Mazzella Family Foundation

Changing Lives One Family at a Time

P.O. Box 537
Katonah, New York, 10536
Phone (914) 000-0000
Web: www.mazzellafamilyfoundation.org

Applicants Seeking Medical Grants

To be eligible for consideration for a Medical Grant from the Foundation, candidates must meet the following criteria:

1. Applicant must have a current medical need that has caused expenses not fully covered by insurance.
2. Applicants must show demonstrated financial need.
3. Applicants must be available for in-person or telephone interviews and must provide a personal reference at the request of the Foundation representatives.
4. Applicants must complete Section B of this application and provide it and all required supporting materials, in a single package, to the address indicated on page 1 of this application.

Item 1. Background Information

____

Last Name First Name Middle Initial

____

Permanent home (or parents') address City State Zip

____

Home (or parents') phone Cell phone

U.S. Social security number, if any: ____

Item 2. Description of Medical Expenses. Please provide a concise and detailed description of the anticipated or incurred medical expenses and **the amount of Medical Grant sought** in 500 words or less. The statement may include your background biological information, a description of the medical procedures or diagnosis, a summary of the basis for the need, and any other relevant information.

Item 3. Financial Data:

1. Please provide evidence of the anticipated or incurred medical expenses relating to the Medical Grant request. Evidence shall be in the form of either (i) a bill or bills; or (ii) a written estimate for the applicant's expected out-of-pocket costs associated with a proposed procedure, which shall be on a medical professional's or insurance provider's letterhead.

2. Please provide a copy of your most recently filed individual income tax return (if filed in the past five years).

3. Please summarize your current financial situation:

Anticipated or Incurred Medical Expenses:

Amount of Medical Expenses ______________________

Anticipated or already incurred? _____________

Do you have insurance? ___________________________

If yes, please explain if insurance will cover a portion of the related expenses:

____

Estimated financial resources

Your earnings ______________________________

Spouse's earnings ______________________________

Parental support ______________________________

Savings ______________________________

Student loans debt _____________________________

Number of children ______________________________

Are you currently employed? ________ Yes ________ No

If yes, how many hours per week? ______________
What is your profession? ______________________

Parents' annual income (if age 26 or under): ____________

Item 4. References. Please list below the names and contact information for at least one and up to three people who may be contacted as references relating to this request:

1 Name ____

Title ____

Institution or Company ____

Address _________________________ Email __________________________

Telephone _________________________

Fax _________________________

Relationship to You ____

2 Name ____

Title ____

Institution or Company ____

Address _________________________ Email __________________________

Telephone _________________________

Fax _________________________

Relationship to You ____
_

3 Name ____________________

Title ____________________

Institution or Company ____________________

Address ____________________ Email ____________________

Telephone ____________________

Fax ____________________

Relationship to You ____________________

Certification

I hereby certify that all the information contained in this application is true, accurate and complete to the best of my knowledge. I hereby authorize the Foundation to verify any information that I have submitted as part of this application and to use that information in evaluating my application.

I hereby certify that I am not an ancestor of, descendant of, spouse of, or spouse of a descendant of, any contributor to the Mazzella Family Foundation or any of the directors or officers of the Mazzella Family Foundation.

I understand that if I use the Medical Grant received for any purpose other than that stated herein, or if any information submitted on this application is found to be untrue, inaccurate or incomplete, I will be subject to forfeiture of the proceeds awarded, and agree to return all such proceeds.

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Signature Date