

The Jennifer Ireland Foundation

Failure to fill out form completely and mail to:

PO Box 124

Blue Springs, Mo 64013-0124

Please email any questions to:

[jenniferirelandfoundation@gmail.com](mailto:jenniferirelandfoundation@gmail.com)

**Please note that failure to complete application in its entirety and enclose the required documentation will significantly delay the application process.**

**Grant Request**

**General Information:**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Sex (circle): Male Female

Address: \_\_\_\_\_ City/State: \_\_\_\_\_

- MUST live in the United States

Zip Code: \_\_\_\_\_

Email (REQUIRED and please ensure legibility): \_\_\_\_\_

All correspondence will be by Email

Marital Status (circle): Single Married Divorced Widowed

List DEPENDENT children (name and age):

- Dependent children defined as under the age of 23
- Verified by review of enclosed copy of current TAX RETURN

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

**Diagnosis Information:**

Cancer Diagnosis: \_\_\_\_\_

- Applicant needs to provide copy of pathology report to confirm diagnosis

Date of Diagnosis: \_\_\_\_\_ Stage of Cancer: \_\_\_\_\_

Attending Physician Name: \_\_\_\_\_

Name of Facility where you are undergoing care: \_\_\_\_\_

Treatment plan: \_\_\_\_\_

- Applicant must either be undergoing active treatment or undergone active treatment for cancer by an established oncologist within the last 12 months

**Financial Information:**

Family household income per year: \$ \_\_\_\_\_

Please list source of income:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Current Checking Account Balance: \$ \_\_\_\_\_

- Please submit most recent statement.

Current Savings Account Balance: \$ \_\_\_\_\_

- Please submit most recent statement

Mortgage or rent (circle) per month: \$ \_\_\_\_\_

Car payment(s): \_\_\_\_\_ Credit Card Debit: \$ \_\_\_\_\_

Loan balances (school, personal, ect):

- \$ \_\_\_\_\_ Loan type: \_\_\_\_\_  
\$ \_\_\_\_\_ Loan type: \_\_\_\_\_  
\$ \_\_\_\_\_ Loan type: \_\_\_\_\_

Outstanding Medical Bills:

\$ \_\_\_\_\_ Doctor or Hospital: \_\_\_\_\_

\$ \_\_\_\_\_ Doctor or Hospital: \_\_\_\_\_

\$ \_\_\_\_\_ Doctor or Hospital: \_\_\_\_\_

Have you lost wages due to diagnosis? (circle) Yes or No

Are you no longer able to work? (circle) Yes or No

If Yes, please explain:

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**Insurance Information:**

Check one of the following:

\_\_\_\_\_ Private Insurance: Name of Insurance: \_\_\_\_\_

Deductible / out of Pocket: \_\_\_\_\_

Has the deductible been met this calendar year? Yes or No

\_\_\_\_\_ No Insurance

\_\_\_\_\_ Medicare. Do you have prescription coverage? Yes or No

\_\_\_\_\_ Medicaid (if you have a spin-down please list amount \$ \_\_\_\_\_)

\_\_\_\_\_ Cobra (\$ \_\_\_\_\_ / per \_\_\_\_\_ )

Please indicate your financial need (medical bills, insurance premiums, household expenses, ect.):

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- Provide copies of the bills that you are in need of paying. This allows us to provide a more rapid response to your financial assistance.
- **Please note that that the average financial assistance given by the foundation is \$1000.00.**
- **The Jennifer Ireland Foundation will pay bills directly.**
- **Patients will be notified through email regarding the decision of their application.**



**The Jennifer Ireland Foundation**

**Release of Information**

**I hereby give The Jennifer Ireland Foundation permission to use my story and photographs taken of me for informational and promotional purposes. I relinquish all rights, title, and interest I may have in the finished pictures and hereby release the Jennifer Ireland foundation of any and all claims or demands for damages of any kind whatsoever arising from the foundations use of said material. I am of legal age and freely sign this release, which I have read and understand.**

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**Name**

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**Signature**

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**Date**