

Dani's FOUNDATION

MISSION STATEMENT:

The mission of Dani's Foundation, a charitable organization that was formed in 1999, is to find the cause and the cure for sarcomas affecting children and young adults.

Dani's Foundation is dedicated to advancing a global initiative that will be aimed at:

- Funding research that will find the cause and the cure for sarcomas including Ewing's Sarcoma (EWS), osteosarcoma and other forms of sarcomas that affect children and young adults;
- Funding studies that will target improved treatment protocols for all sarcoma patients;
- Implementing community education programs that will inform the public-at-large on the varieties of sarcomas;
- Providing valuable information, resources and support to sarcoma patients and medical professionals.

GRANT GUIDELINES

- Grant applicants must have a pediatric sarcoma cancer diagnosis and be receiving active cancer treatment and/or receiving treatment for side effects resulting from his/her pediatric sarcoma treatment
- Grant applicants must be residents of the United States of America
- Grant applicants must be 21 years or younger.
- Grant applicants must enclose copy of identification.
Parents must supply their personal identification on behalf of their minor child.
- Grant applicants may submit one request per twelve month period, maximum of two lifetime awards.

WHAT IS TYPICALLY FUNDED / NOT FUNDED

The Dani's Foundation Patient Assistance Grant Program will provide funding directly to patient vendors. We do not make any payment directly to a patient.

Items typically covered are for medical treatments that are not covered by insurance and are necessary for the overall health and well-being of the patient; therapy treatments that are not covered by insurance and are necessary for the overall health and well-being of the patient; medical equipment that is not covered by insurance and is necessary for the overall health and well-being of the patient; health and human welfare items such as a portion of the patient's mortgage and/or rent; utility payments; medical lodging; medical transport; food; and necessary daycare.

Items typically NOT FUNDED include payments to hospitals/physicians/other medical providers. We encourage the patient and his/her family members/guardians to work with those institutions on negotiating all fees associated with the treatment given.

Dani's FOUNDATION

INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS CAREFULLY.

Please use black ink, print clearly and complete ALL sections of the application.

Incomplete applications will not be processed until missing information is provided.

Patient's Parent/Guardian (subsequently referred to as Parent(s)) Form Completion Check List

- I have signed and dated this application and have enclosed a form of identification (i.e. copy of driver's license).
- I have included copies of bills for which assistance is being requested.
- I have provided a current copy of income verification and other financial documents, requested within the application.
- I have completed each section accurately and legibly. Leave no section unmarked. If an item does not pertain to you, please mark with "N/A".
- I have included the Grant Request Verification form completed by a referring professional, i.e. medical doctor (MD), oncologist, registered nurse (RN), social worker (MSW) or patient navigator (PN) within a treatment facility. *Forms will not be processed or reviewed without a referral.*

REFERRING PROFESSIONAL:

- I have included on the Grant Verification form a recommendation for this patient for assistance and have verified cancer diagnosis and current cancer treatment for this patient. To do this you must be an MD, RN, MSW or PN.
- I have checked application for accuracy and completeness and made sure proper documentation is attached, i.e. all current copies of bills, income verification if possible, and any other pertinent information.
- I have completed the Grant Request Verification form and affixed with my signature, my credentials, name of office or facility and address, and dated.

NOTE: Typical grants are in the range of \$250 - \$500.

Dani's FOUNDATION

PATIENT ASSISTANCE APPLICATION

(Revised 6/30/2011)

CLIENT BIOGRAPHICAL INFORMATION

All fields are required. Please provide explanation for incomplete items.

Date of Application _____ Date of Birth _____
Patient Name _____
First _____ Middle Initial _____ Last _____
Address _____
City _____ State _____ Zip Code _____
Work Phone _____ Home Phone _____
Email Address _____
Age _____ Patient Gender _____ Male _____ Female
Race _____ American Indian/Native Alaskan _____ Caucasian
_____ African American _____ Hispanic
_____ Asian/Pacific Islander _____ Other _____

NAMES & AGES OF THOSE RESIDING IN THE HOME

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What financial support have you received from extended family, friends, or others (i.e. church, business, community groups, etc.)

PATIENT/FAMILY FINANCIAL INFORMATION

Monthly Household Income

Salary and/or Wages

Gross \$ _____

Take-Home \$ _____

Income Overview

Income Source (Net)	Monthly Amount	Starting Date	Ending Date
Take Home Pay			
Spouse/Partner Take Home Pay			
Other Member Take Home Pay			
Disability Payment			
Sick Leave Pay			
Employer Group Disability Insurance			
Workman's Compensation			
Personal Disability Insurance			
VA Benefit			
Social Security Disability			
Social Security Retirement			
Retirement, Pension, 401K or IRA			
Income from Investments			
Child Support			
Alimony			
Public Assistance			
Food Stamps			
Other			
Other			
Other			

Total Monthly Household Income \$ _____

Monthly Household Expenses

Rent Mortgage	Amount \$	Trailer Space	Amount \$	Gas Electric	Amount \$	Water Sewer	Amount \$
Telephone	Amount \$	Cell Phone	Amount \$	Cable	Amount \$	Internet	Amount \$
Auto Payment	Amount \$	Auto Insurance	Amount \$	Auto Fuel	Amount \$	Public Transport	Amount \$
Medical	Amount \$	Pharmacy	Amount \$	Therapy	Amount \$	Dental	Amount \$
Food	Amount \$	Daycare	Amount \$		Amount \$		Amount \$

Total Monthly Household Expenses \$ _____

HOUSEHOLD ASSETS

Please fill out all of the information below. Incomplete applications will be returned.

Asset Type	Current	Value	Loan	Income
Home Ownership				
Auto Ownership				
Checking Account				
Savings Account				
Rental Income				

EMPLOYMENT STATUS

Employment Status of Head of the Household

Employed Full Time
 Employed Part Time
 Full Time Student
 Part Time Student
 Disabled
 Retired
 Unemployed
 Self Employed

Employer Name _____

Employer Address _____

Employer City _____ State _____ Zip Code _____

Employer Phone _____ Email _____

Supervisor Name _____

Your Position _____

How long have you worked for this employer? _____ months _____ years

If unemployed, the date your job ended? _____

Reason for unemployment

Employment Status of Spouse or Partner

Employed Full Time Employed Part Time Full Time Student Part Time Student
 Disabled Retired Unemployed Self Employed

Employer Name _____

Employer Address _____

Employer City _____ State _____ Zip Code _____

Employer Phone _____ Email _____

Supervisor Name _____

Your Position _____

How long have you worked for this employer? _____ months _____ years

If unemployed, the date your job ended? _____

Reason for unemployment

Patient's Employment Status

Employed Full Time Employed Part Time Full Time Student Part Time Student
 Disabled Retired Unemployed Self Employed

Employer Name _____

Employer Address _____

Employer City _____ State _____ Zip Code _____

Employer Phone _____ Email _____

Supervisor Name _____

Your Position _____

How long have you worked for this employer? _____ months _____ years

If unemployed, the date your job ended? _____

Reason for unemployment

UNEMPLOYED: If applicant and/or other household adults are unemployed, please explain why and describe plans for returning to work.

GENERAL: Please describe the situation of the applicant and explain why he/she is in need of assistance from Dani's Foundation.

PATIENT ASSISTANCE REQUEST

Please attach copies of current bill(s) for which assistance is being requested.
 Bills must be no more than two months old at time of application submission.

Company Name _____

Address _____

City _____ State ____ Zip Code _____

Name on Account _____

Account Number _____

Amount Due \$ _____ Amount Requested \$ _____

Explanation of Charges

Have you ever applied to Dani's Foundation before? ____ Yes ____ No

If yes, please give date and amount of grant _____

Important: Must be 12 months before you re-apply. There is a 2 grant lifetime limit.

Have you ever applied for assistance to any other agency? ____ Yes ____ No

OTHER SOURCES OF FUNDING PURSUED

Additionally, applicants are encouraged to apply for additional funding

Name of Agency	Assistance Requested	Amount Requested	Agency Response
		\$	
		\$	
		\$	
		\$	
		\$	

PATIENT VENDOR OVERVIEW

Medical Treatment	Name of Physician	Address	Number of Treatments	Amount of Treatments
Outpatient Chemotherapy	Name of Oncologist	Address	Number of Treatments	Amount of Treatments
Outpatient Physical Therapy	Name of Therapist	Address	Number of Treatments	Amount of Treatments
Outpatient Occupational Therapy	Name of Therapist	Address	Number of Treatments	Amount of Treatments
Prepaid Gas Card	Number of Medical Visits Anticipated	Facility of Treatment	Location of Home	Amount Requested \$
Interstate Bus Ticket	Number of Medical Visits Anticipated	Facility of Treatment	Location of Home	Amount Requested \$
Air Transport Ticket	Number of Medical Visits Anticipated	Facility of Treatment	Location of Home	Amount Requested \$
Shelter	Home Mortgage	Rent Payment	Other	Amount Requested \$
Utility Assistance				Amount Requested \$
Eviction of Possessions				Amount Requested \$
Emergency Childcare				Amount Requested \$
Health Insurance Premium	Premium Payment \$	COBRA Payment \$		Amount Requested \$
Additional Medical Care	Type of Care Needed	Physician	Address	Amount Requested \$
				\$
				\$
				\$
Patient Lodging	City of Treatment	Name of Lodging	Address	Amount Requested \$
				\$
Medical Equipment	Type of Equipment	Insurance Payment?		Amount Requested \$
				\$
				\$
				\$

An appropriate bill and/or other documentation must accompany all applications.

APPLICATION DECLARATION & AUTHORIZATION

I authorize Dani's Foundation to use this information to assess my eligibility for participation in the Foundation's Patient Assistance Grant Program, including the audit of my medical records and/or by contacting me directly to confirm my eligibility or receipt for matters related to such program. I understand that this assistance is temporary and that this Program may be discontinued or changed at any time. I understand that Dani's Foundation will use my personal information in connection with the operation of the Program and issues related to such program. I certify I do not have the ability to pay for the assistance requested. I also certify that I do not have other sufficient financial resources or assets to pay for the assistance requested or that by paying for the assistance from my own resources or assets would cause me severe financial hardship. I attest the information that I have provided is correct and complete.

I authorize the Supplier of the Program to disclose to Dani's Foundation all personal information relating to my medical condition, treatment and insurance coverage needed to administer my participation in this Patient Assistance Grant Program. I understand that if I refuse to sign this authorization, I will not be able to participate in this Program, but it will not affect my ability to obtain medical treatment, my ability to seek payment for treatment or affect my insurance enrollment or eligibility for insurance benefits. I understand that I may cancel this authorization at any time by mailing a letter to Dani's Foundation. Cancelling this authorization will prohibit disclosures of my personal information after that date the cancellation letter is received and processed but will not affect disclosures made before that time. I understand that once my personal information is disclosed to Dani's Foundation, federal privacy laws may no longer protect the information from further disclosure. This authorization expires at the end of my participation in the program.

Parent/Legal Guardian/Personal Representative Signature

Patient Legal Guardian Personal Representative

Printed Name

Date of Application

Dan's FOUNDATION

GRANT REQUEST VERIFICATION

To be completed by a referring MD, RN, MSW, PN

Name	
Title	
Facility Name	
Facility Address	
Facility Phone	
Email	

Name of Patient _____
 Date of Diagnosis _____
 Current Diagnosis _____

Current Treatment

Please list chemotherapy agents and dates of treatment including expected duration of treatment

Name of Physician treating cancer:

Has this patient had surgery for cancer? Yes No

If yes, date(s) and type(s) of surgery

PATIENT'S FINANCIAL NEED

<input type="checkbox"/> Medical	<input type="checkbox"/> Housing
<input type="checkbox"/> Pharmaceutical	<input type="checkbox"/> Utilities
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Food
<input type="checkbox"/> Other Therapy	<input type="checkbox"/> Transportation
<input type="checkbox"/> Medical Lodging	<input type="checkbox"/> Other _____

Application Recommendation

Question	Yes	No
Does the patient adhere to medical direction?		
Does the patient smoke?		
Does the patient consume alcohol?		
Does the patient use un-prescribed drugs?		

Additional Comments

To my knowledge, health insurance and/or other programs will not cover the type of assistance requested above.

Medical Professional's Signature: _____

_____ Printed Name _____ Title _____ Date of Submission

Please attach a Letter of Assessment and/or comment to this application releasing information pertaining to the visible candidacy of the patient in regard to positive lifestyle choices

All information is strictly confidential. Funds are limited and based on availability. Incomplete application will be returned. Completed application will be processed within 2-4 weeks.

Dani's FOUNDATION

For Office Use Only

Date Application Received	
Complete Application	
Bill for Payment Attached	
Date Application Reviewed by Committee	
Funding Requested	\$
For	
Foundation Approval	
Foundation Decline	
Reason for Decline	
Amount of Funding Approved	\$
Date of Notification Approval/Decline	
Date Funding Paid	
DF Program Director Signature	
DF Chairman Signature	
DF Executive Director Signature	