



## Friends4Michael Foundation

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The mission of The Friends4Michael Foundation is to support children like Michael and their families, to keep alive the memory of Michael and his spirit, to increase awareness of the devastating effects of brain tumors on afflicted children and their families and to continue to “Fight for a Cure” for this horrible disease.

In support of this mission, the Friends4Michael Foundation provides supplementary financial assistance to families with financial needs resulting from expenses associated with their child’s brain tumor treatment. This program covers specific non-medical costs related to a primary brain tumor diagnosis. Direct medical expenses will not be covered.

The Family Assistance Committee (FAC) within the Friends4Michael (F4M) Foundation processes all requests for the Foundation. Grants of up to \$600.00 per family are available for those families that meet the following criteria:

1. The patient must be a child (defined as a person under the age of 18 at the time of diagnosis.)
2. The patient must be undergoing treatment for a brain tumor as defined by doctors the Foundation consults within the medical community.
3. The request for assistance must be submitted by a certified Social Worker on the behalf of the family.
4. The request/need must be validated by a member of the FAC via telephone interview with the submitting Social Worker and a second source at the hospital (i.e. Nurse or Hospital Administrator).

Funding is limited and based on availability. Applications will be processed in the order received. All information is strictly confidential. Once reviewed, the Friends4Michael Foundation will contact the person requesting assistance to confirm or reject the request for funding.

Please complete the following form completely and submit it to the FAC via fax to (703)842-8350, email to [assistance@friends4michael.org](mailto:assistance@friends4michael.org) or mail to the address above to be considered for a grant.

**For Foundation use only**

Date application received: \_\_\_\_\_

**Patient Information**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender Male/Female Date of Application \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Applicant name: \_\_\_\_\_

In a brief paragraph, please explain your reasons for requesting assistance from the Friends4Michael Foundation:

The undersigned individually and as the parent of the minor child/patient hereby acknowledges and agrees that the information submitted herein is accurate, true and complete, to the best of my knowledge. I further acknowledge and agree that by the execution of this application I am granting the F4M Foundation, its Directors and Officers permission to contact the medical provider(s) to confirm the foregoing information. I further acknowledge and agree that any and all sums received from the F4M Foundation by the undersigned shall be used solely for the purposes specified in this application. I further agree to indemnify and defend the F4M Foundation, its Directors and Officers against any costs, claims and expenses, including reasonable attorneys' fees, arising out of the breach of this agreement.

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Medical Information**

Date of Diagnosis: \_\_\_\_\_ Tumor Type and Grade: \_\_\_\_\_

Patient is actively in treatment:      yes      no

Patient is currently in inpatient treatment and/or rehabilitation:      yes      no

Hospital/Clinic Name and Address: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Nurse Name: \_\_\_\_\_

Hospital Clinic Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Social Worker completing this section: \_\_\_\_\_

Social Worker Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

The undersigned hereby acknowledges and agrees that the information submitted herein is accurate, true and complete, to the best of my knowledge.

Social Worker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The F4M Foundation will review the information you have provided and contact you and/or the individual requesting assistance if more information is needed or for request verification.

During Michael's illness and eventual passing, we all prayed very hard for him to be healed. Though we did not get the miracle we wanted, we witnessed many miracles and other blessings during and since that time. We are a faith based organization and to assist us as we pray for your family and your child's healing, please tell us about your family and your wonderful child.