

## **BOARD OF DIRECTORS**

### **CEO**

ANGELA MERRILL

### **CFO**

KRISTINA AUCLAIR

### **SECRETARY**

ATHANASIA D.  
PANOPOULOS, PH.D.  
*THE SALK INSTITUTE*

### **VICE PRESIDENT**

JULIE A. LEWIN, ESQ.

### **DIRECTOR OF MARKETING**

CHRISTOPHER WELCH  
*ASCENT REAL ESTATE*

### **FOUNDING BOARD**

NATHAN AUCLAIR  
*BOSTON FINANCIAL PARTNERS*

JENNIFER BAKER  
*DEL MAR PUBLIC SCHOOLS*

ALEX BEATON  
*SWINERTON BUILDERS*

COLLEEN BORETTO

SANDY BRADY  
*COUNTY OF SAN DIEGO*

MICHAEL CROSBY  
*DESIGN MICHAEL PAUL  
CROSBY*

YOLANDE HAMILTON  
*AT&T*

RICH HONEA

JUDI JORDEN  
*JORDEN INK*

OLIN M. LEWIN, ESQ  
*PREVOLOS & ASSOCIATES*

CAROL LIVINGSTON  
*JACK HENRY & ASSOCIATES*

MARK MERRILL  
*PACIFIC CONSOLIDATED  
EQUITIES*

BRAD MILLER  
*PARSONS BRINKERHOFF*

SARA MILLER  
*NUVASIVE*

LAURA PADILLA

DIANA PEREZ  
*COUNTY OF SAN DIEGO*

JULIE SILVA  
*PLATT COLLEGE*



THE LOIS MERRILL FOUNDATION  
*FOR CARCINOID AND OTHER RARE CANCERS*  
11754 CARMEL CREEK RD  
SAN DIEGO, CA 92130  
INFO@THELMF.ORG

## **Medical Assistance Grant Criteria and Supplemental Information Requirements**

1. Grant applications will be accepted year-round from patients, immediate family members, or primary caretakers of patients suffering from carcinoid or other rare cancers. The Foundation will review grant applications twice annually: November 1 of each year and May 1 of each year, or as deemed necessary or appropriate by the Board of Directors.
2. For the purpose of awarding Medical Assistance Grants, rare cancer will be defined as any cancer that has been classified as a rare cancer by U.S. governmental granting agencies. Examples include but are not limited to the National Institute of Health (NIH), the National Cancer Institute (NCI) or the American Cancer Society (ACS). Preference will be given to patients suffering from carcinoid cancer, as that is our primary focus.
3. **Please submit the following information with the completed application:**
  - Demonstration of diagnosis with carcinoid or another rare cancer as defined above. This can come in the form of a letter from your current doctor or treatment facility on appropriate letterhead and signed by a physician.
4. If a Medical Assistance Grant is awarded, the following information will be required by the Foundation prior to payment:
  - Patient and/or caregiver's household income tax returns for prior 2 years. The Foundation may consider the annual household income relative to the U.S. government's poverty standards as part of the determination of financial need. Provide any additional supplemental information you determine might be useful.
  - Copy of all bills to be paid by Medical Assistance Grant. These can be household bills or medical bills depending on your specific situation. The Foundation prefers to provide payment directly to the provider/vendor. However, we understand that this may not always be possible. If funds must be reimbursed to the patient or caregiver, please provide an explanation as to why the reimbursement is necessary. In this situation, recipient(s) must execute a legally binding contract with The Lois Merrill Foundation, agreeing to spend funds as outlined in the grant approval. Contract will require the recipient to submit receipts for payment as proof of the use of funds. This may take additional time to process.

**Please send application and required information to the Lois Merrill Foundation at [info@theloismerrillfoundation.org](mailto:info@theloismerrillfoundation.org) or [info@TheLMF.com](mailto:info@TheLMF.com)**

*Our Mission: To help people affected by cancer through funding research for new treatments, providing financial support for patients and their families, and promoting awareness and education for carcinoid and other rare cancers. [WWW.THELMF.ORG](http://WWW.THELMF.ORG)*

**Medical Assistance Grant Application**

Please type or clearly print the information below. In addition to the application, please provide the information requested in the "Medical Assistance Grant Criteria and Supplemental Information" form. Submission of an incomplete application will delay your grant review process.

Date of Application: \_\_\_\_\_

Note: grants are reviewed on November 1 and May 1 of each year. Due to the large number of applicants, we are currently unable to review grant needs outside these timeframes. Thank you for your understanding.

APPLICANT INFORMATION: Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

---

How did you hear about The Lois Merrill Foundation's grant program? \_\_\_\_\_

PATIENT INFORMATION: Patient's Name: \_\_\_\_\_

Patient's Birth date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

---

Diagnosis (provide letter from treatment facility as described in Medical Assistance Grant Criteria and Supplemental Information form):

---

Diagnosing physician name: \_\_\_\_\_ Diagnosis Date: \_\_\_\_\_

Diagnosing physician's office number: \_\_\_\_\_

Current physician or medical provider: \_\_\_\_\_

*Our Mission: To help people affected by cancer through funding research for new treatments, providing financial support for patients and their families, and promoting awareness and education for carcinoid and other rare cancers. [WWW.THELMF.ORG](http://WWW.THELMF.ORG)*

The Lois Merrill Foundation  
for carcinoid and other rare cancers

FINANCIAL INFORMATION:

Patient's expected annual household income for current year (Gross Income / Adjusted Gross Income per tax return) \$ \_\_\_\_\_ / \$ \_\_\_\_\_ (A)

Patient's annual household income for prior year (Gross Income / Adjusted Gross Income per tax return) \$ \_\_\_\_\_ / \$ \_\_\_\_\_ (B) \*

Gross Income is defined as the income earned for the household BEFORE taxes are taken out. This includes income from all jobs, unemployment, social security and other fixed income sources.

Adjusted Gross Income is defined as you adjusted gross income as shown on your tax return records. This number MUST match patient's tax returns otherwise grant application will be returned for resubmission

If there is a decrease in annual income from the prior year (B) to the current year (A), please provide an explanation below:

---

---

Source and description of income (patient/spouse/other). Please describe if income is from a job, fixed income or other. Please include any other information deemed necessary by the applicant:

---

---

Does the patient own or rent their current residence? \_\_\_ Own \_\_\_ Rent

Value of mortgage (if owned): \$ \_\_\_\_\_ Payment = \$ \_\_\_\_\_/month

Monthly HOA Bills, if applicable: \$ \_\_\_\_\_/month

Monthly rent (if rented): \$ \_\_\_\_\_/month

Do you own any other real estate? If yes, please indicate type and approximate value below:

---

Monthly Car Payment(s):

Car #1: \_\_\_\_\_ \$ \_\_\_\_\_/month

Car #2 \_\_\_\_\_ \$ \_\_\_\_\_/month

*Our Mission: To help people affected by cancer through funding research for new treatments, providing financial support for patients and their families, and promoting awareness and education for carcinoid and other rare cancers. [WWW.THELMF.org](http://WWW.THELMF.org)*

The Lois Merrill Foundation  
for carcinoid and other rare cancers

Monthly Health Insurance Premium (out of pocket monthly payment only): \$ \_\_\_\_\_/month

TOTAL OUTSTANDING MEDICAL DEBT: \$ \_\_\_\_\_ \*

TOTAL OUTSTANDING HOUSEHOLD DEBT: \$ \_\_\_\_\_ \*\*

\*This number should be the total debt accumulated as a result of the patient's above diagnosis. This number should not include any other household related debt (credit cards, unpaid utility bills, past due taxes, etc) nor should it include medical debt associated with any other members of the household.

\*\*This number should be the total debt accumulated by the household. This number should include the medical debt from above plus any other household related debt (credit cards, unpaid utility bills, past due taxes, etc) or medical debt associated with other members of the family.

INSURANCE INFORMATION:

Insurance provider: \_\_\_\_\_

Annual deductible (please put \$0 if you do not have one). This is your annual out-of-pocket maximum over and above your monthly premium listed in the previous financial section: \$ \_\_\_\_\_/year

Please describe source of insurance (job, spouses' job, COBRA coverage or a personal policy):

\_\_\_\_\_

HOUSEHOLD INFORMATION:

Please list patient's spouse and any dependents, including age and relation (use a separate sheet if more room is needed). For the purpose of this application, dependents may only include spouses, children under the age of 18 and children in college.

Name	Relation to patient	Age
_____		
_____		
_____		
_____		

*Our Mission: To help people affected by cancer through funding research for new treatments, providing financial support for patients and their families, and promoting awareness and education for carcinoid and other rare cancers. [www.THELMF.org](http://www.THELMF.org)*

The Lois Merrill Foundation  
for carcinoid and other rare cancers

CAREGIVER INFORMATION: Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email \_\_\_\_\_ Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Provide an itemized list of expenses to be paid by Medical Assistance Grant (if grant is awarded, copies of bills will be required prior to payment):

Item	Amount	Payable to *
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____
4. _____	\$ _____	_____
5. _____	\$ _____	_____

\* If applicant is requesting reimbursement to be paid directly to patient or caregiver please provide an explanation for reimbursement on a separate sheet. If applicant is requesting payment be made directly to supplier/vendor, no explanation is required. Please see Medical Assistance Grant Criteria and Supplemental Information Form for reimbursement criteria and information.

\*\*If patient is requesting payment of travel expenses for a spouse or caregiver, please provide a brief explanation of the situation and the patient's need or desire for a travel companion. The Lois Merrill Foundation will evaluate applications on a case-by-case basis to determine if we can provide funds for a travel companion. While we wish we could do this in all situations, our priority is to ensure we are able to help the largest number of patients receive necessary treatment.

Thank you for your interest in our organization. Please know that you will be in the thoughts of everyone at The Lois Merrill Foundation, and that we wish you all the best. We will be in touch soon.

*Our Mission: To help people affected by cancer through funding research for new treatments, providing financial support for patients and their families, and promoting awareness and education for carcinoid and other rare cancers. [WWW.THELMF.org](http://WWW.THELMF.org)*