To apply for financial assistance from Gabriella's Smile, please complete and submit the attached application along with the required accompanying documents. Submission of an application is not a guarantee of receiving a grant. Funds are limited and based on the availability. Once your application is approved, we will notify you via email.

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1. Any family with a child diagnosed with DIPG in the **United States** prior to the child's 18th birthday is eligible for consideration.

2. Grants are also made available to any family with a child diagnosed with a pediatric brain tumor being treated in San Antonio. Child must be in current treatment and not be in remission for more than one year. *If the child is NOT under current treatment and is in hospice care, the application will be reviewed and special consideration for expedited grant approval will be made.*

3. The applicant must be the parent or legal guardian of the diagnosed child and the primary caregiver of the child. A photocopy of the child's birth certificate or other evidence of parental or guardian status must be submitted with the application. **Applicants must reside in the United States.**

4. The application must be accompanied by a signed letter from the child's treating physician on that physician's letterhead stating the child's full name, date of birth, diagnosis and date of last treatment provided. ***Child must be in current treatment or referred to hospice.***

5. All sections of the application must be completed and all accompanying documents must be submitted in order for our Finance/Grant Committee to review the request. Failure to provide complete information is a basis for denial of an application.

6. Assistance may be requested once during any 12-month period.

7. Please contact us at info@strongerthandipg.org if you have any questions concerning the application process.

Applications MUST be submitted by your child's social worker or healthcare provider via email or fax. Submission of an application is not a guarantee of receiving a grant from our foundation. We will not process INCOMPLETE applications.

Gabriella's Smile Foundation
Fax 1-210-670-6201
Email: info@strongerthandipg.org

Financial Assistance Application

Parent/Guardian's Name (first, middle, last): ____

Street: ____

City: ________________________ State: _________________ ZIP Code: ______________________

Home Phone: ______________________________ Daytime Phone: ___________________________

Email Address: ____

Child's Website or Care Page: ____

Medical Information Section
(To be completed my social worker or healthcare worker)

Child's Name (first, middle, last): ____

Social Security Number: ____

Date of Birth: ____

Type of Brain Cancer Diagnosed: ____

Date of Diagnosis: ____

Medical Institution Where Diagnosed/Treated: ____

Name of Treating Physician: ____

Phone Number and Email Address of Physician: ____

Is The Child Currently Receiving Treatment? ____

If Yes, Please Describe. ____

Date of Last Treatment Provided: ____

Name and Title of Person Completing the Medical Section

Printed Name: _______________________________________ Title: _________________________

Phone: _______________________________________ Email: ________________________________

Signature: ____________________________________ Date: _________________________________

Gabriella's Smile Foundation is a non-profit 501(c)(3) foundation.
EIN 82-4804148. For more information, visit strongerthandipg.org

Financial Assistance Application

***About the grant:** Gabriella's Smile Foundation wants to gift your family a $750 grant to help with the financial stress that comes with a DIPG/ Brain Cancer diagnosis and we want to help. We understand that there are many additional expenses that families incur almost immediately after receiving such devastating diagnosis.*

You are free to use the money at your discretion for medical expenses, travel expenses, treatments, living expenses, bills, etc..... You can also use it to treat your child to a special day or occasion. Our goal is to bring a SMILE to your family during such difficult circumstances.

I ◻ grant ◻ do not grant (Please check one) permission for Gabriella's Smile Foundation and its representatives to use photographs of my child or myself, our names and my child's story to inform families, volunteers, the media and the general public about Gabriella's Smile Foundation and its programs, services and events. Such materials may be used in, among other items, promotional materials, newsletters or on the internet. If permission is granted above, I, for myself and my child, release all claims against Gabriella's Smile Foundation and its representatives with respect to copyright ownership and publication, including any claim for compensation related to use of these materials.

I heard about Gabriella's Smile Foundation through the following:

◻ Family

◻ Parent of a child with brain cancer

◻ Physician

◻ Social Worker

◻ Other ___________________________________

Financial Assistance Application

By signing below:

◻ I authorize Gabriella's Smile Foundation and its agents and representatives to contact the above named medical institution and physician in order to verify my child's brain cancer diagnosis.

◻ I authorize the above named medical institution and physician to release to Gabriella's Smile Foundation and its agents and representatives any information and medical records deemed necessary by Gabriella's Smile Foundation to complete its verification of my child's DIPG/Brain Cancer diagnosis.

◻ I acknowledge that Gabriella's Smile Foundation will pursue and is entitled to restitution for a grant if it is determined that the information submitted on this application is false.

Signature of Parent/Guardian ____ Date ________________

Please provide the following information:

Name the check should be made out to: ______________________________________

Mailing Address: ____

City: _____________________ ***State:*** _______________ ***ZIP Code:*** ___________________

All applications will be reviewed on a case-by-case basis and a final determination will be made based upon other applications submitted to Gabriella's Smile Foundation and the availability of funds. You will not be discriminated against based on race, religion, color, national origin, sex or political affiliation.

For Gabriella's Smile Foundation Use Only
Date Received:__________________ Date Reviewed: ____________________ Approval Status: ________