# Grant Application/Nebraska Greats Foundation

Please complete each question as accurately and completely as possible. Please include all required documents. Note: ***all information presented will be kept confidential and only shared with those parties deemed necessary for grant approval***. All documents included WILL NOT BE RETURNED so it is advised that applicants make copies for personal use. When completed, please mail to:

Nebraska Greats Foundation

5010 Underwood Ave

Omaha, NE 68132

If you have any questions or concerns during the application process, please reach out to:

Sandy Zoroya

szoroya@negreats.org

702-321-9136

PLEASE PRINT

**SECTION 1/Personal information**

First Name: _____ Last Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ zip code: _____

Cellphone: _____ other phone: (if any) _____

Email address: _____Date of birth: _____

Social Security number: _____

College of University attended in Nebraska: _____

In which sport(s) did you compete: _____

Letters earned: _____

Did you play professionally: Yes_____ No_____ How many years did you play pro: _____

Are you eligible for any health benefits from your professional career: Yes_____ No _____

If yes, please detail those benefits_____

_____

Do you have any sports related injuries: Yes_____ No_____ If YES, please detail those injuries_____

_____

(Note, it is not required that your illness or injury be sports related to qualify for an NGF grant)

Are you clinically disabled: Yes _____ No _____ If yes, have you applied for disability benefits from either a private policy or the government? Please provide information on your disability benefits _____

_____

Please continue page 3

## SECTION 2/Needs

The NGF provides assistance to qualified applicants for the following items: equipment, surgical procedures, rehabilitation services (physical not substance abuse), pre and post operative care, insurance deductibles, in home care, travel to and from authorized care, insurance short falls, prescribed medication, overdue expenses related to injuries or illness. Please note that at no time will applicants receive any direct subsidy. No social or living expenses are eligible. All authorized grant funds will be sent to approved providers only

Please detail how the Nebraska Greats Foundation can assist you

Please continue page 4

## SECTION 3/Medical and Insurance information

***(Important: Before completing this application, please contact your doctor's office and inform them of your application for assistance from the NGF granting them permission to share your patient information with the NGF when and as necessary. The NGF will not SHARE your confidential information with anyone)***

Are you currently seeing a doctor: Yes_____ No _____. If yes, please provide the following information:

Primary Doctor's name: _____

Primary Doctor's office phone: _____

Secondary or Specialist Doctor (if applicable): _____

Secondary Doctor's office phone: _____

What is your current treatment_____
_____
_____
_____
_____
_____

(Please include a copy of a doctor's note confirming your patient status with that doctor)

Do you currently have ANY health insurance (employer, individual or government sponsored):

**Note: Having insurance does not DISQUALIFY you from a grant from the NGF**

Yes: _____ No: _____ If yes, please provide the following information:

Employer sponsored. Yes_____ If Yes, circle one Employee or Dependent.

Status: Are you an **active** or **former** employee (circle one).

Are you on **COBRA** or **state sponsored** continuation coverage (circle one)

If active employer sponsored, what is your Group number: _____

Are you receiving any VA Benefits Yes_____ No _____ Don't know_____ Were you ever active military? Yes_____ No _____

Please continue page 5

**SECTION 3/Medical and Insurance information cont.**

Are you receiving any benefits from TriCare Yes _____ No _____.

Have you or are you receiving any health-related proceeds from a property/casualty policy (car accident, motorcycle, or boating accident). Yes _____ No _____

Do you have or have access to any tax-preferred health spending accounts:

Health Saving account (HSA) Yes_____ No _____

Flexible Spending Account (FSA) Yes_____ No _____

Health reimbursement arrangements (HRA) Yes_____ No_____

Individual or Private health insurance through the affordable Care act (Obamacare): Yes _____ No _____

Do you receive any benefits from Social Security Yes _____ No_____

**Do you receive from any or all of the following sources:**

Disability Income insurance - state or private Yes _____ No _____
Supplemental insurance coverage (e.g., accident, cancer, critical illness, hospital indemnity) Yes _____ No _____
Participation in a clinical trial and/or experimental care Yes _____ No _____
Prescription Drug Manufacturer incentive (i.e., copay assistance, $0 cost, etc.) Yes _____ No _____
Medicare (Medicare Advantage (Part C) or "traditional Medicare" (Parts A, B, D, and a Medicare Supplement policy): Yes _____ No _____
Medicare disability: Yes _____ No _____
Medicare - End Stage Renal Disease: Yes _____ No _____
Medicare - Amyotrophic Lateral Sclerosis (ALS): Yes _____ No _____
Medicaid: Yes _____ No

If the answer is YES to any of these please detail the following including how much money is available in your spending accounts or how much you are receiving monthly from these funding sources. *Example: I have $1000 in an HAS that I use for prescription drugs. Or I received 10,000 from a property casualty settlement after a car accident that I used for medical bills. Or I receive $1500 per month from my disability policy)*

_____
_____
_____

Please continue on page 6

Please continue on page 7

## Section 4/Income and Assets

Currently employed? Yes: _____ No: _____

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

Phone of employer: _____ _____

Email of employer: _____

How long have you been employed there: _____

What is your monthly take home pay? _____

Is your spouse/partner/significant other employed? Yes: _____ No: _____

If yes, what is their monthly take home pay: _____

Does your spouse/partner/significant other contribute towards your expenses? Yes: ___ No_____

Do you receive a monthly pension or living payment from any source: Yes_____ No: _____

*(Could include but not be limited to disability insurance or any insurance proceeds)*

If yes, from what company or organization and what is the monthly payment: $_____

Is there a limit on the amount of your pension or disability payment? If YES, please describe below:

_____
_____
_____
_____
_____

Do you receive any income from any of the following sources:

Social Security

Annuity

401K or IRA plan

Trust Fund

Insurance Proceeds

Investment accounts

Please continue on page 8

If yes, please detail the monthly amount you receive from each

_____
_____
_____
_____
_____
_____

Do you own your own home?

If YES

What is your current mortgage balance? _____

If you rent your home, what is the monthly rent payment $ _____

**DEBTS**

If applicable, please provide detailed information on your current indebtedness:

Home: _____ (mortgage balance)

Home Equity Line of Credit (2nd mortgage) _____

Vehicles (cars, boats, motorcycles, motor homes, etc.: _____

Credit Cards: _____ (combine amounts of all credit cards)

Personal loans: _____

Please list your regular monthly expenses (current)

Food: _____

Rent/Mortgage: _____

Utilities: _____

Phone/Internet_____

Credit Cards: _____

Miscellaneous: _____

Medical Bills outstanding

_____
_____
_____

please continue on page 9

## CONFIRMATION/RELEASE

I certify that the information I have provided to Nebraska Greats Foundation is accurate and correct to the best of my knowledge and ability. I understand that any misrepresentation or falsification of information on this form will void my application. I further understand my request will be treated with confidentiality. However, I also understand that the Nebraska Greats Foundation may seek additional pertinent verification of the information provided on this application and I expressly consent to such inquiries.

Applicant's Name: (Please print): _____

Applicant's Signature: _____

Applicant's Phone Number: _____

Applicant email_____

Date application Signed: _____

Witness Name: (Please print): _____

Witness Signature: _____

Witness Phone Number: _____

Witness Email address: _____

Date application Signed: _____

Your application must also include:

1. Letter from you attending physician verifying your condition
2. Copies of bills or medical estimates relevant to the assistance for which you are applying –
3. Two months copies of pay stubs from your employer (if employed)
4. Three months bank statements (checking or savings) verifying your income and expenses

Any additional supporting documentation that will help us to understand your circumstances

Please mail applications to:

Nebraska Greats Foundation Attention:

Sandy Zoroya 5010 Underwood Ave Omaha, NE 68132

Phone: (702) 321-9136

Please continue on page 10

Please note that the NGF may request additional information such as income tax returns or other verifying documents.

***THE FOLLOWNG INFORMATION IS OPTIONAL***

NOTE: The decision on your application is not based upon you filling or not filling out this form. Your application is reviewed independently, and you are NOT required to fill out this form. This is a voluntary form we use to help assist you by providing your information to others who may be able to provide support to you and raise the funds needed to help other former, fellow Nebraska athletes.

One of the ways we can help all players and their families who contact us is to get the word out about the medical situations among our former Nebraska athletes. We are asking for your permission to tell your story to potential donors and if you allow the media and public. We will share a general description of your story and possibly a general description of your current injuries. We will NOT disclose financial or medical information from doctors, hospitals, etc., unless you specifically authorize below. An example of what a release would sounds like would be *"John Doe, former athlete at the University of Nebraska has lingering health issues. Because this issue is difficult, he has medical bills that exceed his income and family assets. "*

You will have complete APPROVAL over any part of your story shared with the media or public. We would also like to publish any appreciation or other notes you send to us. Initial in appropriate columns to indicate authorization for release of the following information: Item Release to Donors Release to Media or Public Injuries/illness Use of Name Release of Medical Information Photos (from playing days) Thank you notes By signing below, you grant the Nebraska Greats Foundation, the authority to publish relevant information we receive from you in order to raise funds for your fellow former Nebraska athletes. You MAY revoke this consent at any time by writing to us.

| | **DONORS** | **NEWS MEDIA/WEBSITE** |
|---|---|---|
| Use of Name | YES/NO | YES/NO |
| Injury illness | YES/NO | YES/NO |
| Release of medical info | YES/NO | YES/NO |
| Photos of you and your family | YES/NO | YES/NO |
| Thank you notes | YES/NO | YES/NO |

SIGNATURE OF APPLICANT _____ DATE _____