More Moments More Memories Foundation Application

Community Foundation of Greater Dubuque

Patient Information

Patient's full name*
Character Limit: 100

If this application is being completed by a third party, what is the patient's address?
Character Limit: 250

If this application is being completed by a third party, what is the patient's phone number?
Character Limit: 15

Patient date of birth*
Character Limit: 10

Patient gender*
Choices
Male
Female

Ethnicity
Choices
American Indian or Alaska Native
Asian
Black or African American
Hispanic
Native Hawaiian or Pacific Islander
White

Type of cancer*
Character Limit: 100

Date of diagnosis*
Character Limit: 10

Stage of cancer*
Character Limit: 50

What is the name, location and contact person of the clinical trial you are enrolled in.*
Character Limit: 250

Please attach two consecutive years Federal Tax Return for the patient or family*
Form 1040 (first page of the return)

File Size Limit: 4 MB

Patient's SSN*
Character Limit: 12

Patient's Driver's License Number*
Character Limit: 20

Issued Date
Character Limit: 10

Expiration Date
Character Limit: 10

State Driver's License is issued in
Character Limit: 30

Essay

Describe your journey to this clinical trial and why you are requesting assistance*
Write as if you are telling a story. Please include information about other ways you have soughtfinancial support such as family members, community benefits or other foundations.

Character Limit: 3000

How did you hear about the More Moments More Memories Foundation*
Character Limit: 200

What are you seeking?

Please note: grant awards will be limited to $5,000 per case within a one year period.

Is a caregiver required for you to participate in the clinical trial?*
Character Limit: 50

Mileage Support

Please use the space below to complete:
Mileage support for travel from _____ to the clinical trial site of _____ for a total of _____ miles x .54 cents per mile (IRS rate) for a total of _____.

Character Limit: 250

Lodging Support

Please use the below space to complete:
Lodging for _____ (days of treatment) at _____ (name of hotel) x _____ (total cost per night = room rate plus applicable fees) x _____ (days of stay) for a total of $_____.

Character Limit: 250

Documentation:

Please upload a screenshot or other documentation of your lodging. This detail should include price per trip including price per day and other relevant information.

File Size Limit: 2 MB

Airfare Support

Please use the space below to complete:
Airfare support for travel from _____ to the clinical trial site of _____for_____(name of patient) and _____(name of caregiver).

Character Limit: 250

Documentation:

Please upload a screenshot or other documentation of your flight plans. This detail should include price per trip and other relevant information.

File Size Limit: 2 MB

Meal Allowance

Please use the below space to complete:
Meal allowance for _____ days of treatment for _____ (name of patient) and_____ (name of caregiver) x $63 per day (IRS rate) for a total of $_____.

Character Limit: 250

Other requests/support*

Have you sought assistance through another charitable organization to support your travel and lodging?

If yes, where have you applied?

Character Limit: 250

Healthcare provider referral form

Third Party Email*

Please enter the email address of your healthcare provider below, then click 'compose email' to send them a personal email asking them to complete the healthcare referral form. They will receive a second email from our online system which will include a link for them to click on and answer questions. Below are generic instructions for you to copy and paste into your email if you would like to use them.

"I would like to thank you for taking the time to complete the healthcare provider referral form associated with my More Moments More Memories Foundation application. You will be receiving another email from the CFGD's grant system which will include a long link. This link will direct you to some questions the committee has requested you complete. Thank you again for your time and please let me know if you have any questions."

Character Limit: 254

Today's date*

Character Limit: 10

Name of Healthcare Provider*

Character Limit: 100

US Mailing Address*

Character Limit: 200

Email address of healthcare provider*

Character Limit: 254

Phone number*

Character Limit: 12

Name of Patient*

Character Limit: 100

How long have you been treating this patient?*

Character Limit: 250

Name of clinical trial to which the patient has been referred

Character Limit: 250

By submitting this form you certify all information submitted is true including but not limited to that this patient has been referred to this clinical trial.