Aryeh Stein-Azen Memorial Fund Request

2014 Princeton graduate Aryeh Stein-Azen, who underwent treatment for cancer during his time on campus, along with his family and many friends, bequeathed a memorial gift to provide these funds as a resource for students who may also experience ongoing and long-term illness while on campus.

Name: _____ Class Year: _____ Date: _____

Student ID: _____ E-mail:_____ Phone: _____

Residential College or Grad Department: _____

Purpose of fund: To financially assist Princeton Undergraduate and Graduate students who have complex or chronic health conditions that require prolonged treatment likely to impede academic progress or significantly limit student life at Princeton University.

Please attach a short narrative describing why you are applying for financial support through the Aryeh Stein-Azen Memorial Fund. Please include any diagnoses, expected duration and types of treatment, nature of costs, and explanation of reason for financial need.

Please attach medical attestation of your diagnoses, insurance claim payment information if requesting funding for direct medical costs, & other pertinent documentation to support your request.

Princeton Staff who referred you to apply for funding: _____

Please initial here to give permission for the Fund Committee to contact this person if additional information is needed. _____

If there is no referring Princeton administrator, please provide name and contact information for a non-family member who can verify the cost and need and initial to give permission to contact this person.

Name: _____ Contact: _____Permission: _____

Total Amount Requested: $_____ Please request only what you are confident you will expend; this enables us to support as many students as possible.

Have you already received any funds related to this expense, in addition to what is being requested, from any other resource? Yes ☐ No ☐

If yes, identify the Source _____ Amount $_____ Date _____

Will any of these costs be covered by insurance? Yes ☐ No ☐

If yes, please explain and include estimate of cost covered and balance: _____

_____

_____

If the total amount is to be used for multiple purposes, please itemize your expenses and attach.

I attest that the information I have provided is complete and true and that I have not received or expect to receive payment from any other source to cover the expense identified on this form. I understand that by signing below, this statement is subject to Princeton University's Honor Code.

_____ _____

Student Signature Date

RETURN FORM TO: Office of Disability Services, Room 241 Frist Campus Center; ods@princeton.edu
FOR QUESTIONS: Call Office of Disability Services at 609-258-8840 or email ods@princeton.edu
ASA-92017-R1