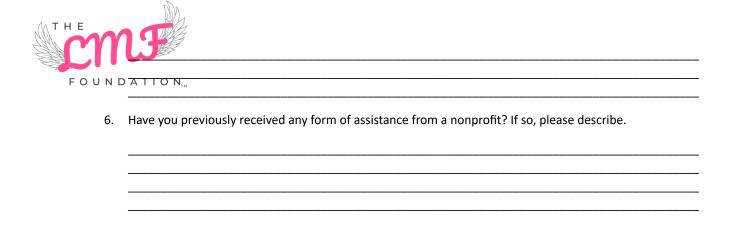


FLY ME TO THE MOON GRANT APPLICATION

PERSONAL INFORMATION:

Please complete the section below with information regarding the potential beneficiary: First Name: Last Name: Age: Gender: City:_____ State:____ Zip Code:____ Phone Number:_____ Email: Address:_____ Please complete the section below with information regarding the <u>parent and/or legal guardian of the potential</u> beneficiary. This individual will be our point of contact. First Name: ______ Last Name: _____ Relationship to Potential Beneficiary: Address: City: _____ State: ____ Zip Code: _____ Phone Number:_____ Email: Address:_____ **MEDICAL INFORMATION:** 1. Please provide some information as to what chronic illness the potential beneficiary has been diagnosed with: 2. At what medical facility does the potential beneficiary receive their care? Who is their lead physician?

THE 3	Does the potential beneficiary have current health insurance? If so, what is the provider?
<u>ELIGIBIL</u>	LITY INFORMATION:
1.	What medical assistance device or service do you wish to apply for to be fulfilled by the Fly Me to the Moon Grant?
2.	Please describe why this device or service is essential to your medical care.
3.	How will having this device or service improve your quality of life with chronic illness?
4.	What does Lea's story and the Lea Marie Faraone Foundation's mission mean to you?
5.	In what ways have you tried to obtain this device or service prior to this application? In other words, why do you need the Lea Marie Faraone Foundation's assistance in achieving this device or service?



Thank you for your interest in the Lea Marie Faraone Foundation's Fly Me to the Moon Grant! We look forward to hearing your story. Please send this completed application to leamariefaraonefoundation@gmail.com and we will get back to you as soon as possible.