



**The Family Fund . . . through Marcel's Way**  
 P.O. Box 392 New Boston, NH 03070 (877) 412-4141 www.marcelsway.org

**Marcel's Way Family Fund Award Request Application** (please type or print clearly)

**Applicant Info** (who the requested Award would benefit)

Applicant's Name \_\_\_\_\_ Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ S.S.# \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

*Note: Please attach a physician's note stating above diagnosis*

**Requestor Info** (who is filling out Award application)  Check here if same as above

Requestor's Name \_\_\_\_\_ Telephone #: \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Are you legally responsible for the Applicant? Yes \_\_\_\_\_ No \_\_\_\_\_ S.S.# \_\_\_\_\_

Requestor's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Number of Family Members in Applicant's Household \_\_\_\_\_ Number of Minor Children \_\_\_\_\_

**Describe the equipment, medicines, vitamins or service requested in this application:**

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*Note: Please attach a physician's recommendation of the service or equipment requested above.*

Estimated Total Cost: \_\_\_\_\_ *Note: Please attach documentation of estimated cost*

**List Funds Available for the Equipment or Service**

**Place a check mark by the Current Family Income from ALL sources (Salary, Disability, SSDI, Child Support, Alimony, etc.)**

From Applicant and family members \$ \_\_\_\_\_ \$2,000 or less per month (\$24,000 or less per year) \_\_\_\_\_

From Insurance, Medicare and Medicaid, and any other sources \$ \_\_\_\_\_ \$2,000 - \$4,000 per month (\$24,000 - \$48,000 per year) \_\_\_\_\_

**Total Funds Available** \$ \_\_\_\_\_ \$4,000 or more per month (\$48,000 or more per year) \_\_\_\_\_

**How Much Money Are You Requesting From the Family Fund?** \$ \_\_\_\_\_

By signing below, I certify that the information provided in this Award application is true, accurate and complete.

Signature of Applicant (if not a minor) \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Requestor (if not Applicant): \_\_\_\_\_ Telephone #: \_\_\_\_\_

## **Marcel's Way Family Fund Award Request Application Checklist**

- 1. Is the Applicant a resident of New England or seeking treatment from a medical professional located in New England?
- 2. Have you included documentation of a definitive diagnosis of a mitochondrial disorder based condition *or* documentation indicating strong suspicion of mitochondrial disorder based condition?
- 3. Have you included copy of prescription or a recommendation from physician or other medical professional for the good(s) or service(s) for which Award is requested?
- 4. Have you included information that demonstrates that the good(s) or service(s) for which the Award is requested is/are necessary on account of the mitochondrial disorder based condition documented in #2 above and not some other cause?
- 5. Have you demonstrated that the good(s) or service(s) for which the Award is requested is/are one(s) that would not be needed to satisfy other life necessities (e.g. food, shelter, clothing, etc.)?
- 6. Have you demonstrated that no insurance is available for part/all of the cost of the good/service to be covered by the Award?
- 7. Have you demonstrated that no public assistance (e.g. Social Security, Medicaid, etc.) is available for part/all of the cost of the good/service?
- 8. Have you demonstrated that you/Applicant will bear a financial hardship as a result of the cost of good/service to be covered by the Award?
- 9. Have you included information on where we can make direct payment for the requested good(s) or service(s)? Preference will be given to those applications in which direct payment is possible.
- 10. Have you agreed to forward all related receipts and any other related documentation of expense needed for the recordkeeping files of Marcel's Way?