Maria's Love
FOUNDATION

Grant Application

Patient information

Full Name: _____ Date of Birth: _____ Age: _____
Male ____ Female____ Phone #: _____ Email Address: _____
Address: _____

Family of patient (if patient is under 18 years)
Guardian #1
Full Name: _____ Occupation: _____
Phone #: _____ Email Address: _____
Address: _____

Guardian #2
Full Name: _____ Occupation: _____
Phone #: _____ Email Address: _____
Address: _____

Insurance information

Health insurance: Private_____ Medicaid____ Medicare____
Annual family income: _____ Total out of pocket expenses to date: _____

Medical information

Clinical diagnosis: _____ Age illness started:_____

Please provide the following with your completed application:

- Medical bills showing total amount owed
- First page of most recent federal income tax return or W2

Application submittal information

Mail to: Maria's Love Foundation
184 North 8th Street
Brooklyn, NY 11211
Email to: Antri@mariaslovefoundation.org

Tell us your story (include history of illness or health condition)

What are some difficulties you and/or your family are experiencing?

What will you be using the grant for?

Are you able to meet with a Maria's Love Foundation board member to get to know you personally and finalize the decision? (phone or in person)

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