Michelle Lynn Holsey Foundation
Treatment Grant Application Form

Purpose of Treatment Grant: Need-based grant for patients who have been affected by cancer or other debilitating diseases and conditions.
Items covered by this grant may include:

- **Treatment**
- **Medical bills**
- **Medicine**
- **Transportation to and from treatment**
- **Housing and living expenses during treatment** **Date:_____**

Name of Applicant: _____

Applicant's Date of Birth: _____ Applicant's Social Security #: _____

Phone: _____ E-Mail Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Applicant's Employer: _____ Applicant's Insurance: _____

Currently Employed: Yes____ No ____ Applicant's Annual Income: _____
Copy of last year's tax return required. Please include schedules C, D, E, & F, Form 4797 or Annual SS or SSI statement. If you have direct deposit, copies of last three months' bank statements showing deposits are acceptable.
Applicant's Diagnosis: _____
A copy of a diagnosis / treatment letter is required, stating the patient's diagnosis and the current course of treatment. This must be signed and dated by the doctor on the doctor's letterhead. Please include any additional information that will help us better understand your situation.
Applicants Current Treatment Plan: _____

_____

_____

Name of person referring you to MLHF: _____

Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Michelle Lynn Holsey Foundation
Treatment Grant Application Form
Page 2

Please complete this form if the applicant is a minor or dependent:

Name of Parent / Legal Guardian: _____

Address of Parent / Legal Guardian: _____

City: _____ State: _____ Zip Code: _____

Parent / Legal Guardian's Social Security #: _____

Phone: _____ E-Mail Address: _____

Employer of Parent / Legal Guardian: _____

Annual Income of Parent / Legal Guardian: _____
Copy of last year's tax return required or other financial documents listed on application.

Grant Applicant or Parent / Legal Guardian must:

- **Submit a copy of last year's tax return or other requested financial documents listed on application**
- **Required Doctor's Statement (Signed by Doctor)**
- **Sign a Terms & Conditions of Agreement.**

Return to: **Michelle Lynn Holsey Foundation**
Grant Board
P.O. Box 652 / 1200 South 4th St.
Crockett, Texas 75835
Email to: michellelynnholsey@yahoo.com
For questions, please call Tina Clarke @ 936-204-4600
Fax: 936-544-7513

Treatment Grant Application Form
Page 3

Terms and Conditions of Agreement:

- I _____ agree to use these funds in accordance with the stated purpose of the Michelle Lynn Holsey Foundation Treatment Grant.

- I understand that the Michelle Lynn Holsey Foundation is in no way responsible for any influence or consequence that may be associated with the recipient's treatment or care.

- I understand that funding is contingent upon the merit of this application; no individual will be discriminated against based on race, religion, creed, nationality or gender, color, disability, or any characteristic protected by law.

Name:	**Date:**

Signature:

Please return the signed and completed Treatment Grant Application, including the "Terms and Conditions of Agreement" to:

The Michelle Lynn Holsey Foundation
Grant Board
P.O. Box 652 / 1200 South 4th St.
Crockett, Texas 75835
michellelynnholsey@yahoo.com
Fax: 936-544-7513
Office: 936-204-4600