

KEEP PUNCHIN

Let's knock brain cancer out for the count.

Patient / Client Information	
Name:	
Diagnosis:	
Family Size: Name, age, and relationship to Patient/Client:	
Guardian or representative (if applicable):	
Household Monthly Income: (Please include all forms of income, including employment, pension, social security, alimony, other assets or assistance from family):	
Have you applied for Medical Assistance?	Yes or No. Explain why you have or have not applied.
Have you applied for State or County Assistance?	Yes or No. Explain why you have or have not applied.
Household Monthly Expenses: (Please include all expenses, rent/mortgage, leases, tuition, insurance, child support, other monthly expenses)	
Referring Physician	
Name:	
Address:	
Medical Specialty:	

Phone #:	
E-mail:	

P.O Box 5359, Baltimore, MD 21209

Requested Equipment, Device, or Service	
Name of Equipment, Device, or Service:	
Rationale/Justification for Request:	
Amount Requested:	
Vendor Providing Equipment, Device, or Service:	

Please make sure all the items listed below are submitted via email to bfisher@keep punching.org.

I have attached:

- Grant Application
- Physician's script stating benefit or need for the requested device or service
- Cost estimate for item and/or service requested

Certification:

I certify that the contents of the proposal are true and accurate, that the noted patient/client has a histologically confirmed malignant brain neoplasm, and that there are no knowingly false statements in the proposal.

Authorizing Signature: _____

Authorizing Name (Print): _____ Date: _____

***Before completing this application, please note that our maximum grant award is \$1,000. If your requested item or service costs more than \$1,000, you will need to demonstrate where the remaining money for the purchase of the item or service is coming from. Do not purchase the items or services you are requesting BEFORE**

getting a response to your application. If your request is granted, we will directly pay the vendor.

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