FACES OF HOPE

APPLICATION FOR FINANCIAL AID

Faces of Hope Foundation (registration number 2008/005116/08) ("Faces of Hope") is a section 21, non-profit organization which assists selected cancer sufferers in meeting basic treatment expenses.

To apply, you must be a South African citizen and be in the process of active treatment or receiving ongoing medical follow-up treatment for cancer.

To apply, please fully, accurately and honestly complete, sign and return this Application form to Faces of Hope. Faces of Hope can be contacted at:

Faces of Hope Foundation
P.O. Box 1120
Rivonia
2128
Telephone Number: +27 (0)11 884 0619 / +27 (0)87 150 4740
E-mail: info@talentfinders.co.za / info@facesofhopefoundation.com
Fax Number: +27 (0)86 550 1347

Please take note that your medical practitioner must complete and sign Section "C" to this Application.

FOR OFFICIAL USE ONLY
On approval, the following Reimbursement Period will apply:

- The Applicant's Financial Aid Program begins each __________ (month) and ends each __________(month).
- Applicant's reapplication date: _________________(month)

A. **Applicant's Details**

Please submit a copy of the first page of your identity document.

Identity number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Date of birth D D M M Y Y Y Y

Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Title ☐☐☐☐☐☐

Full names ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Initials ☐☐☐☐☐☐

Gender ☐ Male ☐ Female

Ethnicity ☐ Black ☐ White ☐ Indian ☐ Asian ☐ Other

Physical address

Post code

Postal address

Post code

Telephone number (h)

Telephone number (w)

Cellphone number

Fax number

E-mail address

Preferred method of communication ☐ Telephone ☐ E-mail ☐ Sms

B. **Guardian's Details (if Applicant is younger than 18 years)**

Parent / Guardian first and last name

Physical address

Post code

Postal address

Post code

Telephone number (h)

Telephone number (w)

Cellphone number

E-mail address

C. **Details of the attending Medical Practitioner**

Hospital / Practice / Clinic Name ______________________________

Surname

Title

Full names

Initials

Physical address

Post code

Postal address

Post code

Telephone number (h) Telephone number (w)

Cellphone number

Fax number

E-mail address

Applicant's diagnosis

(Please provide relevant medical reports confirming diagnosis)

Treatment plan

(Please list treatments received and dates received, as well as planned future treatments)

Prognosis of condition / likely outcomes of treatment

Is Applicant in active treatment and/or ongoing follow-up? Yes No

If 'Yes', projected costs of treatment plan

Medical Practitioner's licence number

D. Motivation by Applicant (please provide a brief outline of your condition)

When were you diagnosed with this condition? D D M M Y Y Y Y

Do you suffer from any other medical condition(s)? Yes No

If 'Yes', please specify other medical condition(s)

What treatment (medication, etc) are you currently taking?

(Please include all medications for all medical conditions)

When was the last time you visited your medical practitioner with regard to the leukemia, lymphoma or other malignancies condition? D D M M Y Y Y Y

Do you have health insurance? ☐ Yes ☐ No Do you have a prescription drug plan? ☐ Yes ☐ No

Do you have a hospital plan? ☐ Yes ☐ No

Do you have medical aid? ☐ Yes ☐ No

If 'Yes', provide medical aid name and number	Name of medical aid: Number: Medical aid plan:

If medical aid available, please provide details of costs covered by medical aid and provide a copy of the Prescribed Minimum Benefits of the medical aid	

Are you currently receiving assistance from any other program? ☐ Yes ☐ No

Has any attempt been made to access health care through other health care providers (including the public sector)? ☐ Yes ☐ No

If 'Yes', please provide details of such attempts / specify health care provider(s) approached	

Details of person responsible for medical accounts:	i) Name: ii) Contact details: iii) Employment details: iv) Salary estimate: v) Estimated amount that can be afforded for monthly medical expenses:

Details of financial assistance requested by this application (e.g. estimated costs of drugs, treatment, nutrition, transport etc)	

I/we understand that all personal and clinical information supplied will be kept confidential. The information will be used to determine the patient's eligibility for funding (and/or the reimbursement thereof).

I/we hereby authorize any medical practitioner and/or medical facility in possession of any medical information with regards to my medical condition to provide the Faces of Hope from time to time, with such information as they may require.

Signature: Medical Practitioner		**Signature: Applicant signature (if minor, the guardian)**	
Date	D D M M Y Y Y Y	Date	D D M M Y Y Y Y

CONDITIONS AND DISCLAIMER

1. It is in the sole and absolute discretion of Faces of Hope to allocate funds to the Applicant and it is further in the sole and absolute discretion of Faces of Hope to determine the amount of funds allocated to the Applicant and when the funds will be allocated. The provision of funds is based on availability.
2. Faces of Hope will take all reasonable steps to ensure that the Applicant's information is kept confidential and secure from unauthorized third parties and shall only be used for the purpose as stated herein. However, Faces of Hope will not be held liable for any confidential information which is obtained by an unauthorized third party.
3. Faces of Hope shall not be liable for any damages or losses (including loss of profit, special damages, incidental damages and consequential damages) suffered by the Applicant, due to any cause whatsoever, including unavailability of funds or services.
4. Faces of Hope expressly disclaims all (express and implied) warranties, to the fullest extent permissible by law, including, without limitation, warranties of availability of funds for a particular treatment.
5. Reimbursement of direct treatment costs will be based on fund availability during the relevant program periods.
6. Only costs incurred as a direct result of treatment may be covered, any indirect or secondary costs are excluded.
7. Reimbursement will only take place on receipt of all relevant invoices and/or statements, including full creditor contact details.
8. Reimbursement monies will be paid directly to the relevant creditors, unless otherwise decided by Faces of Hope
9. Faces of Hope reserves the right to contact the creditors and/or medical doctors and/or any other treatment institutions in order to confirm invoice amounts and/or treatments received.
10. Successful Applicants will need to re-apply for funds every consecutive year.
11. Misleading and fraudulent applications and/or information supplied will lead to the termination of all funding provided; all funds already paid will have to be paid back to Faces of Hope; as well as the possibility of further legal action being taken.
12. The Applicant hereby acknowledges that this Application and the use of the services offered herein are optional and the Applicant has a choice to complete this Application for the funds and the services offered and has in no way been induced to apply.
13. Faces of Hope will contact the Applicant in the event that the Application for funding is successful.

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