

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, be receiving active cancer treatment and/or receiving one year post-treatment care.
- Grant applicants must be 26 years or younger.
- Patients/Parent(s)/Legal Guardian of Grant applicants must enclose copy of identification.
- Grant applicants may submit one request per twelve month period, maximum of two lifetime awards.

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 (page 2 of the application) completed by a referring professional, i.e. medical doctor (MD), oncologist, registered nurse (RN), social worker (SW) 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, SW 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.

GRANT REQUEST – VERIFICATION

THIS PAGE IS TO BE COMPLETED BY REFERRING MD, RN, SW, PN

Please answer each question completely. Do not leave any blanks. Be sure to sign application where appropriate. Please print and use black ink only.

Name of patient:	Today's date:
What is the patient's health insurance coverage?	
Date of diagnosis:	
Current diagnosis?	
What is current treatment (please list chemotherapy agents and dates of treatment – include expected duration)?	
Name of physician treating cancer:	
Has this patient had surgery for cancer? If yes date and type of surgery:	
What are the Parent(s)' financial needs: <input type="checkbox"/> Utilities <input type="checkbox"/> Medical <input type="checkbox"/> Rent <input type="checkbox"/> Mortgage <input type="checkbox"/> Food <input type="checkbox"/> Transportation <input type="checkbox"/> Financial Assistance	
Comments:	
Name and Credentials of Referring Person: <i>(Must be MD, RN, SW or PN) Please print legibly</i>	
Email:	
Name of Office or Facility & Address:	
City/State/Zip	Phone
Signature of Referring Professional:	Date:

Parent(s)' Personal Information Profile

Please answer each question completely. Do not leave any blanks (use N/A as applicable). Be sure to sign application where appropriate. Please print and use black ink only.

Applicant personal information:

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Parent(s)' Name: _____

Address: _____

City, State, Zip: _____

County: _____

Telephone: (work) _____ (home) _____

(cell) _____ (e-mail) _____

Where and when can you be reached most easily during the day? _____

Patients Date of Birth: _____ Age _____

Who lives in the household: _____

What are their ages: _____

What financial support do you receive from extended family, friends, or other supports, *i.e.*, church, business, social club: _____

Parent(s)' Monthly Income Financial Profile

Current employment status: (please circle) Disabled Retired Unemployed Self Employed
Employed Full time Employed Part time Full time student Part time student

If you are employed, who is/was your employer?

How long have you worked for this employer?

What kind of work do/did you do?

If unemployed, the date your job ended?

If employment status has changed due to your child's cancer treatment, please provide date of change and previous monthly net take home pay. Date _____ Previous monthly net take home pay: \$ _____

After your child has recovered, can you return to work for this employer? YES NO

What kind of work does your spouse or partner do?

What is the name of that person's employer?

Please tell us about your current total (MUST include ALL household income, regardless of relationship to patient. If all income is NOT disclosed, application will NOT be processed.) household income; please complete each question entering not applicable (N/A) where appropriate.

<i>INCOME SOURCES (NET)</i>	<i>AMOUNT</i>	<i>Starting Date (Date you began receiving this income)</i>	<i>Ending Date (Date you no longer received this income)</i>
1) <i>Your monthly take home pay</i>			
2) <i>Your spouse/partner's monthly take home pay</i>			
3) <i>Other household member's monthly take home pay</i>			
4) <i>Monthly disability payments:</i> a) <i>Sick leave pay</i> b) <i>Employer group disability insurance</i> c) <i>Worker's comp</i> d) <i>Any personal disability insurance</i> e) <i>VA benefits</i> f) <i>Social security disability</i>			
5) <i>Social security retirement benefits</i>			
6) <i>Retirement, pension, 401-K or IRA</i>			
7) <i>Income from investments</i>			
8) <i>Child support</i>			
9) <i>Alimony</i>			
10) <i>Public Assistance</i>			
11) <i>Food Stamps</i>			
12) <i>Other income please list</i>			
<i>Total</i>			
<i>Comments:</i>			

Parent(s)' Monthly Expense Financial Profile

<i>Expenses</i>	<i>Monthly Payment Amount</i>	<i>Remaining Balance (where applicable)</i>
1) Rent or Mortgage		
2) Condo/HOA Fees		
3) Utilities (electric, water, gas)		
4) Monthly food expense		
5) Child care/child support		
6) Pet Care		
7) Tuition		
8) Telephone		
9) Car payment		
10) Spouse or partner's car payment		
11) Transportation (bus/cab or other)		
12) Gasoline and oil		
13) Insurance		
a) Health		
b) Car		
c) Home/Renters		
d) Life Insurance for you		
e) Life insurance for your family		
14) Property taxes (if not incl in mortgage)		
15) Other Loan payments (ex: Home Equity)		
16) Prescription costs after insurance		
<u>TOTALS</u>		

Parent(s)' Asset Profile

<i>Please circle the answer to the following questions and if yes, include current value and current loan amount.</i>	<i>Current Value</i>	<i>Current Loan</i>	
1) <i>Do you own a home?</i> Yes No			
2) <i>Do you own a car?</i> Yes No			
3) <i>Do you own another car?</i> Yes No			
4) <i>What is your current checking account balance? \$</i> <i>(as shown on current bank statement)</i>			
5) <i>What is your current savings account balance? \$</i> <i>(as shown on current bank statement)</i>			
<i>Please circle the answer to the following questions and if yes, include current value, current loan and income.</i>	<i>Current Value</i>	<i>Current Loan</i>	<i>Income</i>
6) <i>Do you own a business or any part of a business?</i> Yes No			
7) <i>Do you have any investments, stocks or bonds?</i> Yes No			
8) <i>Do you have any rental properties?</i> Yes No			
9) <i>Do you own any other real estate properties?</i> Yes No			
10) <i>Do you own any IRA/401(k)/Pension savings/ annuities?</i> Yes No			
11) <i>Do you own "cash value" life insurance?</i> Yes No			
12) <i>Do you have any other assets?</i> Yes No			

Do you have Medical Debt as a result of your child's cancer diagnosis? If yes, please provide amount and explain:

Do you have any other, recurring debt, not already covered above that you would like to disclose? If yes, please provide amount and explain:

PLEASE ATTACH COPIES OF CURRENT BILLS FOR WHICH ASSISTANCE IS BEING REQUESTED (MUST BE NO MORE THAN 2 MONTHS OLD AT TIME OF APPLICATION SUBMISSION).

Please provide the following information regarding the assistance you are requesting

To be paid to:

Name on Account:

Account Number:

Amount Requested:

Other Information:

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 agencies? YES NO

If yes, please list them and their responses:

Patient / Parent(s)' Signature

If there is any other information about your situation that you want the Foundation to consider, please note below or attach a separate page or pages.

I certify that the information provided on this application is true and accurate to the best of my knowledge. I release Dani's Foundation of all liabilities or claims arising out of the donation of money or services provided to my family or myself.

Applicant's Signature:

Date:

Applicant's Parent Signature

Date

Submit the completed application to:

**Dani's Foundation
1600 Broadway, Suite 2400
Denver, CO 80202
Office: 303.601.1881 Fax: 970.532.1077**

**PLEASE BE REMINDED THAT THIS APPLICATION WILL NOT BE REVIEWED UNLESS
COMPLETED IN FULL**

FOR OFFICE USE ONLY

Date of Initial Application	Amt of Request	Bill for Payment Attached	Date of Committee Review	Date of Decision	Patient Notification