**Application Packet**

**For Financial Assistance**

Mission Statement

In 1997, The Biological Medicine Network (BioMed Network) was created as a program of the Marion Institute, a non-profit organization in Marion, MA. The BioMed Network is dedicated to the vision of complete health and wellbeing through the advancement, accessibility and widening availability of biological medicine in North America.

The Biological Medicine Network provides these three core services:

* Education through lectures, seminars and online resources to a community of doctors, holistic and alternative health practitioners, patients and concerned individuals.
* Patient information and coordination to biological medicine clinics in North America and Switzerland.
* Networking between some of the most revered and well-respected holistic health providers in the medical community.

History of Biological Medicine Network

The Marion Institute’s Biological Medicine Network was created out of a mother’s and father's love and a vision for others to benefit from biological medicine. Biological medicine emphasizes noninvasive diagnostic and treatment methods and the natural healing power of the body.

When Michael and Margie Baldwin’s youngest son was diagnosed with cancer, he was treated with three rounds of chemotherapy, followed by a bone-marrow transplant from his sister. Complications from the transplant reduced his lung capacity by 50 percent. The Baldwins were told his lung capacity would never recover. They began to search for alternative treatments to reverse his loss of function, and they read about biological medicine and the Paracelsus Clinic in Switzerland. After speaking with the clinic director Dr. Thomas Rau, and their son was well enough to travel, they took him to the clinic. Now, over twenty years later, with 97 percent of his lung capacity, their son is thriving and they credit biological medicine.

The Biological Medicine Network (BioMed Network) was created with the goal of spreading this essential knowledge of healing. Over the years. The has hosted several seminar series for practitioners to educate and train North American doctors, dentists and holistic health providers so that they may incorporate biological medicine into their practices. Additionally, the BioMed Network hosts lectures for laypeople to become aware of the power of healing through biological medicine. In addition to educational services, the BioMed Network provides patient coordination services to the Paracelsus Clinic in Switzerland, as well as individual practitioners in North America. As the rates of chronic illnesses soar and patients become increasingly frustrated with allopathic pharmaceutical-based, symptom-suppressive medicine, the demand for alternative, holistic, root-cause solution based medicine continues to increase.

Financial Assistance Criteria

* Financial assistance is offered for patients seeking biological medicine care with a diagnosis of cancer, an autoimmune disease, infectious disease, heart disease or digestive disorder.
* The Biological Medicine Network provides partial financial assistance for treatment. The Biological Medicine Network is unable to provide full payment for treatment. Therefore, the patient/applicant will be responsible for the remainder of the treatment costs, paid directly to the facility/medical provider.
* Financial assistance is based on the following criteria:
* Urgency of need;
* Financial need; and
* Commitment to treatment program and desire to change 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. (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 to help the Biological Medicine Network Application Committee determine financial need.**

**2016 Federal Poverty Guidelines**

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| **Family Size** | **100% FPG** | **500% FPG** |
| 1 | $11,770 | $58,850 |
| 2 | $15,930 | $79,650 |
| 3 | $20,090 | $100,450 |
| 4 | $24,250 | $121,250 |
| 5 | $28,410 | $142,050 |
| 6 | $32,570 | $162,850 |
| 7 | $36,730 | $183,650 |
| 8 | $40,890 | $204,450 |

* Funds will be paid directly to the clinic/doctor administering treatment, restricted for the specified patient’s care. Funds are limited to direct diagnostic testing and therapeutic treatment. Funds may be used for dental care in the United States and Canada ONLY.
* Funds may not be used for services covered by the patient’s health and/or dental insurance plan. In addition, funds may not be used to pay for copayments, coinsurance, and/or deductibles, which are the patient’s responsibility.
* Funds may not be used for transportation, lodging, food, spa services, elective procedures not prescribed by the practitioner, supplements or pharmaceuticals.
* The treatment facility must have at least one trained biological medicine practitioner on staff, within the Biological Medicine Network.
* Financial assistance may not be used to cover payments for past treatment.
* Funds may not exceed the cost of treatment incurred at the designated facility and must be returned to the Biological Medicine Network if charges are not incurred.

Application Committee

The Application Committee is comprised of members of the Marion Institute Staff and Board of Directors, and may include, but is not limited to: the Marion Institute Executive Director; Biological Medicine Network Program Manager; and Biological Medicine Network Patient Coordinator.

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: Abigail Smith, Biological Medicine Network, 202 Spring Street, Marion, MA 02738; or scanned to [abby@marioninstitute.org](mailto:abby@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 Biological Medicine Network with your legal authority to contact your medical providers.
5. If there are questions regarding any of the items to be completed, please contact Biological Medicine Network at [abby@marioninstitute.org](mailto:info@moonshadowsspirit.org).

Process for Reviewing Applications

1. Once your completed application has been received by Biological Medicine Network, the application will be reviewed for missing or confusing information. If additional information is needed, the applicant (or parent/guardian) will be contacted by the Application Administrator.
2. Applications are reviewed on a rolling basis. We will notify the applicant when the application is received. Applicants will be notified of the Application Committee’s decision within one month from the date that the application is received.
3. The Application Review Committee will review all applications and will make final decisions, based on the following criteria:
   1. Urgency of need;
   2. Financial need; and
   3. Commitment to treatment program and desire to change behaviors.
4. Award amounts will be based on the criteria listed above, the number of applications, available funds and potential cost of treatment.
5. The Application Committee reserves the right to make any exceptions to the criteria as is deemed necessary.

Notification of Financial Assistance

1. All applicants will be notified of the Application Committee’s decision within one month from the date that the application was received.
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 treatment facility.
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 Biological Medicine Network will send all checks directly to the facility/health care 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 email and may reapply at any time in the future.

Financial Assistance Application

The Biological Medicine Network, a program of The Marion Institute, Inc., and the Application Committee, 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:**

Attention: Abigail Smith

(508) 748-1976

**U.S. Mail:**

Attention: Abigail Smith

Biological Medicine Network

202 Spring Street

Marion, MA 02738

**Email:**

[abby@marioninstitute.org](mailto:abby@marioninstitute.org)

***Before you begin, please be sure you have carefully read the application instructions.***

**Section I: General Information**

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| **Date Submitted** |  |

1. **Applicant Information**

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

1. **With whom do you reside?** (List each person, their relationship to you and their age.)

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| **Name** | **Relationship to me** | **Age** |
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1. **How did you hear about the Biological Medicine Network?**

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

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**Section II: Current & Ongoing Conditions**

1. **Describe your main health concern/diagnosis.**

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1. **Describe your current treatment plan for your main health concern/diagnosis.**

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1. **Please describe your overall current physical health and how you believe your main health concern/diagnosis has affected it.**

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

**Severity Success**

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| **Describe Problem** | **Mild** | **Moderate** | **Severe** | **Prior Treatment/Approach** | **Excellent** | **Good** | **Fair** |
| *Example: Post Nasal Drip* |  | *X* |  | *Elimination Diet* | *X* |  |  |
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| 10. |  |  |  |  |  |  |  |

1. **Please list your current Medications and Supplements (including Vitamins, Minerals, Herbs and Homeopathic Remedies).**

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| **Medication/Supplement** | **Brand** | **Dose** | **Frequency** | **Start Date month/year** | **Reason for Use** |
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1. **Have you made any changes in your eating habits because of your health? Please describe and include information about any special diet or nutritional program you may follow.**

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1. **Do you exercise regularly? If yes, please describe your exercise habits.**

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1. **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.**

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1. **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.**

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1. **Please describe your dental health. Do you have metal amalgam fillings, root canals?**

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1. **What do you hope to gain by receiving biological medicine treatment?**

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**Section III: Treatment History & Recommendations**

1. **Treatment Team Information:** Please include who you see, what their role is in your treatment, whether you see them currently and, if not, clearly state why you are no longer seeing them. Also note how long you were seen by each practitioner.

**Please include the names and contact information for your current doctors and practitioners (primary care physician, oncologist, chiropractor, psychiatrist, etc.).**

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| **Role (nutritionist, etc.)** | **Full Name (with medical title)** | **Contact Information** |
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**Section IV: Financial Information**

1. **Provide the name, address, and telephone for the facility/health care provider for which you are seeking financial assistance. The Biological Medicine Network may provide recommendations on specific treatment facilities, as needed. Please contact Abby Smith, (abby@marioninstitute.org) if you need assistance selecting an appropriate facility for your needs.**

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1. **Do you have any travel restrictions?**

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1. **Have you been in contact with the facility? If yes, when are the proposed dates of service for treatment?**

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1. **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.

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1. **Please briefly describe your family’s finances. Include a description of all sources of income, your family’s monthly expenses, and any other information that the Biological Medicine Network may find useful in determining your financial needs.** Please note, the Biological Medicine Network only provides partial financial assistance for treatment and is unable to provide full payment for treatment. Therefore, the patient/applicant will be responsible for the remainder of the treatment costs, paid directly to the facility/medical provider.

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**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 Biological Medicine Network, Inc., a non-profit organization, to make determinations for financial assistance and to request donations, training, education and/or other assistance for individuals. I understand that my Protected Health Information may be subject to re-disclosure by Biological Medicine Network, Inc. pursuant to this authorization. I understand that Biological Medicine Network, 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 Biological Medicine Network, Inc. in writing, but if I do, it will not have an effect on any actions Biological Medicine Network, Inc. took before it received the revocation of this Authorization.

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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)*:

The purpose of obtaining your records is only in furtherance of consideration of your application. Only the application committee will have access to such records.

***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 this award.

Dated: , 20\_\_\_\_\_\_

Signature

***Checklist for completed Biological Medicine Network Financial Assistance Request Form***

\_\_\_ Application completed

\_\_\_ Financial documentation (most recently submitted tax return or tax transcript from the IRS)

\_\_\_ Completed release of information