DISABLED VETERAN WISH FOUNDATION

APPLICATION FORM 2010 REV.2

Dear Wish Applicant,

The Disabled Veteran Wish Foundation is a 501(c)3 non-profit charitable organization that grants Wishes to any Indiana United States Disabled Military Service Personnel, age 18 years and older, and / or who have been diagnosed with a Terminal disease. A copy of the applicants DD214 Military Separation Document is required to become eligible for a WISH.
We believe that everyone has a desire for the ability to make one Wish and we are dedicated to making that Wish come true while helping to create lasting memories.

Enclosed is the necessary paperwork to apply for our Program. We ask for a letter describing the requested Wish and its significance to you. The letter should be no longer than one (1) page in length and can be written by you, a family member, or friend. Please enclose a photograph of you and your family with the letter.

The applicant, a family member, or friend can also complete the application but the required signature must be that of the applicant. The applicant and all of the participants must also sign The Disabled Veteran Wish Foundation Agreement.

A Criminal Background Check is required if the Applicant is up for selection and the granting of his WISH. Failure to agree to this requirement or pass this restriction will disqualify the applicant from selection process. If the Applicant has ever had a Felony Conviction, please do not apply.

A Release of Medical Information form is included in the application. The applicant's treating physician plays a major role in determining whether the recipient's condition will permit a particular wish to be carried out safely. The Disabled Veteran Wish Foundation will respect the individual's right to privacy and treat all information as confidential and will not be shared except as stated in the Disabled Veteran Wish Foundation's Agreement form.

Once The Disabled Veteran Wish Foundation receives the completed application, you will be contacted by our office. Due to limited funding, Wishes may not be all-inclusive. You may be responsible for your own spending money to cover such things as gas, souvenirs, tips, and some meals.

Please return the paperwork to the address below to start the Wish granting process.

The Disabled Veteran Wish Foundation
P.O. Box 247,
Orleans, Indiana, 47452

The Disabled Veteran Wish Foundation Please Print
Wish Request Application

Recipient's Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Type: __Home __Cell __Other_____

E-Mail Address: _____

Date of Birth: _____ Age: _____

Employer: _____
(Present or Most Recent)

Recipient's Diagnosis: _____Percentage of Disabliablity_____

Name of Recipient's treating physician: _____

Physician's Address: _____

(Please include City/State/Zip)

Physician's Phone: _____ Physician's Fax: _____

If you are working with Hospice, please provide:

Name _____ Phone: _____

Alternative Contact (Spouse, Nearest Relative, or other Contact Person)

Name: _____ Relationship: _____

Address: _____ Phone: _____

Has recipient ever been granted a dream by another organization? __ Yes __ No

Does recipient or one of the participants have a major credit card? __ Yes __ No

Does recipient or one of the participants have a valid driver's license? __ Yes __ No

Does your car insurance cover the use of rental cars? __ Yes __ No

The Disabled Veteran Wish Foundation
Wish Request Application
Please Print

Wish Requested: First Choice

Wish Requested: Second Choice

Wish Requested: Third Choice

Requested Wish Participants:
We can only provide for immediate family members. Immediate family is defined as spouse or significant other, children under the age of 18 living in the same household; or mother, father, siblings (brothers and sisters) under the age of 18 living in the same household. Parents must sign for those children under the age of 18.

NOTE: Any exceptions made regarding the participant's will need to be agreed upon between The Disabled Veteran Wish Foundation and applicant.

Participant's Name	Relationship	Age	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Witnessed Signatures:
I understand and agree that no promises or assurances whatsoever have been made to me by any Representative of The Disabled Veteran Wish Foundation regarding my requested Wish.

I understand and recognize that the granting of any Wish and the participation of any Person(s) in the Wish is contingent upon (1) approval from The Disabled Veteran Wish Foundations well as (2) compliance with all conditions, qualification, and restrictions designated by The Disabled Veteran Wish Foundation, and (3) available resources of the Foundation.

I acknowledge that I have been given ample opportunity to ask any questions I may have and certify that I have provided the information above to the best of my ability.

Recipient's Signature: _____Date: _____

Witness Signature: _____ Date: _____
(CANNOT be participant in WISH)

Witness name printed: _____ Phone: _____

Release of Medical Information

I give my permission to The Disabled Veteran Wish Foundation to contact my treating physician for the release of any and all medical records, the verification of my eligibility to participate in my Wish, for information on necessary medical restrictions, my medical needs, and any other information The Disabled Veteran Wish Foundation deems to be useful for this purpose.

WISH Recipient Information: (Please Print)

Name: _____ Date of Birth: _____

Physician Information: (Please Print)

Name of Treating Physician: _____

Physician's Address: _____

Physician's Phone number: _____

Persons authorized to use/disclose the information: The Physician identified above, as well as his / her authorized representatives.

Person authorized to receive the information: Employees or other Authorized Representatives of:

The Disabled Veteran Wish Foundation
P.O. Box 247 Orleans, Indiana, 47452

Purpose for which information will be used / disclosed: To enable The Disabled Veteran Wish Foundation to obtain:
(a) Physician's assessments regarding whether Patient is medically eligible to have a Wish granted by The Disabled Veteran Wish Foundation and, if so, whether the requested Wish is medically appropriate; and (b) pertinent information relating thereto.

Expiration date/event: This authorization expires once The Disabled Veteran Wish Foundation has granted Patient's Wish or a final determination has been made that Patient is not eligible to receive a Wish.Recipient

Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following:

(a) I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization;

Patient Name	Patient Signature	Date

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Witness Name	Witness Signature	Date