The McCourt Foundation Financial Assistance Program

The McCourt Foundation is committed to providing financial and emotional assistance to the broad community of Alzheimer, MS, ALS and Parkinson's patients and families. We aim to serve as many patients as possible, continually growing our giving to meet the immeasurable need. The McCourt Foundation Financial Assistance Program provides grants to these families in need.

Guidelines

All candidates must provide verification of a diagnosis, and documentation of financial need. We serve patients throughout New England.

The McCourt Foundation's financial assistance is designed to help families cover expenses incurred due to these diseases. For example: redoing a bathroom to make it handicapped accessible, in-home health care, a ramp to make a home accessible, outside day care needs and other similar expenses. All grant monies are mailed to the patients with checks written directly to the service providers. The Financial Assistance Program does not help with the cost of medical expenses or credit card bills. The program does not pay money directly to applicants or family members. You may only receive one award in a twelve month period.

To Apply

Applications must be submitted directly to The McCourt Foundation via fax or email.

ONLY COMPLETED APPLICATIONS WILL BE REVIEWED.

We, at the Foundation, know firsthand how challenging these diseases can be – for both patients and their caregivers. We hope to provide comfort and financial support at a time when patients and families need it the most.

FINANCIAL ASSISTANCE GUIDELINES AND APPLICATION

Financial Assistance

The McCourt Foundation provides financial assistance to patients and their families battling Alzheimer's and Multiple Sclerosis. Applicants are required to provide verification of diagnosis and active treatment as well as documentation supporting their need for financial assistance. Patients must work with their physician when completing the application. Applications must be submitted directly to The McCourt Foundation via fax or email.

Financial Assistance Grants are designed to assist with daily living expenses such as:

- ✓ Rent
- ✓ Electricity
- ✓ Heat (Gas/Oil)
- ✓ Home Assistance
- ✓ Other expenses i.e. remodeling to help mobility (ramps, bathrooms, bedrooms, van, wheelchair)

Monetary awards of up to $2,500 are available, but not guaranteed of full funding. All Financial Assistance monies are mailed to the patient with checks made payable directly to the service providers. Each individual or family may only receive one award in a twelve month period.

Applicants will be notified of awards by e-mail. Review of a complete application generally takes up to six weeks. Financial assistance is awarded annually. A submitted application is not a guarantee of receiving financial assistance. Funds are limited, and based on eligibility and availability. All information will be held strictly confidential. We are unable to process incomplete applications.

Applications

To request an application, return a *completed* application, or to get more information:

Mail:	The McCourt Foundation 100 Grandview Road Suite 212 Braintree, MA 02184 Attn: Financial Assistance Program
Fax:	781-817-6271
Email:	grants@mccourtfoundation.org
Web:	www.mccourtfoundation.org

The McCourt Foundation Financial Assistance Program welcomes applications from, and financial assistance will be awarded to, candidates actively being treated for these diseases (AZ, MS, ALS and PD) who live in New England.

The McCourt Foundation is a registered 501(c)(3) non-profit organization based in the Commonwealth of Massachusetts.

Confidentiality and Privacy

The McCourt Foundation respects your privacy. Any medical, financial, family or other private information submitted by applicants will be kept confidential by the Foundation and will be used only to evaluate the applicant's eligibility for financial assistance. No medical information sent by a physician or healthcare provider will be reviewed by the Foundation and no communications regarding medical information will take place between a physician or healthcare provider and a representative of the Foundation unless the medical information release form has been signed by the patient or the patient's guardian and received by the Foundation.

FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION: (*please print clearly)*

Date: _____

Name: _____
First **M.I.** **Last**

Date of Birth: _____ **Age:** _____ □ **Male** □ **Female**

Marital Status: _____

Email Address: _____

Street Address: _____ **Apt/Suite #:** _____

City: _____ **State:** _____ **Zip code:** _____

Phone Numbers: **Home:** _____ **Cell:** _____

If patient is a minor, younger than 18, name of parent or legal guardian: _____

How did you hear about the McCourt Foundation Financial Assistance Program?

_____

Briefly explain your circumstances/case, including diagnosis and current issues resulting in financial aid:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ASSISTANCE REQUESTED:

_____

(Patient's Name)

The McCourt Foundation provides financial assistance up to $2,500.00.

Bills considered for payment are mortgage, rent, electricity, gas, oil, telephone, cable or other similar expenses. We do not pay medical bills or credit card bills. All Financial Assistance checks are mailed to the patient, with the checks written directly to the service provider. The McCourt Foundation does not pay money directly to applicants or family members.

Please list your specific requests for financial assistance in order of priority to you.

Priority	Request	Amount Requested	Company to Pay (Name & Address of Addressee)	Account Number	Invoice included?
Example	Electricity	$220.75	National Grid, PO Box 10, Springfield, MA 11111	#123456789	Yes
1.					
2.					
3.					
4.					
5.					

Special Instructions: _____

- Please continue to pay your bills, while your application is being reviewed, until you hear from us.
- For all requests, PLEASE ATTACH COPIES OF BILLS (do not send originals)
    - Bills must include:
        - Name & address of account holder (must be patient or member of household)
        - Account Number
        - Name and payment address of provider company
        - Current due date
        - Amount Due
        - If requesting RENT assistance, a copy of the first page of the lease or a letter from the landlord is required.
        - Applications will not be reviewed without copies of bills.

____ I have attached copies of the bills I would like The McCourt Foundation to consider for assistance.

HOUSEHOLD INFORMATION:

Please list all of the people in your household.
Number of people in household: _____

Name	Date of Birth	Age	Relationship with Patient	Employment Status
			Patient	

Employment status before diagnosis?
□ **Full time** □ **Part time** □ **Self Employed** □ **Child/Student**
□ **Unemployed** □ **Retired**

Employment status AFTER diagnosis?
□ **Full time** □ **Part time** □ **Self Employed** □ **Child/Student** □ **Retired**
□ **Disability** □ **Sick Leave**

Your present or most recent employer: _____

Date you last worked (if currently not employed): _____

Length of employment? _____Position Held: _____

Have you been able to return to work? _____ If not, do you expect to be able to return to work?: _____

INCOME VERIFICATION:

MONTHLY FAMILY INCOME SOURCES (please check all that apply):

	Patient	All Other Household members
o Salary	$	$
o Social Security (retirement)	$	$
o Pension	$	$
o Unemployment	$	$
o Child Support / Alimony	$	$
o Public Assistance, Housing vouchers, or Food Stamps	$	$
o Disability (Long or Short Term)	$	$
o SSD or SSI (Disability)	$	$
o Family / Friends provided support	$	$
o Other (please specify)	$	$
Total Monthly Income	**$**	**$**

_____ I have attached copies of my income sources (most recent award letter, benefit statement, checks, or pay stubs). You must submit copies to verify your total monthly income. Applications will not be reviewed without copies.

Have you applied to other agencies for assistance? □ No □ Yes

If yes, which ones?: _____

We strongly encourage you to seek assistance from any and all resources. Assistance from other agencies does not affect eligibility with TMF.

PATIENT VERIFICATION AND RELEASE

I declare that all information that I have submitted with this application is true and correct to the best of my knowledge. I understand that The McCourt Foundation will review and evaluate this information in connection with my request for financial assistance, and I fully and knowingly waive and release The McCourt Foundation, and its employees, representatives, advisors, partners, directors and agents, from any claims or liability associated, in any way, with the application process, the review of my application materials, or the award of financial assistance. I understand and acknowledge that The McCourt Foundation does not promise or guarantee that I will receive the requested assistance.

Patient Signature: Date:

_____ _____

(*if patient is a minor – under 18 years old – then parent or legal guardian)*

NOTE: No applications will be accepted without a signature!

MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ Age: _____

Address: _____

Describe any treatments you have received for your disease (for example surgery, physical therapy, etc): _

_____

_____

_____

Physician Name: _____

Hospital or Medical Facility Associated with: _____

Address: _____

Phone #: _____ Fax #: _____

PHYSICIAN CERTICATION STATEMENT – TO BE COMPLETED BY PHYSICIAN (NOTE: MEDICAL INFORMATION RELEASE FORM MUST BE SIGNED AND RETURNED TO THE FOUNDATION BEFORE THIS FORM CAN BE COMPLETED):

Patient's Diagnosis: _____

Date of Diagnosis: _____

How long have you been treating the patient?: _____

Is patient in active treatment? □ No □ Yes If yes, please indicate type of treatment: _____

_____

_____

Please list any additional information: _____

_____

_____

_____

Physician Signature DATE

MEDICAL INFORMATION RELEASE:

I, _____ hereby release _____
(*Patient Name)* *(Physician Name)*

and members of his/her staff to provide a medical certification or to otherwise communicate in writing or via phone with representatives of The McCourt Foundation for the purposes of confirming that I am a patient being treated for

_____.
(*diagnosis).*

_____
PATIENT SIGNATURE DATE

OR

I, _____ hereby release _____
(*Parent/ Guardian name))* *(Physician Name)*

and members of his/her staff to provide a medical certification or to otherwise communicate in writing or via phone with representatives of The McCourt Foundation for the purposes of confirming that my son/daughter _____

_____ is being treated for _____.
(*Patient Name)* (*diagnosis).*

_____
PARENT/GUARDIAN SIGNATURE DATE

Consent Agreement for Photo and Comment Summary

I agree to allow the foundation to use my comments and photos:

1.) Photo of project when completed or if not a project photo of you
2.) Summary of how the assistance will impact your daily living and or will help your family's life.

_____ _____
Signature: Date:

_____
Print Name:

_____ _____
Parent/Guardian Signature: Date:

_____
Print Name:

Please write a brief summary of what this program means to you and your family:

_____

_____

_____

_____

_____

APPLICATION CHECKLIST

Please make sure to submit and sign a complete application package:

1. **Financial Assistance Application** □
    a. **Patient Information** □
    b. **Assistance Requested** □
    c. **Household Information** □
    d. **Income Verification** □

2. **Patient Verification and Release** □

3. **Medical Information Form** □

4. **Physician Certification Statement** □

5. **Medical Information Release** □

6. **Photo and Consent Agreement** □