The Mary Maguire Foundation

Financial Request Form

Awards range from $50.00 to $1000.00 and are intended for the purposes listed below.

Please send your request form to: The Mary Maguire Foundation
5881 Cook Road, Suite A, Milford, OH 45150

Or fax the request form to 513.576.6778

Applicant's Name: ____ Date of birth: ______________________
Address: ____
City: ________________________ State_________ Zip:______________
Home Phone: ______________________________ Work Phone: ____________________________________
Person completing the form: ___________________________________ Phone: ________________________
Relationship to applicant: ____

Request[+]	**Amount Requested****	**Check Payable to:**
Health & Fitness Assistance (personal training, weight management[+])		
Nutritionist/Dietitian[+]		
Medications/Co-Pays/OTC drugs		
Hospital Services		
Clinic/Laboratory Services		
Insurance		
Counseling/Emotional Assistance[+]		
Groceries/Health Food Gift Cards[+]		
Medical/Therapeutic Massage[+]		
Medical Acupuncture[+]		
Exercise Class(es)[+]		
Health Club Membership[+]		
Other: (Please specify)[+]		

****Copies of the bills/receipts must be attached to the application to receive payment. If your request is approved, the Mary Maguire Foundation will make the check payable to the recipient on your behalf. The recipient may be the nutritionist, trainer, health club or facility, pharmacy, health food store, etc. Please send copies only and retain the originals for your files.**

***Restrictions apply.**

[+]Must be approved prior to payment.

Briefly add any other information that you think would be helpful for the committee:

____
____
____
____
____
____

I certify that the above information is true and complete to the best of my knowledge.
Signature: ____ Date: ______________________

This Section to be completed by Oncologist or Surgeon

(Name)_________________is a patient of mine and is currently or has been receiving treatment for _________ cancer.

Location of Treatment (Clinic & City)

____

Treatment Type(s):

____

Other Information that may be of importance (optional):____________________________________
____
____

Doctor's name (print): ______________________________ Doctor's phone number: ____________
Doctor's Signature: ________________________________ Date: _______________________