EVAN DAVID FOUNDATION

"Because a Child is a Precious Gift"

FUNDING REQUESTED

Applicant and Partner (if any): _____

Tel: _____ **Email:** _____

Total Cost of Procedure(s): **$**_____
(as stated in the Physician Letter)

Funding Sources:

Yourself: $_____

Family or Friends: $_____

Other Grants, etc. $_____

Total of Funding Sources: **$**_____

AMOUNT of FUNDING REQUESTED from EVAN DAVID FOUNDATION **$**_____ **(Grant Request)**

Medical Procedure(s) Needed: _____

_____

All forms are found under the Application section at www.EvanDavidFdn.org

Note to Applicant: The Evan David Foundation has a limited amount of funding available for grants, and many Applicants who need these funds. Therefore, we encourage you to find sources of funding (family, friends, etc.) in addition to the funds requested here.

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CERTIFICATION OF APPLICATION

Please be sure to read over your Application before sending it in.

I/We, the undersigned, declare my/our Application to be the full truth to the best of my/our knowledge.

_____	_____
Signature	**Signature**
_____	_____
Print Name	**Print Name**

I/We, the undersigned, hereby authorize verification of any information contained in this Application, including, but not limited to, contacting credit card companies, credit agencies, lenders, Physician, background checks, criminal history, and any other means deemed necessary by Evan David Foundation for consideration of our Application.

I/We have been notified that the Evan David Foundation allocates funding without regard to race, creed, color, religion, national origin, gender, handicap or marital status.

_____	_____
Signature	**Signature**
_____	_____
Print Name	**Print Name**

HIPAA Waiver and Records Release

I/We hereby authorize: Reproductive Associates of Delaware (RAD)
4735 Ogletown-Stanton Road
MAP 2, Suite 3217
Newark, DE 19713

To Release Medical, Personal & Financial Information to:
Evan David Foundation (the Foundation)
P.O. Box 4156
Wilmington, DE 19807

Regarding (Names): _____

In addition, with my/our consent, the EDF may call my/our home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Foundation in carrying out the payment of any Grant Funds that have been awarded to me/us. Any and all medical, personal and financial information may be released by RAD and forwarded to the Foundation.

I/We agree to forward to the Foundation copies of the Explanation of Benefits (EOB) from our health insurance company for covered expenses. Grant funds will be paid directly to RAD by the Foundation. No Grant funds will be given to us.

I/We realize that we are waiving my/our rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Patient Safety and Quality Improvement Act of 2005 (PSQIA), and to any and all other applicable governmental regulations, and hereby agree to all of the above.

Accepted By: _____
Name:

_____
Name: