BEAUTY FOUNDATION
For Cancer Care

GRANT APPLICATION & POLICY

The Beauty Foundation for Cancer Care is asked to support hundreds of individuals undergoing cancer treatment each year. We make every effort to accommodate as many requests as possible. However, due to the number of requests the Foundation receives on a monthly basis, we are not always able to accommodate all applicants and all requests that fit our guidelines due to limited financial resources.

APPLICATION FOR SUPPORT

1. Completed **application** including a **signed consent form**.

2. Applicants **must submit a letter from your treating oncologist** on the physician's letter head stating the date of diagnosis, type of cancer and proposed length and course and type of treatment.

Please be advised that medical bills from the following; including but not limited to, hospitals, laboratories, physicians' offices; etc, **ARE NOT** a substitute for the actual letter from the applicant's physician. PLEASE DO NOT SEND ANY MEDICAL RECORDS.

SUBMISSION OF APPLICATION FOR SUPPORT – The completed application, signed consent form and a letter from your treating oncologist on the physician's letter head may be sent either by **electronic mail** to diane@beautyfoundationnj.com or **by facsimile** (877) 330-6649. **We do not accept JPEG or any images/photos.** All applications for support are considered and kept confidential.

ELIGIBILITY – Please be advised that only those individuals who are **actively and currently undergoing treatment** for cancer are eligible to apply for support. In addition, only applicants residing in the United States of America are eligible to apply.

ONE-TIME ONLY SUBMISSION – The Beauty Foundation does NOT ALLOW applicants to submit more than one application for support during a grantee's lifetime. A rare exception may be considered and approved by a majority of the Board in situations where a prior grantee received a grant, the grantee was deemed in remission or NED; and then after a minimum of 2 years, the grantee was diagnosed with a recurrence or a given new cancer diagnosis.

ALLOWABLE USES FOR SUPPORT – A grant from the Beauty Foundation can help with the following; including but not limited to: household bills, transportation costs associated with treatments, childcare, housekeeping services, groceries and non-covered medical expenses such as wigs, copayments and medications.

The Beauty Foundation wishes to provide support in the areas where it is most needed. In order to better assist our families, please be as specific as possible. **A copy of 1 or 2 past due bills may be included in the application. Please do not send copies of lease or rental agreements.**

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REVIEW PROCESS

The Board of Trustees meets once per month to consider grants. Once the Board approves an application, it may take up to two or more additional weeks for processing. Please allow at least 4 to 8 weeks for processing and payment of grants. All applications must be received by the second Monday of every month. Any application received after such time, will be considered during the following month.

EXCLUSIONS – It is the responsibility of the applicant to provide all required documentation. Please be advised that Beauty Foundation personnel WILL NOT contact an applicant for missing documentation. Incomplete applications will not be considered and will be discarded.

SUBMISSION BY CANCER CENTERS AND HOSPITALS – The Beauty Foundation will accept NO MORE THAN TWO (2) grant applications from a particular cancer center or hospital per month. Social Workers and Patient Advocates/Coordinators in the same organization must agree amongst themselves how to handle this process. In addition, it is the responsibility of the social workers/advocates to ensure that the grant application is complete when submitted.

CLOSED GRANT CYCLE PERIODS – To allow for year-end processing, no application will accepted in December. In addition, no applications will be accepted in the month prior to the Foundation's Annual Gala, its major fundraiser.

In carrying out its fiduciary duties, the Board of Trustees of the Beauty Foundation reserves the right to close a grant cycle at any time based upon necessity. In addition, the Board reserves the right to make an exception, modify and adjust any provision of this policy upon majority consent of Board.

THE BEAUTY FOUNDATION FOR CANCER CARE'S POLICY AGAINST DISCRIMINATION – The Beauty Foundation for Cancer Care shall not discriminate on the basis of race, color, gender, religion (creed), age, national origin, disability, sexual orientation, political affiliation or military status, in any of its activities or operations. These activities include, but are not limited to, selection of trustees and advisory board members, hiring and firing of staff (if any), selection of volunteers, selection of vendors, selection of grant recipients including the grant amount provided, and provision of services.

Due to the overwhelming number of applications received by the Foundation, only those COMPLETED applications with ALL supporting documents will be considered. Once approved, grants may take up to 4 to 8 weeks to process.

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PATIENT INFORMATION

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____ Mobile: _____

Age: _____ DOB: _____ Male/Female (Please circle)

Please list the name, DOB and relationship to applicant of each person living in the applicant's home:

_____

_____

_____

_____

_____

MEDICAL INFORMATION

Date and Type of Diagnosis:

_____

_____

_____

_____

_____

Physician's Name: _____

Physician's Address: _____

Physician's Phone: _____

Primary Hospital: _____

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CONTACT INFORMATION FOR THE APPLICANT OR THEIR REPRESENTATIVE

Please include individual's name, email and phone information. If the representative works for an organization, please include name of organization and the name, email and phone of contact representative.

_____

_____

_____

NEED

In order for the Board of Trustees to get a better understanding of the patient's circumstances and the needs of the patient's family, please provide a brief description of the current daily issues:

_____

_____

_____

_____

AREAS WHERE FINANCIAL ASSISTANCE; IF AVAILABLE, IS NEEDED MOST

Please be as specific as possible. You may include a **copy of 1 or 2 past due bills**. (For example: transportation to treatment, gas, groceries, childcare, household and utility bills, etc):

_____

_____

_____

_____

Please note: The Beauty Foundation DOES NOT and WILL NOT pay patient's creditors directly. DO NOT SEND LEASE AGREEMENTS OR RENTAL AGREEMENTS.

OTHER RESOURCES OR ASSISTANCE

Please list the names of other organizations, foundations and federal/state and local government agencies to which applicant has either received assistance or has applied or is in the process of applying. If applicant has received assistance from another organization(s), please include a description of assistance and monetary amount received to date:

_____

_____

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The Beauty Foundation does not permit a Grantee to apply multiply times.

Have you have ever applied for a grant for the Beauty Foundation? ___Yes ___No

If YES, please indicate the date that you applied for a grant and the grant that was awarded to you; or in the case of a denial, please indicate those circumstances as well:

_____

_____

If you are requesting an exception to ONE TIME ONLY policy, please state the reasons for the request.

_____

_____

Please note: grants will not be awarded to the same individual in consecutive years under any circumstances.

CERTIFICATION

I, _____, residing at _____ hereby certify that the foregoing information on the Beauty Foundation application for support is true and correct to the best of my knowledge.

Signature of Applicant or Parent/Guardian Signature if Applicant is under 18:

_____ Date_____

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MEDIA CONSENT FORM

Any applicant seeking assistance MUST sign a media consent form. If the Beauty Foundation chooses to use an applicant's personal story, it will only use the applicant's first name, the first letter of their last name and their town and state.

A parent or guardian must sign the consent form on behalf of the minor applicant. The only exception to the media consent form is for minors under the age of 18. A parent or guardian, in only that circumstance, may request that their child's personal story not be used.

I, _____, residing at _____ hereby consent to the use of my personal story and/or likeness by the Beauty Foundation for Cancer Care and understand that my personal story and/or likeness may be used in connection with all charitable fundraising efforts, including being published on a website and /or other electronic media promoting a charity event and/or in any and all print materials, press releases, articles and news stories of the Foundation.

The right to the use of my personal story/likeness is granted worldwide and in perpetuity but only for the uses set forth hereinabove and not for any other purpose.

Signature: _____

Printed: _____

Date: _____

Signature of Parent/Guardian of Applicant is under the age of 18:

_____

Printed name of Parent/Guardian and relationship:

_____

Date: _____