



THE DREAM LIVES ON

The Dave Bruchhauser Fund

Dear Dream Applicant,

The Dream Lives On is a 501(c)3 non-profit charitable organization that grants dreams to adults, age 18 years and older, who have been diagnosed with a year or less to live. We believe that everyone has a dream and we are dedicated to making that dream 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 dream 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 Dream Agreement.

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 dream to be carried out safely. The Dream Lives On will not accept forms completed by RNs, social workers, or any other individuals and all information is confidential and will not be shared.

Once The Dream Lives On receives the completed application you will be contacted by our office. Due to limited funding, dreams will not be all-inclusive. You will be responsible for your own spending money to cover such things as gas, souvenirs, tips, and most meals.

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

The Dream Lives On
The Dave Bruchhauser Fund
9138 Arlon Street
Suite A3 – Box 134
Anchorage, Alaska 99507
(907) 250-2961

Sincerely,

The Dream Lives On Organization

The Dream Lives On – The Dave Bruchhauser Fund
Dream Request Application
Please Print

Recipient's Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Type: Home Cell Other _____

E-Mail Address: _____

Date of Birth: _____ Age: _____ Ethnicity: _____
(Optional – Used for Statistical Purposes)

Employer: _____ Annual Income: _____
(Present or Most Recent)

Recipient's Diagnosis: _____

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

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Dream Request Application
Please Print

Dream Requested: First Choice

Dream Requested: Alternate Choice

Requested Dream 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.

NOTE: Any exceptions made regarding participant's will need to be agreed upon between The Dream Lives On 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 Dream Lives On – The Dave Bruchhauser Fund regarding my requested dream.

I understand and recognize that the granting of any dream and the participation of any person in the dream is contingent upon (1) approval from The Dream Lives On – The Dave Bruchhauser Fund as well as (2) compliance with all conditions, qualification, and restrictions designated by The Dream Lives On – The Dave Bruchhauser Fund, and (3) available resources of the charity.

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 dream)

Witness name printed: _____ Phone: _____

Release of Medical Information

I give my permission to The Dream Lives On – The Dave Bruchhauser Fund to contact my treating physician for the release of any and all medical records, the verification of my eligibility to participate in my dream, for information on necessary medical restrictions, my medical needs, and any other information The Dream Lives On – The Dave Bruchhauser Fund deems to be useful for this purpose.

Dream 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 Dream Lives On – The Dave Bruchhauser Fund
9138 Arlon Street, Suite A3 – Box 134
Anchorage, Alaska 99507
(907) 250-2961

Purpose for which information will be used/disclosed: To enable The Dream Lives On to obtain:

(a) Physician's assessments regarding whether Patient is medically eligible to have a dream granted by The Dream Lives On and, if so, whether the requested dream is medically appropriate; and (b) pertinent information relating thereto.

Expiration date/event: This authorization expires once Patient's wish has been granted by The Dream Lives On or a final determination has been made that Patient is not eligible to receive a dream.

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;
- (b) I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

Patient Name _____ Patient Signature _____ Date _____

Witness Name _____ Witness Signature _____ Date _____