriptions Monthly Disbursement_________________

☐ Vehicle Transportation Monthly Disbursement_________________

☐ Utilities Monthly Disbursement_________________

☐ Other Monthly Disbursement_________________

Please Describe____

____

____

Affirmation

To be completed by Patient or Parent/Guardian if under 18

I have read the general guidelines for financial assistance herein and fully understand the policies of the Thomas Matthew Miloscia Foundation, Inc. I declare that the information submitted on this application form is true and accurate to the best of my knowledge.

If awarded financial support, I agree to use the funds received from the Thomas Matthew Miloscia Foundation, Inc. towards the specific expenses declared on this application, in direct connection with patient's illness.

All financial applications will be reviewed by the Thomas Matthew Miloscia Foundation, Inc. on a case by case basis and eventual determination will be made based upon other applications submitted and the availability of funds held by the organization.

The Thomas Matthew Miloscia Foundation Inc. reserves the right to deviate from the general guidelines herein when special needs should arise.

Authorized Signatures

Patient____Date________________

Please Print Name____

Mother/Guardian if under 18____________________________________Date________________

Please Print Name____

Father/Guardian if under 18______________________________________Date________________

Please Print Name____

All information disclosed on this form is strictly confidential

Checklist

Please be sure to include a copy of the following documentation with your completed application. If patient is under 18, provide documentation of Parent/Guardian.

☐ Insurance Card/s if requesting assistance with co-pays and/or deductible: Primary and Secondary (if there is a secondary policy)

☐ Proof of income: Acceptable forms; last 2 paychecks, W2, 1040 or 1099

☐ Letter from current Doctor stating diagnosis and date care began

☐ Endorsed HIPPA Form

☐ Acknowledgement of Receipt of Privacy Policy