The Brodie Fund Grant Application

APPLICANT INFORMATION		
Name:		
Street Address:		Phone:
City:	State:	Zip Code:
☐ Own ☐ Rent	Monthly payment or rent: $ ___________________	How long have you resided here?

EMPLOYMENT INFORMATION		
Employer:		
Street Address:		How long have you been employed here?
City:	State:	Zip Code:
Phone:	Email:	
Position:	☐ Salary ☐ Hourly Rate $____________________	Annual Gross Household Income (please include SSI, SSDI, unemployment, child support, alimony, or any other assistance): $________________________

ADDITIONAL INFORMATION & FINANCIALS
Reason for Applying (please check all that apply): ☐ Loss of Job ☐ Fixed Income ☐ Personal Medical Issues ☐ Permanently or Temporarily Disabled ☐ US Veteran ☐ Other (please describe)
Do you have Care Credit? ☐ Yes ☐ No If No, apply here: https://carecredit.com/
Do you have pet insurance? ☐ Yes ☐ No If Yes, please indicate name of company and coverage information
Are you receiving additional financial assistance? ☐ Yes ☐ No If yes, please list here
How much are you able to contribute towards the cost of care? $______________________
Amount requested: $_______________________

COMPANION ANIMAL INFORMATION

Pet's Name:		☐ Dog ☐ Cat ☐ Other
Age:	Date of Birth:	Breed:

Are you interested in sharing your story with The Brodie Fund community via a blog post, e-news article, social media, or other communications vehicles? ☐ Yes ☐ No

If Yes, please read, insert name and sign below:

I,_________________________________, do hereby give The Brodie Fund, their assigns, licensees and legal representatives the irrevocable right to use my name, my pet's name, picture, photograph, portrait, visual likeness, or voice in all forms and media in all manners, including photo, film, audio and video representations, for non-profit, public purposes, and I hereby waive any right to inspect or approve the finished product that may be created in connection therewith. I have read this release and am fully familiar with its contents.

___________________________ ___________________
Signature Date

SIGNATURE(S)

I confirm that all information has been provided to the best of my knowledge. I understand that any false information given will result in the denial of my application.

Signature of Applicant	Date
Signature of Co-Applicant (if necessary)	Date

In signing this application, you understand that The Brodie Fund

- Is not responsible for the outcome of treatment or lack thereof
- Is not responsible for covering all costs associated to the animal's cancer treatment
- Cannot assist with charges incurred prior to application approval
- Does not pay for diagnostics, does not pay for spay, neuter, or vaccinations
- May request back-up or additional information to support this application
- May deny the request without reason

Dollar amount distributed in response to this application is based on financial ability of the organization at the time of request.

SUMBISSION OF APPLICATION

Please include a copy of the Care Credit statement or decline letter and a copy of your IRS Form 1040 for the previous year with your grant application. In addition, include copies of your last three monthly bank statements for review.

Submit to:
The Brodie Fund
P.O. Box 13
Rumson, NJ 07760
Email: brodiefund@gmail.com
Website: https://thebrodiefund.org/

<table>
<tr><th colspan="6">VETERINARIAN INFORMATION
(To be filled out by veterinarian)</th></tr>
<tr><td colspan="6">Hospital Name:</td></tr>
<tr><td colspan="6">Street Address:</td></tr>
<tr><td colspan="2">City:</td><td colspan="2">State:</td><td colspan="2">Zip Code:</td></tr>
<tr><td colspan="6">Phone:</td></tr>
<tr><td colspan="3">Veterinarian’s Name:</td><td colspan="3">Veterinarian’s Signature:</td></tr>
<tr><th colspan="6">MEDICAL INFORMATION</th></tr>
<tr><td colspan="6">Pet’s Name:</td></tr>
<tr><td colspan="6">Diagnosis (please include stage or other disease qualifiers you believe to be important):</td></tr>
<tr><th colspan="6">Primary Treatment Plan:</th></tr>
<tr><td colspan="3">Treatment Recommendation(s):</td><td colspan="3">Risk/Side Effects of Treatment:</td></tr>
<tr><td colspan="2">Median Survival Time/Prognosis:</td><td colspan="2">Expected Response Rate:</td><td colspan="2">Estimated Cost of Service(s):
$ ___________________</td></tr>
<tr><th colspan="6">Secondary Treatment Plan (if unable to fund primary treatment plan):</th></tr>
<tr><td colspan="3">Treatment Recommendation(s):</td><td colspan="3">Risk/Side Effects of Treatment:</td></tr>
<tr><td colspan="2">Median Survival Time/Prognosis:</td><td colspan="2">Expected Response Rate:</td><td colspan="2">Estimated Cost of Service(s):
$ ___________________</td></tr>
<tr><td colspan="6">Life Expectancy Without Primary/Secondary Treatment:</td></tr>
<tr><th colspan="6">Overall Health Assessment:</th></tr>
<tr><td colspan="6">Other Comorbidities:</td></tr>
<tr><td colspan="6">Will these comorbidities increase cost of treatment? ☐ Yes ☐ No

If Yes, estimate monthly amount: $__________________---</td></tr>
<tr><td colspan="6">Current Quality of Life (Scale of 1 (worst) - 10 (best)):
__________</td></tr>
</table>