THE STEVE MCGIRR CHARITABLE FOUNDATION
APPLICATION FOR NON-REIMBURSED MEDICAL EXPENSES

Please fill out this application in its entirety. Incomplete applications may not be considered.
Once completed, you may submit via email to: info@mcgirrfoundation.org
If you have any questions, please contact Mike McGirr: 415-342-8063

Name (First, MI, Last):		
Date of birth:	Patient's Diagnosis:	
Primary Care Provider:		Acct. #:
Primary Care Physician:		Phone #:
Primary Care Center Address:		
City:	State:	ZIP Code:
Name (First, MI, Last):		
Spouse/Co-Guardian Name:		
Primary Email:	Secondary Email:	
Current address:		
City: Sacramento	State:	ZIP Code: 95826
Do You (check one) ☐Own ☐Rent (Check One)	Monthly Mortgage/Rent Payment:	Estimated Monthly Household Expenses:
Current employer:		
Employer address:		How long employed?
City:	State:	ZIP Code:
Phone:	Position:	Fax:
☐Hourly ☐Salary (Check One)		Approx. Monthly Income:
Employed Less Than 1 Year? ☐ Yes ☐ No		
Please briefly explain circumstances:		
Spouse/Co-Guardian Current employer:		
Employer address:		How long employed?
City:	State:	ZIP Code:
Phone:	Position:	
☐Hourly ☐Salary Check One)		Approx. Monthly Income:
Employed Less Than 1 Year? ☐ Yes ☐ No		
NON-COVERED MEDICAL EXPENSES REQUESTED VIA THIS APPLICATION (Please include copies of receipts provided from these expenses)		
Transportation for Treatment/Diagnosis (Gas, Rental Car, Airfare, Meals, Lodging): $		
Treatment and/or Diagnosis Costs: $		
Medicines: $		
Other:		

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With this application, please include a signed Letter of Confirmation by the patient's primary care physician that explains the patient's diagnosis and condition, in addition to a brief overview of patient's past and current treatment requirements.

I verify that I have provided the information included herein voluntarily, and as presented is accurate and complete. I understand that The Steve McGirr Charitable Foundation has requested this information to verify the legitimacy of the patient's diagnosis and condition, the treatment regimen associated with it, and the reasons surrounding this request for financial reimbursement for the expenses described herein. I have made these statements truthfully and honestly, without intent to deceive or misrepresent the patient's condition for financial benefit for anything other than circumstances related to the patient's condition and treatment. I have not received any other reimbursement for the expenses for which I am seeking reimbursement from, nor will I receive such reimbursement from any source (including, but not limited to, Medicaid, state drug assistance programs, copayment assistance programs or other foundations), or a health care flexible spending account. I understand that I must submit claims as soon as possible after services are rendered and that The Steve McGirr Charitable Foundation will not pay claims received more than 120 days after the patient's date of service. I understand that The Steve McGirr Charitable Foundation reserves the right at any time and without notice to modify or discontinue any or all of the programs with respect to any applicant or in their entirety, to modify the related eligibility criteria, or to terminate assistance. Most importantly, I have made all statements and representations of information included herein under penalty of perjury by law. Finally, I am aware that the Board of Directors, donors, and all supporters of The Steve McGirr Charitable Foundation maintain this organization in the spirit of love and support of those experiencing the same hardships that Steve McGirr himself experienced during his battle with brain cancer, and I understand and am aware that if I am attempting to scandalously and fraudulently extort finances from the organization, that upon discovery of such fraud, The Steve McGirr Charitable Foundation will seek, at a minimum, full compensation for reimbursed expenses, and any other prosecutorial remedies available under California State and Federal laws.

Signature of Patient/Parent/Guardian	Date
Signature of Spouse/Co-Guardian	Date