**T** 888.648.6228 **E** INFO@MITOACTION.ORG PO BOX 51474 BOSTON MA 02205 WWW.MITOACTION.ORG

**MitoAction's mission is to improve quality of life for all who are affected by mitochondrial disorders through support, education, and advocacy initiatives.**

**PURPOSE:** To promote health or provide relief to those who are affected by mitochondrial disease through one-time grants.

**ELIGIBILITY:** Patients and families of patients living within the United States with a mitochondrial disorder will be eligible to apply for grants. There is no income eligibility to apply.

**AWARDS:** Grants will be <u>no more than $500</u> and will be awarded, based on need, to families who are struggling financially with costs associated with mitochondrial disease. Grants are awarded once per lifetime, per patient.

**ELIGIBLE COSTS –** Expenses that "promote health" or "provide relief" could include:

- Medical costs not covered by insurance
- Housing costs for families while patients are receiving treatment away from home
- Costs for special equipment, services, or supplies
- Costs of modifying a home, vehicle, or workspace
- Costs of respite care or suitable recreational activities

**INSTRUCTIONS:**

1. Complete Application.
2. Send Application to: **Marcel's Way Family Fund of MitoAction**<br>**PO Box 51474**<br>**Boston, MA02205**
3. Please arrange for 2 letters of reference to be mailed directly to MitoAction on your behalf, including one from a Physician who will confirm the diagnosis of a mitochondrial disorder and confirm the usefulness of the service for which funds are requested, and one from a Community Worker (Social Worker, Case Manager, Clergy, etc.). Please provide a copy of the enclosed Reference Cover Letter to your references. MitoAction will confirm receipt of reference letters with the Applicant prior to the formal review.
4. Applications to Marcel's Way Family Fund of MitoAction are reviewed quarterly.
5. MitoAction will notify Applicant of its decision *(e-mail preferred)*, upon decision of the Marcel's Way Family Fund Review Committee.

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## APPLICANT/BENEFICIARY OF GRANT

[FOR OFFICE USE ONLY: Application No.______________ ]

| Name (First, Middle, Last) | | Street Address |
|---|---|---|
| Home Telephone | | City/State/Zip Code |
| Date of Birth | Gender<br>☐ Male ☐ Female | Preferred Language |

## FAMILY INFORMATION

| Parent/Guardian/Adult Applicant | Parent/Guardian/Spouse |
|---|---|
| Name (First and Last) | Name (First and Last) |
| Relationship to Applicant ☐ Self | Relationship to Applicant |
| Street Address | Street Address |
| City/State/Zip Code | City/State/Zip Code |
| Mailing Address (if different from Home Address) | Mailing Address (if different from Home Address) |
| | |
| **Preferred Contact Methods and Times** (*indicate all that apply*) | **Preferred Contact Methods and Times** (*indicate all that apply*) |
| ☐ **Home Phone:**____________________<br>Times: ☐ Mornings ☐ Afternoons ☐ Evenings | ☐ **Home Phone:**____________________<br>Times: ☐ Mornings ☐ Afternoons ☐ Evenings |
| ☐ **Cell Phone:**____________________<br>Times: ☐ Mornings ☐ Afternoons ☐ Evenings | ☐ **Cell Phone:**____________________<br>Times: ☐ Mornings ☐ Afternoons ☐ Evenings |
| ☐ **Work Phone:** ____________________<br>Times: ☐ Mornings ☐ Afternoons ☐ Evenings | ☐ **Work Phone:** ____________________<br>Times: ☐ Mornings ☐ Afternoons ☐ Evenings |
| ☐ **E-mail:**____________________<br>Times: ☐ Mornings ☐ Afternoons ☐ Evenings | ☐ **E-mail:**____________________<br>Times: ☐ Mornings ☐ Afternoons ☐ Evenings |
| | |
| **Preferred Language** | **Preferred Language** |
| **Household Type** (select one): ☐ Single-parent/guardian | ☐ Two-parent/guardian |

### List all people who live in Applicant's home, including Parents/Guardians/Adults listed above.

| **Name**<br>(first and last name) | **Date of Birth**<br>(month / day / year) | **Relationship to Applicant** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

***Attach another page if you need more space.***

**Number of Family Members affected by Mitochondrial Disease (including Applicant/Beneficiary):**________________________

**Number of previously approved Applications to Marcel's Way Family Fund of MitoAction:** ______________________________

## PERMISSION TO SHARE INFORMATION

I understand that the information given to you will be used solely by members of **Marcel's Way Family Fund of MitoAction Review Committee** for consideration of this Grant Application. I understand that all decisions of Marcel's Way Family Fund of MitoAction are final. I understand that I should not make financial decisions assuming that I will receive payment from Marcel's Way Family Fund of MitoAction.

I/We give permission for MitoAction and its Marcel's Way Family Fund Committee to contact any provider listed on this Application in order to:

- obtain or verify any information needed to determine if Applicant is eligible for the Fund;
- assist in the review of this Application; or
- find other services or resources for which Applicant may be eligible.

Unless I/we cancel this permission, it will cover the period of time needed to process this Application. I/We understand that I/we can rescind this Application and cancel this permission at any time by writing to MitoAction.

I/WE ATTEST THAT THE INFORMATION PRESENTED ON THIS APPLICATION IS TRUE AND COMPLETE.

**Parent/Guardian/Adult Applicant:**

______________________________
*Signature*

______________________________
*Print Full Name*

______________________________
*Date*

**Parent/Guardian/Spouse:**

______________________________
*Signature*

______________________________
*Print Full Name*

______________________________
*Date*

### FOR DEPENDENT APPLICANTS, AGE 18 OR OLDER:*

I have read and understand the information above. I give permission to MitoAction to receive and share information in the ways described above. I also give MitoAction permission to share information about me with my parent(s)/guardian(s), and to receive information from my parent(s)/guardian(s) in order to determine eligibility and the amount of assistance.

__________________________ __________________________ ________________
*Signature of Applicant, age 18 or older* *Print Full Name* *Date*

* A signature is required of all applicants age 18 or older unless they have a court-appointed guardian. If you are the court-appointed guardian for the Applicant, please provide documentation of guardianship.

Please return complete Application with requested medical documentation to:

**Marcel's Way Family Fund of MitoAction**
**PO Box 51474 ~ Boston, MA 02205**

Applications are reviewed on a quarterly basis.

[FOR OFFICE USE ONLY: Application No.______________ ]

# APPLICANT'S MEDICAL INFORMATION AND FUND REQUEST

**Diagnoses:** ______________________________________________

______________________________________________

**Briefly describe Applicant's condition, including whether the Applicant is currently hospitalized or at home:**

______________________________________________

______________________________________________

______________________________________________

**Does Applicant use a wheelchair? __ No __Yes-Comment, as needed:**______________________

______________________________________________

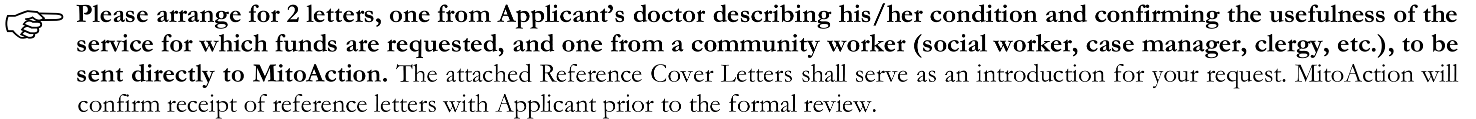
______________________________________________

**Marcel's Way Family Fund of MitoAction** is intended to support expenses that "promote health" or "provide relief" for an individual affected by mitochondrial disorder. Please explain your intended use of this funding, if your application is approved, including any extenuating family circumstances:______________________

______________________________________________

______________________________________________

## Fund Request: Supporting Documentation



☞ **Please arrange for 2 letters, one from Applicant's doctor describing his/her condition and confirming the usefulness of the service for which funds are requested, and one from a community worker (social worker, case manager, clergy, etc.), to be sent directly to MitoAction.** The attached Reference Cover Letters shall serve as an introduction for your request. MitoAction will confirm receipt of reference letters with Applicant prior to the formal review.

| *Provider* | *Name and Department* | *Facility/Address* | *Phone* |
|---|---|---|---|
| **Primary Care Doctor** | | | |
| **Mitochondrial Specialist** | | | |
| **Community Worker** | | | |

***Your signature on Page 2 gives MitoAction permission to contact providers listed above.***

## Fund Request: Associated Costs and Family Resources

***Note: Please attach documentation of estimated cost***

**Estimated Total Cost** $____________

**Funding Available for the Service, Equipment, or Assistance:**

-From Applicant and family members $ ____________

-From Insurance, Medicare, Medicaid, and Any Other Sources $ ____________

**TOTAL Available Funding** $ ____________

**Request From the Family Fund $** ____________

***NOTE: Maximum Request: $500.00***

**Additional Circumstances of Note:**______________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

FOR OFFICE USE ONLY:
Application No.______________ Date:__________

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## Letter to the Physician/Community Worker

*To be completed by Applicant:*

| Patient's Name (First, Middle, Last) | Street Address |
|---|---|
| Date of Birth | City/State/Zip Code |
| Telephone | |

Description of the service, equipment, or assistance for which this grant is being applied:

______________________________________________________________

______________________________________________________________

______________________________________________________________

Signed: ________________________________ Date: ______________________
(Parent/Guardian/Adult Applicant)

..................................................................................................................

Dear ______________________________ ,
*(Name of Provider)*

Your patient/client is applying for assistance from the Marcel's Way Family Fund of MitoAction. ***Please provide a statement on hospital/agency letterhead*** describing how the service/ equipment/assistance described above relates to his or her condition. Please include any information about the patient's situation that may be pertinent for the Marcel's Way Family Fund Committee to consider. In addition:

- ***Physicians:*** Please verify your patient's diagnosis of having a mitochondrial disorder.

- ***Community Workers (Social Worker, Case Manager, Clergy… etc.):*** Please describe your involvement with this patient (including length of relationship and your role in their care). Please explain your knowledge of the patient's background, living situation, and financial situation *(Please note that there is no income eligibility to apply for this grant)*. Please list any other resources which this family has contacted for support, to your knowledge.

**Please attach this cover letter to your letter of explanation and return to Marcel's Way Family Fund of MitoAction (**address above). All communication will be kept confidential. We will acknowledge receipt of your submission to the Applicant, on your behalf. If you have any questions, please contact MitoAction. ***Thank you for your time!***

[FOR OFFICE USE ONLY: Application No.______________ ]

**MARCEL'S WAY FAMILY FUND** of mitoACTION
**T** 888.648.6228 **E** INFO@MITOACTION.ORG PO BOX 51474 BOSTON MA 02205 WWW.MITOACTION.ORG

## Letter to the Physician/Community Worker

*To be completed by Applicant:*

| Patient's Name (First, Middle, Last) | Street Address |
| --- | --- |
| Date of Birth | City/State/Zip Code |
| Telephone | |

Description of the service, equipment, or assistance for which this grant is being applied:

___________________________________________________________

___________________________________________________________

___________________________________________________________

Signed: ______________________________ Date: ____________________
(Parent/Guardian/Adult Applicant)

.....................................................................................................................

Dear ______________________________ ,
*(Name of Provider)*

Your patient/client is applying for assistance from the Marcel's Way Family Fund of MitoAction. ***Please provide a statement on hospital/agency letterhead*** describing how the service/ equipment/assistance described above relates to his or her condition. Please include any information about the patient's situation that may be pertinent for the Marcel's Way Family Fund Committee to consider. In addition:

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