Big Jim's Foundation Application

PATIENT Information -Please provide details on the patient for which aid is being applied for.

Name *

First Name Last Name

Birth date *

Month Day Year

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Area Code Phone Number

Email *

example@example.com

Name and ages of children, if any *

Name of spouse/significant other *

Is spouse/significant other currently employed? *

- ○ YES
- ○ NO

Is spouse/significant other the primary caregiver? *

- ○ YES
- ○ NO

If spouse/significant other is not the primary caregiver, please provide name of who is and their relationship to patient.

Is the patient able to walk on their own? *

- ○ YES
- ○ NO

Is the patient able to drive? *

- ○ YES
- ○ NO

How did you hear about the Big Jim Foundation? *

Name of person completing this form *

Relationship to patient *

If this form is being submitted by someone other than the patient, this signature certifies that you am authorized to act on behalf of the patient and provide/discuss their medical condition. If you are someone other than the patient, spouse, parent, or health care provider, a notarized Power of Attorney may be required for consideration of this application and discussion of a potential grant award. As a secondary means of getting to know our applicants better, and in an effort to make the best decisions regarding where we distribute funds, our application process will include a virtual interview with the patient, caregiver, and/or other family members submitting this application. Doing so affords us the opportunity to get to know you better, allow you to get to know us better, and provides the opportunity to connect in a manner beyond what is possible in a written application. Signing your name below acts as your agreement to these conditions of the application process

First Name Last Name

Insurance & Finances

Is the patient covered by medical insurance? *

- ○ YES
- ○ NO

Type of insurance *

- ☐ Private (provide detail below)
- ☐ Medicare
- ☐ Other
- ☐ Medicaid
- ☐ VA

If Private, provide insurance company name

Annual deductible (if applicable) *

Annual "out of pocket" maximum *

Is there an annual deductible for prescription drugs? *

- ◯ YES
- ◯ NO

If YES, how much?

Is there a separate "out of pocket maximum" for prescription drugs? *

- ◯ YES
- ◯ NO

If "YES", how much?

Income

What is your monthly income from the following sources:

Salary/Hourly Wages	
Unemployment	
Social Security	
SSD Disability	
Short-term Disability	
Long-term Disability	
Public Assistance	
Family/Friends	
Other (Please specify)	

How much aid are you applying to receive? *

What would be the use(s) of the aid you are applying to receive? *

Have you ever generated financial aid from GoFundMe or another public funding source? *

- ◯ YES
- ◯ NO

If "YES" please specify organization, date, and amount of grant

Medical Information

Date of initial GBM diagnosis *

Month Day Year

Date of recurrence (if applicable)

Month Day Year

Name of primary treatment facility *

Pathology Report (Please Ensure Diagnosis of Glioblastoma is Included)

Please provide documentation showing physician-confirmed diagnosis of glioblastoma

Please provide details of surgical intervention(s) - biopsy, resection, ablation, etc.

Neurosurgeon name & date

Hospital clinic name

Oncologist/Neuro-Oncologist's Name

Hospital/Clinic Name

If multiple surgical interventions, type details below.

Is the patient currently receiving active treatment? *

- ◯ YES
- ◯ NO

If "YES", please name and frequency of treatment

Is the patient currently receiving hospice care? *

- ◯ YES
- ◯ NO

If "YES", please provide name of hospice organization/provider

Please provide details and timeline of the patient's journey from initial diagnosis to present time (include all treatments completed and successes/failures of those treatments as well as any alternate or additional treatment plans under consideration) *

Submit