Mission Myeloma, Inc.
P.O. Box 103
Kimberly, WI 54136
www.MissionMyeloma.org
501(c)(3) non-profit organization

Showing support to patients and their families affected by myeloma and funding research for a cure.

FINANCIAL GRANT APPLICATION

About the Applicant

NOTE: Applicant **MUST** have a myeloma diagnosis.

First Name **Last Name**

Address **City** **State** **Zip Code**

Phone Number **Email Address** (must be active)

Date of Birth (mm/dd/yyyy)**:** _____ **Age** (at the time of application)**:** _____

If applicant is younger than 18 years old, guardian's name: _____

Has the applicant received a grant from Mission Myeloma, Inc. before? ❍ Yes ❍ No
If Yes, include the following details ➔ Date: _____ Amount: _____

Which medical facility/clinic/hospital is the applicant being treated at? Provide all details below.

Name Street

City State Zip Code County Phone Number

Applicant's Myeloma Story

When were you diagnosed? (month/year): _____ / _____

What is your current diagnosis? _____

Are you currently receiving treatment(s)? ❍ Yes ❍ No

If yes, specify: ❍ Radiation ❍ Chemotherapy ❍ Other (specify) : _____

How long do you anticipate receiving treatments? _____

Share your story in your own words. _____

_____

_____

_____

Financial Information

Are you currently employed?

❍ Yes ❍ No ❍ Disabled ❍ Retired

If Yes: ❍ Part Time
❍ Full Time

If No or Disabled: How long do you anticipate being out of work because of treatment(s)?

_____

How many dependents do you have? _____

Is your significant other currently working?

❍ Yes ❍ No ❍ Retired ❍ Disabled ❍ N/A

How many hours per week? _____

What is your monthly household income? $_____

Has your monthly household income decreased since you started treatments? ❍ Yes ❍ No

If Yes: By approximately how much?
$_____

Household Monthly Expenses:

Description	**Amount**	**Item**	**Amount**
Mortgage / Rent	$	Utilities + Phone + Cable	$
Vehicle Expenses	$	Medical Expenses (exclude insurance premiums/co-pays)	$
Other Expenses	$		
		Total Expenses (add up all expenses)	$

Medical Insurance Information

Do you currently have medical insurance? ❍ Yes ❍ No

Describe the insurance benefits, including deductibles, co-pays and/or co-insurance? _____

_____

Mission Myeloma, Inc.

How did you learn about Mission Myeloma, Inc.? _____

_____

Additional Information: Please share anything you'd like the *Mission Myeloma, Inc.* Board of Directors to consider when reviewing your grant application.

_____

_____

_____

Signature of Acknowledgement

I certify the above information is true and complete to the best of my knowledge.

_____	_____	_____
Applicant's Name (Print)	Applicant's Signature	Date

Myeloma Medical Team Confirmation

We need to verify your diagnosis and treatment with your medical team. Attach a signed letter from a member of your medical team where you are currently receiving, or have recently undergone, myeloma treatment(s). (MUST be on official letterhead.)

Release of Medical Information Authorization: I give the facility/clinic/hospital (listed on page 1) permission to release my medical diagnosis and treatment in the form of a letter to *Mission Myeloma, Inc.* solely for my application for financial assistance.

_____	_____
Applicant's Signature	Date

Submitting the Application

Submit completed grant application and myeloma medical team confirmation, <u>together</u>, to the following:

Mail Mission Myeloma, Inc.
PO Box 103
Kimberly, WI 54136

NOTE: We will reject incomplete applications. Submit completed grant application and myeloma medical team confirmation, <u>together</u>, via mail. A completed application does <u>not</u> guarantee the applicant will receive a financial grant. Applications will be reviewed by the *Mission Myeloma, Inc.* Board of Directors. You will be notified by email or phone call once a decision has been made.