Application for Support

(Please send completed application, consent form, and doctor's note stating diagnosis via fax 732-358-0542 or e-mail to info@stompthemonster.org)

*******As our application volume has increased significantly, below are the updated procedures that are now in effect:

- Please allow 3-4 weeks for processing and payment of all grants.
- STOMP only assists patients residing **in NJ and NYC**
- A confirmation will be sent once the grant payment has been made.
- To allow for year-end processing NO applications will be accepted in December.
- Patients may only apply once for a grant from STOMP the Monster
- Please make sure the new consent form is reviewed and signed
- If you are requesting assistance for a specific bill, then the invoice must be included or application will be denied
- **Please include a doctor's note stating the diagnosis and that the patient is currently in active treatment undergoing chemotherapy or radiation at the present time.**
- STM can help with the following but not limited to, rent (**only with a copy of a signed, legal lease**), child care, utilities, cable, phone, auto expenses, insurance, food & gas gift cards, medical bills, prescription co-pays, etc**, but we do not help pay mortgages, taxes, credit cards or give money directly to applicant**

Date:_____

Patient Information

First Name:_____ *Last Name*:_____

Street Address: _____

City: _____ *State*: _____ *Zip*: _____

Phone Number: _____ *E-mail*: _____

Age: _____ *Male/female (please circle one)*

Medical Information

Diagnosis: _____

Doctor Name:_____ Primary Hospital: _____

Current Issues resulting In Need to help understand the big picture: (Please give a detailed description of daily situation ie. Job/work, kids, living circumstance, family situation, insurance):

_____

_____

_____

_____

Area in which help is needed most and financial amounts– be as specific as possible and PRIORITIZE your needs: (transportation, prescription/medical, utilities, rent, child care, food, etc):

If a Bill needs to be paid, **please include a copy of the invoice** (ensuring who and where bill needs to be paid).

Assistance requested *(e.g., Electric bill, or rent – please prioritize list of bills)*	**COST** *(e.g., $150.00)*	**Payee/Vendor** *(e.g., PSE&G company)*	**Invoice Included** (yes/no)

Other Resources or Assistance applied for/ received or receiving:

_____

_____

_____

Contact information of Medical/Health Care provider or social worker:

Name:_____Organization:_____

Phone Number:_____ E-mail:_____

Please make sure the application is filled out completely and the signed doctor's note with a diagnosis and any invoices are included.

CONSENT FORM

I, _____(name), residing at _____*(address)*
Hereinafter referred to as "I" or "my"), hereby consent to the following:

1. Stomp The Monster ™ has express permission for the use of my story/image(full names will never be used). I understand that my image/story may be used in connection with all charitable fundraising efforts including it being published on a website promoting a charity event, and/or in press releases, articles, news stories and/or other related media. The right to my image/story is granted worldwide and in perpetuity, but only for use as set forth herein, and not in any other manner.

_____
Signed By:

Dated:_____

2. In the event that I am awarded a grant from Stomp The Monster ™ I certify, promise and affirm that I will utilize such grant for the specified intended purposes thereof, and for no other purpose. I understand that this promise is a material condition of being awarded a grant.

_____
Signed By:

Dated: _____

As an all-volunteer based organization, we continue to be passionate about our work and thank you for your continued support.