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THE LOIS MERRILL FOUNDATION
FOR CARCINOID AND OTHER RARE CANCERS
1050 ISLAND AVE, SUITE 517
SAN DIEGO, CA 92101
INFO@THELMF.ORG

Medical Assistance Grant Criteria and Supplemental Information Requirement

1. Grant applications will be accepted year-round from patients, immediate family members, and 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 United States 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 will 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 the email address or street address shown above.

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

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.

Date of Application: _____ Date funds needed: _____

Note: grants are reviewed on November 1 and May 1 each year. If you are requesting a review outside these dates, please attach a letter explaining your timing and need. We will do our best to accommodate each applicant.

APPLICANT INFORMATION: Name: _____

Relation to Patient: _____ Phone Number: _____

Email Address: _____

Mailing Address: _____

PATIENT INFORMATION: Patient's Name: _____

Patient's Birth date: _____

Medical 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: _____

Current medical provider's office number: _____

Patient's annual household income for current year: \$ _____

Patient's annual household income for previous year: \$ _____

The Lois Merrill Foundation
for carcinoid and other rare cancers

Please list patient's spouse and any dependents, including age and relation (use a separate sheet if more room is needed):

| Name | Relation to patient | Age |
|-------|---------------------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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 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.