GRANT QUALIFICATION

To qualify for the Dandelion Charity Corp Financial Assistance Grant Program, you must:

1. Live in Orange County, NY or be receiving cancer treatment in Orange County, NY.
2. Be in active treatment for a cancer diagnosis. Active treatment includes receiving chemotherapy, radiation, immunotherapy, or stem cell therapy. This also includes recent cancer surgery and bone marrow or stem cell transplants. Patients receiving hospice care are also eligible for assistance.

APPLY FOR A GRANT

To apply for a grant, please fill out the grant application for financial assistance. All required forms must be filled out completely to be considered for a grant. Please note that your oncologist or social worker must confirm that you are currently receiving treatment for cancer.

1. Please make sure you sign the release form.
2. Please send application to:

<div align="center">

Dandelion Charity Corp

PO Box 126 Wallkill, NY 12589

or

info@dandelioncharity.org

</div>

Dandelion Charity Corp. Financial Assistance Application

Please complete all fields. Your application will remain confidential.

NAME

DATE OF BIRTH

HOME ADDRESS

CITY

STATE

ZIP CODE

PHONE

EMAIL

Types of Assistance Offered

- ❖ *Medical Co-Pays*
- ❖ *Prescription Co-Pays*
- ❖ *Grocery Assistance*
- ❖ *Gas & Transportation*
- ❖ *Utility Bills*
- ❖ *Rent Assistance*
- ❖ *Dinner Vouchers*

What type of assistance you would like to receive:

*Initial assistance is determined on a case-to-case basis. Any subsequent assistance is limited to $250.

DANDELION
CHARITY CORPORATION

Medical Information

To be filled out by a healthcare provider

_____   _____

CANCER DIAGNOSIS/TYPE   **STAGE**

_____

DATE OF DIAGNOSIS

Treatment plan (check applicable):

☐	**CHEMOTHERAPY**	☐	**BONE MARROW TRANSPLANT**
☐	**SURGERY**	☐	**STEM CELL TRANSPLANT**
☐	**RADIATION**	☐	**HOSPICE CARE**

I (*patient name*) _____ , give permission

for (*healthcare provider's name*) _____ , to

share this information with Dandelion Charity Corp for the purpose of applying for a Dandelion Charity Corp

Financial Assistance Grant.

_____

PATIENT NAME (*Please print*)

_____   _____

PATIENT SIGNATURE   **DATE**

_____

REPRESENTATIVE SIGNATURE

HEALTHCARE PROVIDER INFORMATION

_____

HEALTHCARE PROVIDER NAME (*Please print*)

_____

TITLE (*Physician, Nurse, Social Worker, Case Manager*)

_____   _____

HEALTHCARE PROVIDER SIGNATURE   **DATE**

_____   _____

PHONE NUMBER   **EMAIL ADDRESS** (*Required*)

Please attach a HIPAA release form, completed by the healthcare provider listed above.

Authorization to Release Protected Health Information

I understand that privacy laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), protect the use and disclosure of health information about me, also known as protected health information. By my signature on this form, I authorize the release of the specific information noted below to the Dandelion Charity Corp, located at PO Box 126 Wallkill, NY 12589 in connection with my application for a Dandelion Charity Corp Financial Assistance Grant.

1. I authorize to disclose the following specific information to Dandelion Charity Corp at the address above covering my past, present, and future periods of healthcare:

   A.   *Cancer Diagnosis / Type*
   B.   *Stage (I, II, III, IV, or unknown)*
   C.   *Treatment: Scheduled or To Be Scheduled*
   D.   *Type: Chemotherapy, Surgery, Radiation, Transplant, Hospice*

2. I understand that signing this authorization is voluntary. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

3. I understand that information used or disclosed pursuant to this authorization may be disclosed by Dandelion Charity Corp and may no longer be protected by federal or state law.

SIGNATURE   **DATE**

PRINT NAME

PRINT ADDRESS