One Ball Foundation

The mission of One Ball Foundation is to raise awareness about testicular cancer and help support those in treatment.

Support Request Application

Patient Information

Full Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Email: _____ T-Shirt Size: _____

Official Diagnosis: _____

Contact Information
(If different from patient information)

Full Name: _____ Relationship to Patient: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Email: _____

Request Information
Maximum $500.00 per 12 month period

Amount Requested: _____

Please indicate item for which you are a requesting a grant.

_____ Deductible/Co-pays not covered by insurance. Submit a copy of the bill with application.

_____ Procedures not covered by insurance (i.e. sperm banking). Submit a copy of the bill.

_____ Prescriptions. Submit a copy of the bill.

_____ Assist with travel expenses for medical appointments. Submit list # of trips and mileage.

_____ Lodging during trips for medical treatments. Submit a copy of the bill.

_____ Assist with daily living expenses due to financial hardship (i.e. loss of wages). Explain below.

_____ Other. Describe in detail below. Copies of bills may be requested upon approval of grant.

_____

_____

_____

I have been diagnosed with testicular cancer (or I am submitting this application on behalf of a minor who has been diagnosed) and require assistance with the costs associated with treatment. I agree by signing and submitting this request that all information contained is accurate and true to the best of my knowledge.

_____	_____	_____
Signature of Patient	Signature of Requestor (if minor)	Date

Publicity Release

One Ball Foundation provides support to patients and families affected by testicular cancer. We are honored to assist those in need and want to acknowledge those we are able to help. We respectfully request the usage of your name and photo in recipient recognition releases, use on our public Facebook, Twitter, and website, recognition at our public events, and any other opportunities we may be given.

This is not mandatory. We will only use your name and photo if given permission. Please provide any specific information you would like us to follow and sign below.

_____

_____

____ I give permission to One Ball Foundation to use my name and photo for recognition and fundraising purposes. Please mail or email photo if permission is given.

____ I DO NOT give permission to One Ball Foundation to use my name and photo for recognition and fundraising purposes.

_____	_____	_____
Signature of Patient	Signature of Requestor (if minor)	Date

Mail this application and supporting documents to:

One Ball Foundation, 1633 Buffalo St. Ext., Jamestown, NY 14701

For more information visit www.1ball4tc.com or email 1ball4tc@hotmail.com