David's Dream & Believe Cancer Foundation
364 North Main Street, Suite 10D
Manahawkin, NJ 08050
Office: 609-489-0011
Fax: 855-219-4556
david@davidsdreamandbelieve.org

Dear Friend,

David's Dream & Believe Cancer Foundation (DDBCF) is a nonprofit organization with the following mission:

David's Dream & Believe Cancer Foundation is a 501(c)(3) nonprofit that raises funds to provide financial assistance, wellness services and HOPE to families, primarily in New Jersey, affected by a cancer diagnosis.

To apply for assistance and consideration, please complete the attached grant application in full and make sure your primary oncologist signs the grant application. Your application will then be processed and you will be contacted by the Foundation.

Please do not hesitate to contact me at 609-489-0011 if you have any questions about our services or require assistance in completing your grant application.

Sincerely,

David Caldarella
Co-Founder & CEO

Enclosures:
Grant Application Information Form
Certification, Waiver and Release

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GRANT APPLICATION

PERSONAL INFORMATION

Full Name: _____ Date: _____

Have you applied for Grant Assistance from DDBCF before? ( ) YES ( ) NO

If yes, when: _____

Date of Birth: _____ /_____/_____ Age: _____ Sex: ( ) M ( ) F

If minor, name of guardian(s):_____

Street Address: _____

City, State, Zip, County: _____

Home phone: _____ Cell phone: _____

Email Address: _____

Employment: ( ) Working ( ) Not able to work ( ) Disabled ( ) Retired

Occupation & Employer: _____

Who referred you to our Foundation? _____

HOUSEHOLD INFORMATION

Are you: ( ) Single ( ) Married ( ) Partner ( ) Widow

Number of dependents living in your household: ( ) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4+

Do you Rent or Own? _____ What is your monthly mortgage/rent? $ _____

Please provide any information in regards to your current living situation that can help us gain a better understanding of how to best help you. Feel free to attached additonal pages if necessary.

_____

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MEDICAL & TRANSPORTATION EXPENSES:

Does your medical insurance cover your treatments and medicine? ( ) YES ( ) NO

Do you currently have outstanding medical bills? ( ) YES ( ) NO

How often do you receive treatments? _____

Where do you travel for your treatments? _____

How do you get to your treatments? _____

Distance for transportation: _____ Travel Expenses for one round trip: $ _____

MEDICAL HISTORY

Cancer Diagnosis: _____

Date of Diagnosis: _____

Primary Oncologist: _____

Signature of Doctor (oncologist or primary): _____

Hospital: _____

Address : _____ Phone: _____

Nurse Navigator: _____ Phone: _____

Primary Insurance Carrier: _____

IN WHAT AREAS ARE YOU SEEKING ASSISTANCE?

( ) Medical Bills ( ) Medication Expenses ( ) Transportation Expenses ( ) Mortgage/Rent

( ) Utilities ( ) Food ( ) Other: _____

CHECKLIST FOR ASSISTANCE

The following information should be provided with your application in order for your request to be effectively processed:

____ Any and all copies of the outstanding medical and/or household bills for which you are seeking assistance. Please do not send originals.

____ Letter from your treating Oncologist or Primary Care stating your diagnosis and current treatment.

Version: 30May19

FOR DDBCF USE ONLY

DATE RECEIVED: _____ DATE REVIEWED: _____ DATE APPROVED: _____ DATE NOTIFIED: _____

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CERTIFICATION, WAIVER AND RELEASE

I certify that the information included in my application for financial assistance is true and correct and that I am a cancer patient incurring atypical expenses associated with the diagnosis and treatment of cancer.

By signing below, I acknowledge that David's Dream & Believe Cancer Foundation, including the board of directors, members, officers, and volunteers (collectively, "DDBCF"), has sole discretion in awarding or refusing to grant funds pursuant to this application for financial assistance. I further acknowledge that DDBCF is not obligated to make or continue such discretionary financial assistance payments to me or on my behalf. I understand and hereby acknowledge that DDBCF reserves the right to refuse or terminate any and all payments for any reason at any time and without notice. I acknowledge that DDBCF shall not be liable for any injury, disease, death or other harm, which may result following any termination or refusal to provide financial assistance.

By signing below, I hereby acknowledge that DDBCF is not responsible for any diagnosis, selection or appointment of physician(s) or medical treatment I require.

By signing below, I hereby release, waive, and discharge DDBCF from any and all liability, and further covenant not to sue DDBCF, as a result of any medical treatment or refusal of treatment in any way associated with this application for financial assistance or which I may receive in conjunction with any funds provided by DDBCF. I hereby acknowledge that funds provided by DDBCF and used for medical care and/or treatment, including any payments for prescriptions, will not subject DDBCF to any liability for any injuries I may receive in connection with such treatment, care or use of prescriptions.

I expressly release the Foundation from any and all liability under any cause of action in connection with any injury, disease or death resulting from the medical care, treatment and/or prescriptions I may receive. In the event of a dispute, the prevailing party shall be entitled to have and recover all costs and expenses, including all attorneys' fees.

I expressly agree that this Certification, Waiver and Release is intended to be as broad and inclusive as is permitted by the laws of the State of New Jersey and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I hereby certify that I have read and voluntarily signed this Application and Certification, Waiver and Release, and agree that no oral representations, statements or inducement apart from what is contained in this application have been made.

I hereby certify that signature below is my own or that of a guardian.

Applicant Name: _____
Applicant Signature: _____
Date: _____