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**INDIVIDUAL GRANT**

**APPLICATION**

*To be completed by Patient or Assisting Applicant if Patient Unable to Complete*

Please submit the completed Individual Grant Application and Diagnosis Verification by email to [fazelfamilyfoundation@gmail.com](mailto:fazelfamilyfoundation@gmail.com) or mail to:

Fazel Family Foundation

3910 East 51st Street

Tulsa, OK 74135

**APPLICANT CONTACT INFORMATION** Date:

Full Name:

Address:

City: State: Zip:

Phone: Email:

Relationship to Patient:

**PATIENT INFORMATION**

Full Name:

Address (if different from Applicant):

Date of Birth:

**DESCRIPTION OF REQUEST FOR EMERGENCY MEDICAL OR DISTRESS GRANT**

(Attach additional pages if necessary.)

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**DIAGNOSIS**

**VERIFICATION**

*To be completed by Treating Provider*

The Fazel Family Foundation offers one-time assistance to eligible patients suffering from medical emergency and distress. By signing this Diagnosis Verification, you are providing valuable information that the Foundation will use in determining individual grant assistance.

**TREATING PROVIDER INFORMATION**

Treating Provider Name, Credentials:

Facility Name:

Address:

City: State: Zip:

Telephone: Fax:

Who is the Primary Office Contact for this application: (social worker, nurse, etc.) first and last name *preferred*; first name and at least last name initial *required.*

Name: Telephone:

**PATIENT INFORMATION**

My patient, , DOB: is being treated for (Diagnosis).

Approximate date condition commenced:

Probable duration of condition:

Describe other relevant medical facts, if any, related to the condition for which the patient seeks financial assistance (such medical facts may include symptoms, effect of condition on work capacity, any regimen of continuing treatment, the need for specialized equipment, etc.):

Signature of Treating Provider:

PRINTED Treating Provider’s Name:

Date:

*Questions can be directed to the Fazel Family Foundation at*

*FazelFamilyFoundation@gmail.com.*