



The Mary Maguire Foundation

Financial Request Form

Awards range from \$50.00 to \$1000.00 and are intended for the purposes listed below.

Please send your request form to: The Mary Maguire Foundation
5881 Cook Road, Suite A, Milford, OH 45150

Or fax the request form to 513.576.6778

Applicant's Name: _____ Date of birth: _____
Address: _____
City: _____ State _____ Zip: _____
Home Phone: _____ Work Phone: _____
Person completing the form: _____ Phone: _____
Relationship to applicant: _____

| Request ⁺ | Amount Requested** | Check Payable to: |
|--|--------------------|-------------------|
| Health & Fitness Assistance (personal training, weight management ⁺) | | |
| Nutritionist/Dietitian ⁺ | | |
| Medications/Co-Pays/OTC drugs | | |
| Hospital Services | | |
| Clinic/Laboratory Services | | |
| Insurance | | |
| Counseling/Emotional Assistance ⁺ | | |
| Groceries/Health Food Gift Cards ⁺ | | |
| Medical/Therapeutic Massage ⁺ | | |
| Medical Acupuncture ⁺ | | |
| Exercise Class(es) ⁺ | | |
| Health Club Membership ⁺ | | |
| Other: (Please specify) ⁺ | | |
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****Copies of the bills/receipts must be attached to the application to receive payment. If your request is approved, the Mary Maguire Foundation will make the check payable to the recipient on your behalf. The recipient may be the nutritionist, trainer, health club or facility, pharmacy, health food store, etc. Please send copies only and retain the originals for your files.**

***Restrictions apply.**

+Must be approved prior to payment.

Briefly add any other information that you think would be helpful for the committee:

I certify that the above information is true and complete to the best of my knowledge.

Signature: _____ Date: _____

This Section to be completed by Oncologist or Surgeon

(Name) _____ is a patient of mine and is currently or has been receiving treatment for _____ cancer.

Location of Treatment (Clinic & City)

Treatment Type(s):

Other Information that may be of importance (optional): _____

Doctor's name (print): _____ Doctor's phone number: _____

Doctor's Signature: _____ Date: _____