

APPLICATION INSTRUCTIONS:

The purpose of this document is for The MacKenzie Grace Foundation (TMGF) to learn more about the potential recipient ('Recipient') of any support which may be provided by The MacKenzie Grace Foundation. The information provided in this application is important to properly assess the needs of Recipient. Please answer all questions thoroughly to provide us with the best information possible.

For consideration, please complete this application entirely. Along with the application, all applicants should include any of the following that are available and appropriate:

- A note from a physician, medical professional, or county agency personnel confirming diagnosis and stating medical need for specific support being requested
- A copy of any denials already received regarding support being requested. Upon completion of the application please submit to The MacKenzie Grace Foundation via one of the following three methods (any method is acceptable):

1. Email to: april@tmgf.org or kelly@tmgf.org
2. Fax to: (303) 223-7608
3. Mail to: The MacKenzie Grace Foundation
7243 Somerset Court
Castle Rock, CO 80108

Once received, TMGF board will review application and contact requestor regarding questions. A final determination to offer support will be given within 21 days of receipt of application.

For assistance with completing this application, please call The MacKenzie Grace Foundation at (303)-916-1027 or (303) 594-1548.

IMPORTANT NOTE:

IT IS THE POLICY OF THE MACKENZIE GRACE FOUNDATION TO STRICTLY OBSERVE THE CONFIDENTIALITY AND SECURITY OF ALL PERSONAL AND MEDICAL INFORMATION. THE MACKENZIE GRACE FOUNDATION WILL USE THE PERSONAL AND MEDICAL INFORMATION, WHICH HAS BEEN VOLUNTARILY PROVIDED IN THIS APPLICATION, ONLY TO ASSIST IN ACQUIRING REQUESTED SUPPORT, SERVICES AND/OR BENEFITS. THE MACKENZIE GRACE FOUNDATION WILL NOT SHARE NAMES OR OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION UNLESS IT IS NECESSARY TO ACQUIRE A REQUESTED PRODUCT, SERVICE OR BENEFIT.

PERSONAL INFORMATION FOR RECIPIENT

Date of Application: _____ Phone: (____) _____

Recipient's Name: _____ Male Female

Recipient's Address: _____

Recipient's City, State, Zip: _____

Recipient's County: _____ Language Spoken: _____

Recipient's Age: _____ Number of people living in Recipient's Home: _____

Social Security #: _____ - _____ - _____ Yearly Family Income*: \$ _____

** The MacKenzie Grace Foundation may request written verification of income.*

Parents/Legal Guardians: _____

Relationship to Recipient: _____ Language Spoken: _____

Street Address: _____

City, State, Zip: _____

Phone: (____) _____ Email: _____

Phone2: (____) _____ Phone3: (____) _____

How did you hear of The MacKenzie Grace Foundation? _____

Referring organization (if applicable): _____

Type of support requested and reason for request (please attach separate sheet if more room is needed):

INSURANCE, MEDICAL & EMPLOYMENT INFORMATION

Insurance Provider: _____

Street Address: _____

City, State, Zip: _____

Phone: (____) _____ Contact person: _____

Does Recipient have Medicaid coverage? Yes No

Is there any other form of coverage? Yes No (If so complete below)

Other Coverage Provider: _____

Parent/Legal Guardian Employer: _____

Street Address: _____

City, State, Zip: _____

Phone: (____) _____ Contact person: _____

Primary Diagnosis: _____

Other Diagnoses: _____

Primary Care Physician: _____ Phone: (____) _____

Physiatrist: _____ Phone: (____) _____

Orthopedic: _____ Phone: (____) _____

Physical Therapist: _____ Phone: (____) _____

Please feel free to provide additional information with this application if necessary.

TERMS AND CONDITIONS AGREEMENT FORM

By my signature below, I (Recipient or Parent/Legal Guardian for minors) acknowledge that I understand and agree:

1. That The MacKenzie Grace Foundation is not obligated to provide any or all of the support that has been requested. The MacKenzie Grace Foundation retains the right to make the final determination on which support to distribute.
2. That I will release, hold harmless, and discharge The MacKenzie Grace Foundation, its agents, officers, employees, affiliates, and all other persons, firms, associations and corporations of and from any and all actions, claims and demands which Recipient may now have, or may later have on account of injuries to Recipient or damages to any property arising out of an accident, casualty or occurrence which may happen through the use or misuse of any support provided by The MacKenzie Grace Foundation.
3. That the personal and medical information that I have voluntarily provided to The MacKenzie Grace Foundation may be used or shared for the sole purpose of acquiring the product, service or benefit I have requested. I understand the policy of The MacKenzie Grace Foundation is to strictly maintain the confidentiality and security of all personal and medical information.
4. I have read, understood and agreed with each of the terms and descriptions as stated above.

Recipient's Parent or Legal Guardian:

Signature: _____ Date: _____

Printed Name: _____