

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 <u>www.TheBarberFund.org</u> 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.

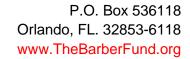
Sincerely,

Dixie L. Todd Vice President

Mobile: (321) 436-1711

VP@TheBarberFund.org







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.



APPLICATION FOR ASSISTANCE

Today's Date:/	How did you lear	n of The Barber F	und?		
Name:			Date of Birth	:/_	/
Address:			Home: ()	
City:	State: _	Zip:	Cell: ()	-
Email:					
			Position	on:	
(If unemployed previous employer)					
Employer Address:			Phone: ()	
If this form is being completed by a p such as a parent, legal guardian of a					
Name of person completing this form: _			Phone: ()	
Relationship to recipient:					
Are you the Primary Point of Contact	t? Yes / No				
Are you currently receiving any othe	r assistance? If s	o, please list fro	m whom.		
REQUIRED: Please give a brief narrati	ve describing your	situation and how	v our assistance will b	e of bene	efit to you.
			- One L	OVE	TRANSAPARENCY
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PERSONAL REFERENCES

REQUIRED. Please provide two person	onal references (non-relative):	
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
MEDICA	L HISTORY/TREATMENT I	NFORMATION
When were you diagnosed with cance	er? Are you curre	ently in treatment? Yes / No
Cancer Type:	Stage of Can	cer:
What type of treatment are you in?		
Physician's Name:	Hospital:	
for this to act as a Proof of Diagnosis,		er care and for what type of cancer. In order official letterhead and include his name and to VP@thebarberfund.org.
Check all that apply: COUNSELING PROGRAM (Provided	PROGRAM SERVICE REC	QUEST
· _	Ith Counselor (LMHC). Circle one: Is the	nis for an adult or child?
	igion:	
SHORT-TERM VOLUNTEER PROGE	RAM	
☐ Yard Care	☐ Treatment Buddy	☐ House Cleaning
☐ Grocery Delivery	☐ Pet Care	Other:
FINANCIAL RELIEF PROGRAM		
Domestic Bills (Fill ou	it next page)	ll Bill(s) (Fill out next page)
☐ Gas Gift Card(s)	☐ Grocery Gift Card(s)	Other:
		One Love Contranson
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CREDITOR INFORMATION				
COMPANY NAME: PHONE:				
ADDRESS TO MAIL				
IN PAYMENT:				
COMPANY WEBSITE:				
#2 BILL TYPE AMOUNT DUE DATE ACCOUNT NO. PRIMARY NA ACCOUNT				
CREDITOR INFORMATION				
COMPANY NAME: PHONE:				
ADDRESS TO MAIL				
IN PAYMENT:				
COMPANY WEBSITE:				
#3 BILL TYPE AMOUNT DUE DATE ACCOUNT NO. PRIMARY NA ACCOUNT				
CREDITOR INFORMATION				
COMPANY NAME: PHONE:				
ADDRESS TO MAIL				
IN PAYMENT:				
COMPANY WEBSITE:				





AMOUNT	DUE DATE	ACCOUNT NO.	PRIMARY NAME ON ACCOUNT
	CREDITOR	INFORMATION	
			PHONE:
AMOUNT	DUE DATE	ACCOUNT NO.	PRIMARY NAME ON ACCOUNT
	CREDITOR	INFORMATION	
			PHONE:
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	AMOUNT S your right to post test to the accuepayment of grant.	CREDITOR AMOUNT DUE DATE CREDITOR S your right to privacy. The information of the shared with anyone outside of the test to the accuracy and truthful the payment of grant. Also, you use.	CREDITOR INFORMATION AMOUNT DUE DATE ACCOUNT NO. CREDITOR INFORMATION CREDITOR INFORMATION S your right to privacy. The information you provided be shared with anyone outside of the grant committee. Itest to the accuracy and truthfulness of the information epayment of grant. Also, you understand that comple



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			





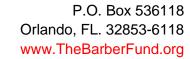
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HIPAA RELEASE FORM

DO <u>NOT</u> 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 <u>The Barber Fund, Inc</u> 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
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 beeligible 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.





Section V - Duration of Authorization

This authorization to share my health information is valid:	
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✓ 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 thisday 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, legal guardian of a minor or health care agent, please complete the following information:	, such as a parent or
Name of person completing this form:	
Signature of person completing this form:	
Describe below how this person has legal authority to sign this form:	
	PANO

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

