

Let Your Bow Glow

Assistance Request Application



Print this application and mail it along with any supporting documents to: Let Your Bow Glow, c/o Elk County Community Foundation, P.O. Box 934, St. Marys, PA 15857

Patient Information

(All fields required)

Full Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

E-mail: _____ Phone _____

Official Diagnosis: _____

Brief History/Description of Illness and Need: (include a second page if needed)

Contact Information *(If different from patient information)*

Full Name: _____ E-mail: _____

Address: _____

City, State, Zip: _____

Phone #: (land/cell): _____

Request For Assistance

Please indicate if you have a preference where you would need assistance:

- _____ Co-pay not covered by insurance (*submit a copy of the unpaid bill with application*)
- _____ Payment towards a doctor visit or treatment facility (*submit a copy of the unpaid bill with application*)
- _____ Medicine/Pharmacy (*submit a copy of the unpaid bill with application*)
- _____ Gas card to assist with travel expenses for medical appointments
- _____ Other* (*please describe request in detail and submit a copy of the unpaid bill with application*)

* This can be an unpaid home utility bill, a mortgage payment, rent payment, etc.

Let Your Bow Glow Assistance Request Application (page 2)

I am submitting this application on behalf of _____ who has been diagnosed as stated above and requires assistance with the costs associated with treatment. I agree that by submitting and signing this request that all information contained herein is accurate and true to the best of my knowledge.



Signature of Adult Patient Signature of Requestor (if a minor) Date

Publicity Release

Let Your Bow Glow organization, with the help of many volunteers and donors, is honored to be able to assist families facing financial hardships due to cancer and other life-threatening illnesses. We respectfully request the usage of your name and/or photo in releases such as Facebook, newsprint, and/or at our public events. This is not mandatory.

- _____ I give permission to the Let Your Bow Glow organization to use my name and photo for media recognition.
- _____ I **do not** give permission to Let your Bow Glow organization to use my name or photo for any media purpose.



Signature of Adult Patient Signature of Requestor (if a minor) Date

Mail this application and supporting documents to:

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Guidelines and Procedures:

After exhausting other options/resources available an individual can submit a grant application to the Bow Glow Fund, held at the Elk County Community Foundation (ECCF).

The Advisory committee will review applications on a quarterly basis, unless an issue is urgent, in which case there will be a response as soon as possible.

If a grant is approved, the payment will be issued to the third party when the invoice is received. ECCF will issue the payment to the service provider or provide vouchers or gift cards.



Office Use Only:	Applications Received _____
Committee Review _____	
Award _____	
Award Letter sent _____	Award Distributed _____