The Brenda Marie Foundation Application for Financial Assistance

Applicants Information

Name Male / Female / Other

Address

City State Zip Code

Home Phone Cell Phone Email

Date of Birth Age Last 4 digits of Social Security

Caucasian ☐ Asian ☐ Hispanic ☐ African American ☐ Native American ☐ Other _____ ☐

Applicants Yearly Income: _____

Relationship to Patient: _____

Patients Information

Name Male / Female

Health Insurance: Yes / No

If Yes Name of Insurance: _____

Doctors Name: _____

Traveling Information

Traveling From

_____

Address

City State Zip Code

Destination

_____

Address

City State Zip Code

Estimated Cost of Trip

Fuel: $ _____ Lodging: $_____

Food: $_____ Other: $ _____

Reason and Use of Requested Money

_____
_____
_____
_____
_____

How did you hear about The Brenda Marie Foundation?

_____
_____

By signing this document I, _____, agree to use the Donation as Stated above and will return donation if not used properly.

_____

Signature Date