The Friends4Michael Foundation

2510 N Castle Rock Drive
Tucson, Arizona 85749
845.401.8689
www.friends4michael.org

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 $500.00 per family are available for those families that meet the following criteria:

1. The patient must be a child (defined as a person age 18 or under 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.

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 online form or the following form and email to assistance@friends4michael.org to be considered for a grant.

Patient Information

(Please print clearly) (This form should be scanned and emailed to assistance@friends4michael.org)

First Name: _____ Middle Initial: ___ Last Name: _____

Date of Birth: _____ Gender: male/female Date of Application: _____

Applicant Information

(Please print clearly)

Make check payable to: _____ Phone Number: _____

Complete home address:

_____
Street Address Apt

_____
City State Zip

Mail check to (if different than home address):

_____
Street Address Apt

_____
City State Zip

Please briefly explain your reasons for requesting assistance from the Friends4Michael Foundation:

The undersigned individually and as the parent of the minor child/patient herby 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 Officer against any costs, claims and expenses, including reasonable attorneys' fees, arising out of the breach of this agreement.

Print Name: _____ Signature: _____ Relationship: _____

Medical Information

(Please print clearly)

Date of Diagnosis: _____ Tumor Type and Grade: _____

Hospital/Clinic Name and Address: _____

Doctor Name: _____ Nurse Name: _____

Name of Social Worker Completing this section: _____

Social Worker Phone: _____ Email: _____

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 will contact you and/or the individual requesting assistance if more information is needed for verification.