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# Beyond the Diagnosis Grant Application

## Applicant Information *(Open to United States residence only.)*

Applicant Name: _____
Relationship to Individual with NF: ☐ Self ☐ Parent/Guardian ☐ Spouse/Partner
☐ Other:_____
Name of Individual Diagnosed with NF: _____
Date of Birth: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone Number: _____
Email Address: _____

## Diagnosis Information

Neurofibromatosis Diagnosis: ☐ NF1 ☐ NF2 Related Schwan ☐ Schwannomatosis
Age at Diagnosis: _____
Treating Hospital/Clinic: _____
Primary NF Specialist: _____

How has NF affected the individual? (Check all that apply)
☐ Chronic Pain
☐ Frequent Medical Appointments (more than 2 times a year)
☐ Tumors/Plexiform Neurofibromas
☐ Hearing Loss
☐ Vision Impairment
☐ Learning Disabilities
☐ Developmental Delays
☐ Mobility Challenges
☐ Mental Health Challenges
☐ Surgeries or Procedures
☐ Disability Affecting Employment
☐ Other: _____

## Household Information

Total Number of Adults in Household: _____
Total Number of Children in Household:

Annual Household Income:
☐ Under $25,000
☐ $25,000 - $50,000
☐ $50,001 - $75,000
☐ $75,001 - $100,000
☐ Over $100,000

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Has your household experienced any of the following within the past 12 months?
☐ Loss of Employment
☐ Reduced Work Hours
☐ Medical Leave
☐ Significant Medical Expenses
☐ Housing Instability
☐ Caregiver Left Workforce Due to NF
☐ Unexpected Family Emergency
☐ None of the Above

## NF Financial Impact

Approximately how much has NF cost your family during the past 12 months? (Out of pocket expenses only.)
☐ Less than $1,000
☐ $1,000 - $5,000
☐ $5,001 - $10,000
☐ $10,001 - $25,000
☐ More than $25,000

Which NF-related expenses have created financial hardship? (Check all that apply)
☐ Medical Bills
☐ Insurance Deductibles
☐ Prescription Costs
☐ Travel Expenses
☐ Lodging During Treatment
☐ Lost Wages
☐ Physical/Occupational Therapy
☐ Educational Support Services
☐ Medical Equipment
☐ Home Modifications
☐ Childcare
☐ Other: _____

Have you postponed, delayed, or skipped medical care due to cost?
☐ Yes
☐ No
If yes, please explain:

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## Grant Request

Amount Requested $ _____ (Up to $2500)

What type of assistance are you requesting? (Select all that apply)
☐ Housing Assistance (Rent/Mortgage)
☐ Utilities
☐ Medical Bills
☐ Prescription Costs
☐ Travel for Medical Care
☐ Lodging During Treatment
☐ Medical Equipment
☐ Vehicle Repair Related to Medical Transportation
☐ Educational Support
☐ Hygiene Items
☐ Household Items
☐ Other: _____

Total Cost of Expense $ _____

Have you applied for assistance from another organization for this same need?
☐ Yes
☐ No
If yes, please explain:

Have you previously received funding from Seventeen22 Foundation?
☐ Yes
☐ No
If yes, please note the funding date: _____ (Patients are eligible to receive funding once per 12 month period.)

## Medical Travel Impact

Approximately how many NF-related appointments occur annually?
☐ 1-5
☐ 6-10
☐ 11-20
☐ More than 20

How far do you typically travel for NF-related care?
☐ Under 25 Miles
☐ 25-100 Miles
☐ 101-250 Miles
☐ More than 250 Miles
☐ Out of State

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## Need and Urgency Assessment

Without assistance, what is the likely outcome? (Check all that apply)

☐ Missed Medical Treatment
☐ Delayed Surgery or Procedure
☐ Housing Instability
☐ Utility Disconnection
☐ Inability to Travel for Care
☐ Food Insecurity
☐ Increased Debt
☐ Other: _____

How would receiving this assistance improve your family's situation?

☐ Access Necessary Medical Care
☐ Reduce Financial Stress
☐ Maintain Stable Housing
☐ Continue Education
☐ Remain Employed
☐ Improve Quality of Life
☐ Avoid Additional Debt
☐ Other: _____

## Additional Resources

Are you currently receiving any of the following?

☐ Medicaid
☐ Medicare
☐ SSI
☐ SSDI
☐ SNAP
☐ CHIP`
☐ None
☐ Other: _____

What kind of treatments have you had for your NF?

☐ Surgeries
☐ MEK Inhibitors
☐ Eye Care
☐ Pain Management
☐ Rehabilitation
☐ Other: _____

I need help navigating options: ☐ Yes ☐ No

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## Follow-Up & Story Sharing

May Seventeen22 Foundation contact you for a follow-up impact survey?
☐ Yes
☐ No

May Seventeen22 Foundation share your story anonymously for grant reporting and fundraising purposes?
☐ Yes
☐ No

May Seventeen22 Foundation contact you regarding future NF resources and support programs?
☐ Yes
☐ No

## Family Impact Statement

Please share your family's story.

Describe how neurofibromatosis has affected your family emotionally, physically, educationally, professionally, and financially. Tell us about the challenges you face and how receiving this grant would make a meaningful difference in your life.

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**THIS SECTION MUST BE COMPLETED BY THE PROVIDER** *(MD, PA, Social Worker, Nurse, etc.)*

This document is to verify that: (Patient's Name _____ (DOB) _____ remains under active care at our institution (Name of Care Facility) _____ (City, State) _____

For the diagnosis of neurofibromatosis.

☐ Type 1 ☐ NF2-related Schwannomatosis ☐ Schwannomatosis

Original Diagnosis Date _____

We hereby attest that this information is true and correct.
_____ Date _____
1st Signature: MD, DO, PA, or NP

Print Name _____ Title _____
Phone _____ Email _____

_____ Date _____
2nd signature NP, Social Worker, Practice Manager
Print Name _____ Title _____
Phone _____ Email _____

## Certification

I authorize Seventeen22 Foundation and its agents to access and review the information I have submitted herein, including any private or confidential health information. I understand that Seventeen22 Foundation intends to use this information in connection with their assessment of funding and potential awarding payment and will not disclose this information to third parties. This authorization expires one year from the date of submission, unless otherwise agreed.

By signing this document, I _____ (name) hereby authorize the release of information in this application and related to my diagnosis to Seventeen22 Foundation for the purpose of seeking assistance. I affirm that all of the information provided in order to qualify for assistance is complete and accurate. I understand that I may be denied assistance if any of the above information is false, and that I may be required to repay any assistance that I have received based on false or incomplete information.

I understand and agree that: (i) Seventeen22 Foundation in its sole discretion shall determine my eligibility, participation and termination in its programs; (ii) Seventeen22 Foundation does not guarantee payment of funding (iii) Seventeen22 Foundation shall have no liability pursuant to my application, participation, continuation or termination in its programs; (iv) I authorize my Physician to release to Seventeen22 Foundation such

medical information of mine as it may require to administer my application and participation in its programs

Applicant Signature: _____

Date: _____

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## Documentation Checklist

Please provide copies of applicable documentation:

☐ NF Diagnosis Verification (two professional signatures required – see above)

☐ Itemized Bill or Invoice

☐ Government-Issued Identification