THE MARY BETH BENISON FOUNDATION

MBB Grant Request 2024
EMAIL: mbbgrants@gmail.com

PATIENT INFORMATION: (please print clearly)

First Name: _____ Last Name:_____

Date of Birth: _____ Age: _____ Male Female (circle one) Marital Status: Single Married Divorced Widowed (circle one)

Street Address: _____

City/Town: _____ State: _____ Zip: _____

Phone Numbers: Home (_____)_____ (Cell Phone) _____

Email Address: _____

If patient is a minor (under 18), name of parent or guardian: _____

How did you hear about the Mary Beth Benison Foundation? _____

Briefly explain your circumstances/case, including diagnosis and financial need: (Note: We require medical certification from treating physician. Please have your physician fill out the page of this document entitled Physician's Certification Letter. If you are working with a social worker have the Health Care Professional page complete

_____

_____

_____

_____

_____

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PURPOSE: My request is for assistance with the following expenses:

_____ **Electric/Heat (Gas/Oil)** Amount Requested: _____ Check made payable to:

Account # _____

_____ **Rent/Mortgage** Amount Requested: _____ Check made payable to:

Account # _____

_____ **Medical Bill/ Medical Equipment or Home Health Services not covered by insurance** Amount Requested: _____

Check made payable to: _____ Account #_____

_____ **Other** Amount Requested: _____ Check made payable to:

Explanation: _____

Special Instructions: _____

_____ I have attached copies of the bills I would like the Mary Beth Benison Foundation Inc. to consider for assistance

****Please attach a copy of the bill(s) or invoice for which payment is requested.** The copy must include: the name on the account, account number, a current due date, amount due, and remit to address.**

Mary Beth Benison Foundation * P.O. Box 160, Holden, MA 01520 * 774-275-0240
Email: mbbgrants@gmail.com * www.mbbloves.org

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CERTIFICATION STATEMENT

***** IMPORTANT - If you already have a letter from your physician, you can submit a copy of the letter in place of completing this section****

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip Code: _____

Phone Number: _____Patient's Diagnosis: _____

Date of Diagnosis: _____ Is patient in active treatment? _____

Please list any additional information: _____

_____

Physician Name: _____

Hospital/Medical Facility Name: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____

Physician NPI:_____

I certify that the above listed information is accurate and current.

Physician's Signature:_____

Date: _____

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Social Worker/Health Care Professional Information:

Name: _____

Hospital/Clinic/Organization:_____

Address:_____

City/State/ZipCode: _____

Phone: _____ Email: _____

Referring Professional Signature: _____ Date: _____

Information regarding the qualifying amount for this patient will be sent to you via email.

Medical Information Release:

I, _____hereby release _____
(patient name) (physician name)
and members of his or her staff to communicate via letter or phone with the Mary Beth Benison Foundation Inc. and its representatives for the purposes of confirming that I am a patient being treated for _____ _____.
(diagnosis)
X_____
(signature) (or signature of parent or guardian if minor, under 18) (date)

Agreeing to Share Your Story on our Website and Social Media pages:

The Mary Beth Benison Foundation Inc. is a 501(c)3 non-profit organization. We are a small "grass-roots" organization and we like to keep our supporters up to date with the work the foundation is doing and how we are helping people. When we provide a grant to a patient and their family, we share the grant recipient's story on our social media pages and website. **Please note:** when you submit an MBB Grant Request Form you are agreeing to allow the Mary Beth Benison Foundation Inc. to share your story on our social media pages and website. If you or a family member or caregiver would like to submit your own write up to help us share your story you are welcome to do that. Photographs can be submitted as well. Thank you.

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