The Mary Shands Scholarship Fund
Application Packet for Financial Assistance

Mission Statement
The Mary Shands Scholarship Fund, operated by The Marion Institute, Inc. (MI), (a nonprofit organization), is based upon the conviction that need based financial assistance be accessible to patients seeking care. Mary Shands was a visionary who dedicated herself with passion and generosity and pioneered the value of the tenets of bioregulatory medicine. This fund has been set up to honor her memory.

The Mary Shands Scholarship Fund is set up to provide monetary assistance to those seeking care from one of the BioMed Network Care Providers, or a provider qualified to become a part of the BioMed Network, please see link to website for list. The Scholarship Fund recognizes that its mission holds that a foundation of health is a necessity for all**.** We are committed that doors will not be closed to those who lack financial resources, and we will service patients with equality, impartiality and humanity.

Financial Assistance Criteria
Financial assistance is offered for patients seeking treatment through bioregulatory medicine regardless of their health concern. The Mary Shands Scholarship Fund provides **partial financial assistance** for treatment in accordance to how much they are awarded in aid. All monetary aid provided by the Mary Shands Scholarship Fund shall be paid directly to the medical facility/medical provider. **No monies awarded shall pass hands through the recipient of the financial assistance.** The patient/applicant will be responsible for the remainder of the treatment costs, paid directly to the chosen medical facility/medical provider.

Financial Assistance is based on the following criteria:

- Urgency of need
- Financial need
- Commitment to treatment program and the desire to change modifiable behaviors

Financial need is based on the Federal Poverty Guidelines (FPG). Applicants with an annual household income exceeding 500% FPG will not be considered for financial assistance unless medical costs within the same application year offset the net income (Please note that this chart is not applicable for residents of Alaska, Hawaii and Washington, D.C.)

Applicants are required to send a copy of their most recent tax return or tax transcript from the IRS as financial documentation for the Application Committee to determine financial need. *We ask that social security numbers are completely obscured.*

2019 Poverty Guidelines (aka Federal Poverty Level or FPL)
Percentages Over 2019 Poverty Guidelines:

Persons in Household	100%	500%
1	$12,490	$62,450
2	$16,910	$84,550
3	$21,330	$106,650
4	$25,750	$128,750
5	$ 30,170	$150,850
6	$34,590	$172,950
7	$39,010	$195,050
8	$43,430	$217,150

- Funds awarded to patient are restricted for the specific care of said patient. Funds are limited to direct diagnostic testing and therapeutic treatment. Funds may not be used for services covered by a patient's health and/or dental insurance plan. In addition funds may not be used to pay copayments, coinsurance, and/or deductibles, which are all the patients' responsibility.
- Funds may not be used for transportation, lodging, food, spa services, elective procedures not prescribed by the practitioner, supplements or pharmaceuticals.
- Financial assistance may not be used to cover payments for past treatments.
- Funds may not exceed the cost of treatments.
- Funds are only to be used by the recipient and are not transferable.

Application Committee
The application process will be overseen by the Biomed Program Coordinator and will include review and selection of recipients by the committee.

Instructions for Completion of Financial Award Request Form

1. It is preferred that the patient complete the application. If the patient is under the age of 18, both the patient and a parent or guardian must sign the consent form. If the patient is over the age of 18 but physically unable to complete the form, a spouse, sibling, parent or friend may complete the form, but the patient must sign the consent form.
2. The application may be submitted via fax (508) 748-1976; hard copy mailed to: Attention: Cheryl Radford/ Marion Institute, Mary Shands Scholarship Fund, 202 Spring Street, Marion, MA 02738; or scanned to scholarship@marioninstitute.org.
3. The questionnaire packet is an expandable Microsoft Word form. Therefore, each item within the questionnaire is an expandable area, so that you may type directly into the application.
4. As part of the application process we may require documentation of the diagnosis and treatment recommendation from your current treatment team. We require a signed release of information at the end of the application to provide The Marion Institute, Inc. the ability to contact your medical providers.
5. If there are questions regarding any of the items to be completed, please contact the Marion Institute, Inc. at scholarship@marioninstitute.org.

Process for Reviewing Applications

1. Once your completed application has been received by The Marion Institute, Inc. you will receive notification confirming its receipt. Applications are reviewed on a rolling basis. The application will first be reviewed for missing or unclear information. If additional information is needed, the applicant (or parent/guardian) will be

contacted. Please allow approximately 30 days for the review process to be completed. It is up to the applicant to provide current and up to date contact information.

2. The application will be reviewed based on the following criteria:
   a) Urgency of need
   b) Financial need
   c) Commitment to treatment program and desire to change
3. Award amounts will be based on the criteria listed above, the number of applications, available funds and potential cost of treatment.
4. The Application Committee reserves the right to make any exceptions to the criteria as is deemed necessary.
5. It is up to the applicant to make sure the all information provided is true and accurate.

Notification of Financial Assistance

1. All applicants will be notified within approximately 30 days from the date that the application was received. (Please note notifications are made on working business days.)
2. Each recipient will be notified via email and letter as soon as the decision has been made, with the amount of financial assistance indicated.
3. A notification letter will be mailed to the recipient and a copy will be emailed to the chosen medical facility/medical provider.
4. The dollar amount awarded must be used within **six months** from the date of the notification letter. After that date, any unused monies will be considered to be available for future applicants.
5. The Mary Shands Scholarship Fund award will be **sent directly to the agreed upon medical center/medical provider**. Any change in treatment requires approval from the Application Committee and may require a new application for consideration at a later date.
6. Applicants not receiving financial assistance will be notified by our preferred means of communication, email. One may reapply at any time in the future based on a change in their criteria.
7. If a patient chooses not to receive treatment from the agreed upon medical facility/medical provider, they would have to resubmit a new application to again become eligible for additional funds.

Financial Assistance Application

The Mary Shands Scholarship Fund under The Marion Institute, Inc. will not use personal information for any reason other than to make determinations for financial assistance.

All application sections should be typed directly into this form. Any text box can be made larger to accommodate your answers, but please limit your responses to a maximum of one page per question. When complete, please print the form, sign where indicated and submit via:

Fax: (508) 748-1976
ATTN: Cheryl Radford

U.S. Mail:
ATTN: Cheryl Radford/Marion Institute
202 Spring Street
Marion, MA 02738

Email:
scholarship@marioninstitute.org

Before you begin, please be sure you have carefully read the application instructions. Questions marked with a * are required and if left blank will affect the processing of your application.

Section I: General Information*

Date Submitted	

Applicant Information*

Name (First, Middle Initial, Last)	
Date of Birth and Age	
Gender	
Address	
City, State and Zip Code	
Home Telephone	
Cell Number	
Email Address	

1. **How many people reside in your household (including yourself)?*** _____
2. **If your answer to the above question was more than 1, please explain further (listing each person, their relationship to you, and their age at the time of this submission.)**

Name	Relationship to me	Age

3. **How did you first hear about the Mary Shands Scholarship Fund? ***

4. **Should you receive financial assistance, would you be willing to provide a testimonial of your care?***

☐ Yes ☐ No

Section II: Current & Ongoing Conditions

5. **Please list current and ongoing problems, in addition to your main health concern/diagnosis, in order of priority:***

	Severity						
Describe Problem	**Mild**	**Moderate**	**Severe**	**Prior Treatment/Approach**	**Excellent**	**Good**	**Fair**
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		
1.							
2.							
3.							
4.							
5.							
6.							

6. **Please list your current Medications and Supplements (includingVitamins, Minerals, Herbs and Homeopathic Remedies).***

Medication/Supplement	**Brand**	**Dose**	**Frequency**	**Start Date month/year**	**Reason for Use**

7. **Have you made any changes in your eating habits because of your health?***

☐ Yes ☐ No

8. **If your answer to the above question was YES, please describe and include information about any special diet or nutritional program you may follow. If your answer to the above question was NO, please enter N/A in the space provided.***

9. **Have you had any of the following dental procedures?***

□ metal amalgam fillings □ root canals □ Other _____

10. **Describe your mental and emotional health. Please include any relevant treatment and/or practices that contribute to your mental and emotional wellness, including but not limited to therapy, meditation, attending church,and mind/body/spirit therapies.** ***(Optional)***

11. **Are you currently or have you recently experienced a significant life event? If yes, please include any life events that feel significant to you, including but not limited to changes in your relationship, family, work, financial status, dietary or stress levels.** ***(Optional)***

12. **What do you hope to gain by receiving bioregulatory medicine treatment?***

13. **What do you feel is your life's purpose?**

Section III: Treatment History & Recommendations

14.CURRENT TREATMENT*			
Full Name (with medical Title)	**Role (nutritionist, etc)**	**Contact Information**	**How long have you been receiving treatment?**

15. PAST TREATMENT*			
Full Name (with medical Title)	**Contact Information**	**How long did you receive treatment?**	**Why did you stop?**

Section IV: Financial Information*

	Applicant	Co-Applicant *(if applicable)*	Combined Monthly Income (Applicant + Co-Applicant)
Monthly Income Sources	$	$	$
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other[s] use these spaces	$	$	$
	$	$	$
Total Household Income			**$**

16. **Name of Health Insurance*** _____

17. **Please describe your employment.** (Include your occupation, the number of hours per week you work, your salary or hourly wage, and how long you have worked there.) Students please note the name of your school (or if you are home-schooled), what your grade/year is, and whether you are enrolled full time, part time or are on any type of leave of absence.*

18. **If you do not have monthly income, please explain how you take care of your monthly expenses. Use additional pages if necessary.***

19. **Please use this space to tell us anything else that you feel we should know.**

Authorization for Use or Release of Information:

I,_____(name), hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") by the Marion Institute, Inc., (Mary Shands Scholarship Fund) a non-profit organization, to make determinations for financial assistance and need. I understand that my Protected Health Information may be subject to re-disclosure by The Marion Institute, Inc. pursuant to this authorization. I understand that The Marion Institute, Inc. will not use my Protected Health Information for any reason other than that which is stated above without my further authorization. I understand that I may revoke this authorization at any time by notifying the Marion Institute Inc. in writing, but if I do, it will not have an effect on any actions The Marion Institute, Inc. took before it received the revocation of this authorization.

_____ _____

Signature of Individual or Individual's Representative Date

Date of Birth _____

Print name of Individual's representative (*if applicable)*:

_____

Relationship to the Individual *(if applicable)*:

_____

By checking this box, the Marion Institute can follow up with me at periodic intervals to access private health care information, if necessary.* ☐

By checking this box, I agree to keep confidential the amount that may be awarded to me as part of this scholarship program.* ☐

SIGNATURE PAGE TO APPLICATION

I hereby certify that all information and attachments are true to my knowledge. I understand that false information may disqualify me from consideration for thisaward.

Dated:_____, 20_____ _____

Signature

Checklist for completed Mary Shands Scholarship Fund Financial Assistance Request Form:

___Application completed

___Financial documentation (most recently submitted tax return or tax transcript from the IRS)

___Completed release of information