TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

Greetings,

On behalf of The Barber Fund, I would like to thank you for the opportunity to share with you our passion!

The Barber Fund is a small, grassroots 501(c)3 organization, established in 2014. As an ALL-VOLUNTEER organization located in Orlando, FL, our mission is to help those battling cancer by paying household expenses so that these warriors and their families can focus on healing. We have paid mortgages, power bills, medical bills, phone bills, purchased groceries, chaperoned appointments, cared for animals, and so much more.

Not only do we help our recipients and their loved ones celebrate life and give them the support they need while on their cancer journey, but we also strive to bring joy and unity to our community. We call this the "ONE LOVE" MOVEMENT, an unprecedented, community-wide effort devoted to standing together as one to make a difference!

NO ONE NEEDS TO FACE CANCER ALONE. When people with cancer seek and receive help from others, they often find it easier to cope. The Barber Fund is extending a helping hand to those in need, and we ask for your help! Help fight back, get involved, and make a difference in the fight against cancer.

Visit our website www.TheBarberFund.org to learn the many ways to support through donations, volunteer opportunities and life-changing events!

Every contribution is significant. Every act of kindness makes a difference. Every donation change lives.

If you have any questions or would like to discuss The Barber Fund further, feel free to contact me directly at (321) 436-1711.

Sincerely,

Dixie L. Todd
Vice President
Mobile: (321) 436-1711
VP@TheBarberFund.org

SEAL OF TRANSPARENCY 2019 BRONZE GuideStar

One Love
JOIN THE MOVEMENT
thebarberfund.org

TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

IMPORTANT INFORMATION

Completion of our program application does not guarantee your request for financial assistance will be approved. The Barber Funds ability to offer financial assistance is solely based on our fundraising activities and financial support from the community as a result we cannot and do not guarantee your request for assistance will be approved. Assistance requests are serviced on a first-come-first-serve basis however, depending on need the order of assistance may change.

Step 1: Complete our Application, Hold Harmless Agreement, and HIPAA Release forms in full.

Step 2: Proof of Diagnosis is required.
This MUST be mailed (certified) or emailed **directly** from the Primary Physician of the recipient. **PLEASE DO NOT SEND YOUR PERSONAL MEDICAL RECORDS**. We only need a letter from your physician stating that you are under his care and for what type of cancer.

Step 3: If requesting monetary assistance…
Copies of your bills are required to be submitted with your application and must match what is notated within the application. The bills must be legible and must provide name, payment information, due date, and current payment due. The bills must be in the applicant's name or of their spouse / legal guardian. Addresses are required to match what's provided on this application. Please contact VP@thebarberfund.org directly for special circumstances.

Please allow and plan for a minimum of 30 days for all payments. The review & processing of applications can take up to 4 weeks depending on how many applicants we have received. The usual form of payment is mailing a check which can take 7-9 days to arrive. We understand that times are tough, and you may need immediate financial assistance. Please contact VP@thebarberfund.org directly for special circumstances.

Note: The Barber Fund does not grant monetary funds directly to the individual/family. If approved, The Barber Fund pays bills directly to the collector.

Step 4: Submit your application and all other required items mentioned above.
You can either EMAIL it or MAIL it in to the addresses below.

EMAIL to both:
Dixie L. Todd, our Vice President, at VP@TheBarberFund.org
Blue Star, our president, at Blue@TheBarberFund.org

MAIL: If mailing application, please notify Dixie at VP@TheBarberFund.org.
The Barber Fund Inc. - P.O. Box 536118 Orlando, FL. 32853

Step 5: Once received, your application will be reviewed by the board.
The Barber Fund notifies applicants through email first for our records. If we do not receive a response in a timely manner, we will call the phone numbers shown on the application.

TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

APPLICATION FOR ASSISTANCE

Today's Date: ___ /____/_____ How did you learn of The Barber Fund? _____

Name: _____ Date of Birth: _____/_____/_____

Address: _____ Home: (_____) _____-_____

City: _____ State: _____ Zip: _____ Cell: (_____) _____-_____

Email: _____

Current Employer: _____ Position: _____
(If unemployed previous employer)

Employer Address: _____ Phone: (_____) _____-_____

If this form is being completed by a person other than the patient with legal authority to act an individual's behalf, such as a parent, legal guardian of a minor, or health care agent, please complete the following information:

Name of person completing this form: _____ Phone: (_____) _____-_____

Relationship to recipient: _____

Are you the Primary Point of Contact? Yes / No

Are you currently receiving any other assistance? If so, please list from whom.

REQUIRED: Please give a brief narrative describing your situation and how our assistance will be of benefit to you.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

One Love
JOIN THE MOVEMENT
thebarberfund.org

SEAL OF TRANSPARENCY 2019 BRONZE GUIDESTAR

TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

PERSONAL REFERENCES

REQUIRED. Please provide two personal references (non-relative):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

MEDICAL HISTORY/TREATMENT INFORMATION

When were you diagnosed with cancer? _____ Are you currently in treatment? Yes / No

Cancer Type: _____ Stage of Cancer: _____

What type of treatment are you in? _____

_____

Physician's Name: _____ Hospital: _____

Please have your Physician send us a letter stating that you are under his/her care and for what type of cancer. In order for this to act as a Proof of Diagnosis, this letter must be on the physician's official letterhead and include his name and signature. This letter must be emailed directly FROM your Physician to us at **VP@thebarberfund.org.**

PROGRAM SERVICE REQUEST

Check all that apply:

COUNSELING PROGRAM (Provided by The Barber Fund)

- ☐ Licensed Mental Health Counselor (LMHC). Circle one: Is this for an adult or child?
- ☐ Pastoral – Specify religion: _____. Is this for an adult or child?

SHORT-TERM VOLUNTEER PROGRAM

- ☐ Yard Care
- ☐ Treatment Buddy
- ☐ House Cleaning
- ☐ Grocery Delivery
- ☐ Pet Care
- ☐ Other: _____

FINANCIAL RELIEF PROGRAM

- ☐ Domestic Bills (Fill out next page)
- ☐ Medical Bill(s) (Fill out next page)
- ☐ Gas Gift Card(s)
- ☐ Grocery Gift Card(s)
- ☐ Other: _____

One Love
JOIN THE MOVEMENT
thebarberfund.org

SEAL OF TRANSPARENCY 2019 BRONZE GUIDESTAR

TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

#1 BILL TYPE	AMOUNT	DUE DATE	ACCOUNT NO.	PRIMARY NAME ON ACCOUNT
CREDITOR INFORMATION				
COMPANY NAME:				PHONE:
ADDRESS TO MAIL IN PAYMENT:				
COMPANY WEBSITE:				

#2 BILL TYPE	AMOUNT	DUE DATE	ACCOUNT NO.	PRIMARY NAME ON ACCOUNT
CREDITOR INFORMATION				
COMPANY NAME:				PHONE:
ADDRESS TO MAIL IN PAYMENT:				
COMPANY WEBSITE:				

#3 BILL TYPE	AMOUNT	DUE DATE	ACCOUNT NO.	PRIMARY NAME ON ACCOUNT
CREDITOR INFORMATION				
COMPANY NAME:				PHONE:
ADDRESS TO MAIL IN PAYMENT:				
COMPANY WEBSITE:				

One Love
JOIN THE MOVEMENT
thebarberfund.org

SEAL OF TRANSPARENCY 2019 BRONZE GUIDESTAR

TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

#4 BILL TYPE	AMOUNT	DUE DATE	ACCOUNT NO.	PRIMARY NAME ON ACCOUNT
CREDITOR INFORMATION				
COMPANY NAME:				PHONE:
ADDRESS TO MAIL IN PAYMENT:				
COMPANY WEBSITE:				

#5 BILL TYPE	AMOUNT	DUE DATE	ACCOUNT NO.	PRIMARY NAME ON ACCOUNT
CREDITOR INFORMATION				
COMPANY NAME:				PHONE:
ADDRESS TO MAIL IN PAYMENT:				
COMPANY WEBSITE:				

The Barber Fund respects your right to privacy. The information you provided on this application will remain confidential and will not be shared with anyone outside of the grant committee.

By your signature, you attest to the accuracy and truthfulness of the information you provided, falsifying application will result in repayment of grant. Also, you understand that completion of this application does not guarantee grant approval.

Signature: _____ **Date:** _____/_____/_____

One Love
JOIN THE MOVEMENT
thebarberfund.org

SEAL OF TRANSPARENCY 2019 BRONZE GUIDESTAR

TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

HOLD HARMLESS AGREEMENT

All applicants must read and sign this form prior to their application being presented to The Barber Fund Board for consideration.

I acknowledge by completing and submitting an application for a grant, I understand that there is no guarantee of my grant being accepted and any monies dispersed. I also understand that any monies dispersed are to be used at my discretion and The Barber Fund is not to be held liable for my decisions in dispersing said monies.

I hereby **RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE, AND AGREE TO HOLD HARMLESS** for any and all purposes The Barber Fund, its Board of Directors and their officers, servants, agents or volunteers **FROM ANY AND ALL LIABILITIES, CLAIMS and DEMANDS.**

I further agree to indemnify and hold harmless The Barber Fund for any loss, liability, damage or costs, including court costs and attorney's fees that occur as a result of my grant application being denied OR accepted.

It is my express intent that this Agreement to Hold Harmless shall bind the members of my family and partner/spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be governed by the laws of the State of Florida.

In signing this Agreement to Hold Harmless, I acknowledge and represent that I have read this Agreement, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducements apart from this agreement that has been reduced to writing have been made. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future.

Signed this _____day of _____, 20_____.

Applicant's Signature _____

Printed Name _____

Witness Signature _____

Witness Printed Name _____

TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

HIPAA RELEASE FORM

DO NOT SEND THIS FORM TO A PHYSICIAN — PLEASE COMPLETE AND SIGN YOURSELF.
Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared, if requested.

Section I

I, _____ give my permission for The Barber Fund, Inc to share the information listed in Section II of this document with the organization I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above organization permission to:

- ✓ Disclose my complete health record, limited to, diagnoses, lab test results, treatment, and billing records for cancer-related conditions ONLY.

Form of Disclosure:

- ✓ Hard copy
- ✓ Electronic copy or access via a web-based portal

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

The sole purpose is to allow the organization I have specified in Section IV of this document to validate my health condition with proof of cancer diagnosis from the doctor providing treatment. This will allow me to be eligible to receive monetary assistance while I'm undergoing treatment.

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Organization: The Barber Fund, Inc Tax ID Number (EIN): 46-5208329

Address: 2126 Palmer Street Orlando, FL 32803

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

TheBARBERFUND
HELPING THOSE LIVING WITH CANCER

P.O. Box 536118
Orlando, FL. 32853-6118
www.TheBarberFund.org

Section V – Duration of Authorization

This authorization to share my health information is valid:

☑ The date of the signature in section VI and ending exactly one year later.

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to the information provided in Section IV.

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signed this _____day of _____, 20_____.

Applicant's Signature _____

Printed Name _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

**A photocopy of this authorization shall be considered as effective and valid as the original.*