Paula's Hero Run Benefit Fund's

Patient Assistant Fund (PAF) assists patients and caregivers with living expenses during treatment.

Grants are $100-$400. We cannot accommodate larger requests.

Who is eligible for Assistance?

- Patients who had a transplant or awaiting a transplant within the last 12 months.
- Transplant patients, regardless type.
- Patients who have not previously received a grant from Paula's Hero Run Benefit Fund.

Expenses We Cover While Patient is Undergoing Treatment:

- Transportation to and from medical care
- Insurance co-pays
- Food
- Lodging
- Utilities

Expenses We Do NOT Cover:

- Medical bills
- Medications

Application Process:

- Application for funds must be completed and verifiable through Medical personnel who can certifies that the patient is in need of financial help.
- ALL sections of the application form must be completed in order to be considered.
- If you have questions, please submit questions that PaulasHeroRun.org
- Please allow two weeks to process once received by Paula's Hero Run Benefit Fund.

Evaluation/Decision/Disbursement of Funds

- Patient and Transplant personnel will be notified via email when application is received.
- Fully completed applications will be reviewed within two weeks of receipt. Incomplete applications will delay review.
- Applicants who are approved will be notified of the decision following review.

Application may be submitted by:

Mailed to: Paula's' Hero Run Benefit Fund
100 Lee Street
Milan, Ga. 31060

Or Faxed: 229-362-0002 (Call First)

E-mailed: PaulasHeroRun@Gmail.com

Please complete the following application with as much detail as possible with the patient/caregiver. Failure to complete the application in full will result in delay of review and funding.
Adult requesting Funds

First Name * ___________________________________________________________

Last Name * ___________________________________________________________________

Home - Street Address * _______________________________________________________

Home - Street Address Line 2 _____________________________________________________

Home - City * ___________________________________________________________________

State/Province * ________________________________________________________________

Home - Postal Code * __________________________________________________________

Email * _________________________________________________________________________

Home - Phone Number * _________________________________________________________

Cell - Phone Number * _________________________________________________________

Birth Date * Month______________ Day ________________ Year ________________

Relationship to Patient *

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

If the person who is requesting the funds is not the patient. Please provide the following*:

Patient's First Name ____________________________________________________________

Patient's Last Name ____________________________________________________________

Patient's Gender: _____Male _____Female

Patient's Birthdate Month______________ Day ________________ Year ________________

Are Members of the Patent's Family Registered Organ donors? _____ Yes _____No

If No please explain:

________________________________________________________________________________________

________________________________________________________________________________________

Would Patient, Family or friends be willing to volunteer at a Paula's Hero Run Fundraising event?

If No please explain: _____ Yes _____No

________________________________________________________________________________________
Who lives with or provided care for the patient?
Names, Age, and Relationship of family, Friends, and/or Outside Service *

____________________  ______  _________________________
____________________  ______  _________________________
____________________  ______  _________________________

Diagnosis *

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Diagnosis Description

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Date of most recent transplant or expected transplant date *

Month____________ Day __________  Year ___________

Patient Age at time of Transplant *: ________________

Transplant Type *: _______________________________________________________________

Transplant Center Name *: _____________________________________________________________

Center Contact Person*: ______________________________________________________________

Center Contact Number:* ___________________________________________________________

What are patient's specific medical needs?

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
The Grant
Names, Age, and Relationship of family and friends utilizing funds *

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

What will the grant be used for *

_____Transportation for medical care  ____ Food  ____ Lodging  ____ Utilities  ____ Other

If other, what will the grant be used for?

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Provide details why funding is needed. *

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Include patient's current medical, living, family and financial situation..

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

List all sources of monthly household income *

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Please include: Wages, Investment income, SSI, Disability payments, etc.
Amount Requested * ___________________________ The maximum amount given is $400.

Has the patient applied for funding from other organizations? * ____ Yes ____ No

  List other organizations applied to and status of applications.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If patient is not awarded funds, how will s/he cover the expense? *

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If requesting a gift card, which would you prefer? *

  _____ Gas  _____ Walmart  _____ Other
  Other gift card: ________________________________
  Gas card Type: ________________________________

Payment to another party

  If requesting payment to another party, such as a landlord or utility company, complete the following: • Name of party to whom payment should be sent • Account number on bill, if applicable • Address • City, state zip

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

In signing this request, I state that the information provided is true and accurate to the best of my knowledge.

Print Name: ____________________________________________ Date: ______________________

Signature: ____________________________ Relationship to Patient: ______________________

Paula's Hero Run Only □ Approved □ Disapproved

Amount Authorized: ___________ Date authorized: _______________

  □ Contact with Results

Mailed: □ Address: _________________________________________________________________

Pick-up: □ By Whom: _____________________________________________________________

  Signature: _________________________________________________________________

Reason for Disapproval: _________________________________________________________