

**ROB ESCHE "SAVE OF THE DAY" FOUNDATION
2008 REQUEST FOR FUNDING APPLICATION**

The Rob Esche "Save of the Day" Foundation is committed to assisting children throughout the Mohawk Valley suffering from a life threatening illness. The costs for health care services and quality of life enhancements typically exceed available funding in a family with a child suffering from a life threatening illness. The Save of the Day Foundation is committed to raise and allocate funds to applicants who fulfill following eligibility requirements: child with life threatening illness must be under the age of 18, the family must reside in New York's Mohawk Valley and physician must provide evidence of illness by submitting attached "Patient Authorization Form."

For questions regarding this application, please call 315.736.7209 or visit our website at saveoftheday.org.

Date: _____

APPLICANT INFORMATION

Name of Recipient: _____

Name of Applicant (Parent/Guardian/etc.): _____

Relationship to the Recipient: _____

How Did You Hear About Us? _____

Date of Birth: _____ School Attending: _____

Address: _____

City, State _____ Zip _____

County: _____

Telephone: _____

Email: _____

Insured: Yes No

Official Use Only
Date Received: _____
Physician Rvw: _____

ILLNESS

Briefly State the Nature of Child's Illness**: _____

**Please Attach Patient Authorization Form (page 3) signed by physician*

Public Disclosure** Waiver: Yes No

***Applicant agrees to allow the Save of the Day Foundation to utilize the grantee's "story" for promotion of good works.*

ROB ESCHE "SAVE OF THE DAY" FOUNDATION

2006 REQUEST FOR FUNDING APPLICATION

Primary Care Provider: _____

Medical Contact Information (Doctor or Specialist Currently Assisting Applicant)

Name: _____

Address: _____

City, State: _____ Zip: _____

Telephone: _____ Fax: _____

Email: _____

*****Medical Release of Information: Please forward Patient Authorization Form signed by physician describing medical condition.***

TYPE OF REQUEST

Please Specify:

- Medical Need – equipment, transportation, medication, uninsured expenses/"exploratory" procedures

- "Deliver a Dream" – Create a *dream come true* for the recipient.

Budget Request: \$ _____

STATEMENT OF NEED

Please attach a detailed description of the elements of your request.

Please mail application to:

**Save of the Day Foundation
Post Office Box 412
Whitesboro, New York 13492**

PATIENT AUTHORIZATION FORM

**THE ROB ESCHE SAVE OF THE DAY FOUNDATION
POST OFFICE BOX 412
WHITESBORO, NEW YORK 13192**

I hereby authorize you to use or disclose the specific information described below for the purpose of providing the Rob Esche "Save of the Day Foundation" appropriate information to support the below mentioned patient's application for funding.

Person requesting the information and authorized to make the requested disclosure on behalf of the patient: _____ Relationship: _____

Physician Information

Name: _____
Address _____
Phone/Fax/Email _____

Recipient of the information: **Save of the Day Foundation
Post Office Box 412
Whitesboro, New York 13492
315-736-7209**

Description of the specific medical condition *(please attach additional documentation if necessary):*

Physician Signature: _____

Date: _____