



## BOBBY PAGE MEMORIAL FOUNDATION REQUEST FOR FUNDING APPLICATION

The Bobby Page Memorial Foundation is committed to assisting children throughout the Rome area that are suffering from a life threatening illness. The Bobby Page Memorial Foundation is committed to raising and allocating funds to applicants who fulfill following eligibility requirements: child with life threatening illness who must be under 18 years of age, the family must reside within Rome or vicinity, and physician must provide evidence of illness by submitting the attached "Patient Authorization Form". For questions regarding this application, please call 336-8364.

### APPLICATION INFORMATION

Date of Application: \_\_\_\_\_

Name of Recipient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School Attending: \_\_\_\_\_

Name of Applicant (Parent, Guardian, etc.): \_\_\_\_\_

Relationship to Recipient: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Insured: \_\_\_ Yes \_\_\_ No

ILLNESS State the Nature of Child's Illness\*\*:

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PLEASE ATTACH PATIENT AUTHORIZATION FORM (PAGE 3) SIGNED BY PHYSICIAN

Public Disclosure Waiver:\*\* \_\_\_\_\_ Yes \_\_\_\_\_ No

\*\*Applicant agrees to allow the Bobby Page Memorial Foundation to utilize the grantee's "story" for promotion of good works.



**BOBBY PAGE MEMORIAL FOUNDATION  
REQUEST FOR FUNDING APPLICATION**

Date of Application: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Medical Contact Information (Doctor or Specialist Currently Assisting Applicant)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**\*\*Medical Release of Information: Please forward Patient Authorization Form signed by physician describing medical condition.**

**STATEMENT OF NEED**

Please give a detailed description concerning the elements of your request:

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Please mail application to:

Bobby Page Memorial Foundation  
8527 Cyrus Ave.  
Rome, NY 13440



**BOBBY PAGE MEMORIAL FOUNDATION  
REQUEST FOR FUNDING APPLICATION**

I HEREBY AUTHORIZE YOU TO USE OR DISCLOSE THE SPECIFIC INFORMATION DESCRIBED BELOW FOR PURPOSE OF PROVIDING THE “BOBBY PAGE MEMORIAL FOUNDATION” APPROPRIATE INFORMATION TO SUPPORT THE BELOW MENTIONED PATIENT’S APPLICATION FOR FUNDING.

Person requesting the information and authorization to make the requested disclosure on behalf of the patient: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Date of Application: \_\_\_\_\_

**PHYSICIAN INFORMATION:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**RECIPIENT OF THE INFORMATION:**

**BOBBY PAGE MEMORIAL FOUNDATION**

8527 CYRUS AVE. ROME, NY 13440 315-336-8364

Description of specific medical condition (please attach additional documentation if necessary)

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Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_