WOMEN'S
HEALTH INITIATIVES
FOUNDATION

Dear Grant Applicant,

Thank you for your interest in the Women's Health Initiatives Foundation (WHIF) Individual Grant Program. On the following pages, you will find our Application Form as well as the terms and conditions of the Individual Grant program.

Applications for Grants from WHIF and any Grants awarded by WHIF are governed by the WHIF Individual Grant Award Terms and Conditions which are included in the Application Form. Every applicant should carefully read the Application and the Terms and Conditions. Each Applicant who submits an application for an Individual Grant agrees to be bound by the Application and the Terms and Conditions. If you do not agree with any of these requirements for any reason, please DO NOT submit an Application.

WHIF's mission is to empower women and guide them to the truth about natural options which prevent, treat, and defeat cancer and other diseases. WHIF fulfils its mission through the following initiatives…

- We provide financial support and access to the New Hope for Cancer program where cancer patients receive life-saving treatment which is often not covered by insurance.
- We educate women about complementary and alternative cancer prevention methods and treatment options.
- We provide financial assistance for non-invasive diagnostic thermography screenings.
- We offer holistic cancer coaching to prevent, heal, and recover from disease.

The initiatives considered in this grant are:

- Financial assistance with the cost (full or part) of diagnostic thermography screenings for men and women on the full upper body through Mindful Wellness Thermography in West Chester, Ohio
- Initial case consultation cost (full or part) with Dr. Mark Rosenberg or other physician as assigned via the New Hope for Cancer Program at the Rosenberg Integrative Cancer Treatment and Research Institute. Consultation by phone or Skype.
- Holistic Cancer Coaching sessions with Kelly Brown who is certified through the Center for the Advancement in Cancer Education.

Thanks to the generous support we receive from our donors, WHIF is able to award full and partial Individual Grants to qualified applicants. The qualification requirements are stated in the application form.

Our Grant Application consists of all or part of the following:

1. Brief personal history of medical condition, need and proposed use of the Grant; 2. Testimonial about you; 3. Doctor's letter of medical condition; 4. Income verification, i.e. W-2 or other government verification; and 5. Household bills, medical invoices or other evidence of outstanding debt related to your medical condition 6. Pay It Forward Donation (Optional)

PLEASE NOTE THAT YOUR APPLICATION WILL NOT BE REVIEWED OR CONSIDERED UNTIL WE HAVE RECEIVED ALL PARTS. OTHER CONSIDERATIONS FOR DOCUMENTATION CAN BE MADE ON AN INDIVIDUAL CASE BASIS AT THE DISCRETION OF WHIF.

Your request is important to us. We carefully evaluate Grant Applications in the order they are received in full. Processing and approval of applications can take up 30 days. Incomplete applications remain open for three months after which the files are closed, and a new application is required.

If your grant request is approved, funds will be dispersed in the approved amount directly to the WHIF service provider partners.

If you need to get in touch with us regarding a pending application, please email grants@womenshealthinitiatives.org

Call or Text: 937-371-4838

Thank you for your support of the Women's Health Initiatives Foundation

WOMEN'S HEALTH INITIATIVES FOUNDATION

Individual Grant Application Form

Name:_____

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Phone (AM): _____ (PM)_____ Other: _____

Email: _____

Occupation:_____ Employer: _____

Insurance:_____

Gender: (Optional) ___ Female _____ Male Date of Birth: _____

Age: __ 18-25 ____ 26-34 ___ 35-45 ___ 46-59 ___ 60-69 ____ 70 and over

Ethnicity: ____ American Indian/ Alaska Native ____ Hispanic/ Latino ____ Asian/ Pacific Islander
____ White/ Caucasian ____ Black/African American ____ Multi-Ethnic
____ Other, please specify_____

I. Eligibility

The limited funds available for Individual Grants requires that WHIF make grants based on need and income levels according to federal poverty guidelines.

Poverty Level as set forth by US Federal Guidelines (see chart below). To be eligible for an Individual Grant, your maximum household income cannot exceed the following amounts (or 250% of the current Federal Poverty Level)

Household Size

One Person: $30,150

Two People: $40,600

Three People: $51,050

Four People: $61,500

Five People: $71,950

Six People: $82,400

Seven People: $92,850

Eight People: $103,300

Nine + People: If the number of people in the household is more than 8, add an additional $4,180 for each person in excess of that number

Please provide information about your household income.

My total Household Gross Annual Income as reported on my most recent tax forms is $ _____ for _____ (tax year).

Child Support Income: Does the Total Household Income include Child Support: (Circle One): Yes or No
If yes, how much do you receive per month in Child Support: $ _____

Total number of people in household (as shown on tax forms): Adults: _____ Children: _____

Check one (1): I am currently under treatment for cancer _____ I was last treated for cancer on _____ I have been told I am at high risk for cancer and am exploring prevention strategies

You can only apply for a grant once per 12 months. You will be able to reapply only after 12 months have passed from the last payment made on the previous grant. Check one (1):

I have never received a grant from WHIF _____

I received a grant from WHIF _____ (Describe previous grant assistance)

My last grant payment was made on _____. (Insert the date of the last payment for your most recently completed WHIF grant).

II. Personal History.

If you meet the eligibility criteria, your application will be further evaluated based on personal need and commitment. Full or partial Individual Grants are awarded based upon an applicant's personal circumstances and total financial need.

I am requesting a grant for one or more of the following services:

_____ Consultation with Dr. Mark Rosenberg

_____ Upper Body Thermogram with Mindful Wellness Thermography

_____ Cancer Coaching Sessions with Kelly Brown

I need this grant because it will help me_____
_____
_____
_____

Not every grant request can be approved in full. If WHIF can only address part of your request, please describe how you would like WHIF to prioritize the parts of your request.

The most important part of my request is to:_____
_____
_____
_____

How did you learn about WHIF's Individual Grant Opportunity?
_____
_____
_____

In a brief paragraph, please explain to WHIF what your future financial plans are after WHIF's financial assistance is complete. This is to ensure that you are moving in a direction to support your healing and wellness goals.

If my grant is approved I will be able to:

Personal Story Please take the time to briefly describe why you should be considered for an Individual Grant. Please write legibly. *(You may attach one additional page about your Personal Story)*

Testimonial Please take the time to share some words of gratitude for how this grant may support you in your cancer journey.

III. Pay-It-Forward Donation

WHIF asks that each application include a $25.00 Pay-It-Forward Donation. Your Pay-It-Forward Donation is totally optional and will be used to help other worthy applicants just like you.
If your financial situation is such that you cannot afford to make this donation, *please continue with the application process.*

Please make your Pay-It-Forward donation payable to Women's Health Initiatives by a certified check or money order. Please do not send cash.

Your Optional Pay-It-Forward Donation will assist others in need of WHIF services. Thank you!

WHIF Individual Grant Terms and Conditions

I confirm that this Application is being submitted by me and that I am age 18 or older. I understand that this Application and any Grant to me that may be approved by the WHIF is subject to the additional terms and conditions below.

1. WHIF shall have the right to use, in whole or in part, my name, likeness, biographical information, and any facts concerning or relating to the Grant in any advertising, press releases, promotion, commercial exploitation, marketing and any other documents for any lawful purpose without the need for my prior review, consent or right to approve such use. I may not use the name, likeness, biographical information or any facts concerning or relating to the Grant without the prior written consent of WHIF.
2. If awarded a Grant I will only use it for the purposes described in this Application and for no other purpose. WHIF shall have the right to confirm my use of the Grant.
3. Prior to the issuance of any Grant, I will submit to WHIF a picture of myself and a written testimonial (hand written or electronic) and/or video describing the use of the Grant. The testimonial shall reflect my needs, how I found WHIF, how WHIF assist me and how my life may be improved. I will submit this testimonial with this completed Application and mail to:
   WHIF, PO Box 292602, Kettering, OH 45429 or grants@womenshealthinitiatives.org
4. I agree to indemnify, defend and hold harmless WHIF, its officers, directors, employees and agents with any action or proceeding resulting from or arising out of, this Application or my actions or inactions related to this Application or the Grant.
5. Any Grant awarded by WHIF will be paid directly to service provider partners. I have voluntarily chosen to obtain the Grant to pay to the provider. I recognize that the services which I have or shall receive from the provider are solely at my request and may subject me potential risks, illnesses, injuries and even death. I have made my own investigation of these risks, understand these risks and assume them knowingly and willingly. Although WHIF is providing a Grant and making payment to the provider, I understand and acknowledge that it is not responsible for any actions or omissions of the provider, its employees, staff, or agents, nor is it responsible for any illnesses, injuries or death that may arise as a result of the services that I am receiving from the provider. To the maximum extent permitted by law, I release and hold harmless WHIF, and its officers, directors, staff, representatives, employees and agents, from and against any present or future claim, loss or liability for injury to person or property which I may suffer, or for which I may be liable to any other person, arising from the WHIF Individual Grant Program resulting from any cause, including but not limited to ordinary or gross negligence.

6. WHIF and I have no partnership, joint venture, agency, franchise, or employment relationship and I shall not make any statement or take any action that I do. WHIF will not be bound or become liable because of any representations, actions or omissions by me.
7. If any provision of these terms is for any reason held to be invalid, illegal or unenforceable, that shall not affect any other provision of these terms.
8. No waiver of any breach of any provision of these terms will constitute a waiver of any other breach of the same or any other provision of these terms, and no waiver will be effective unless made in writing.
9. This Application and these Terms must be construed and enforced exclusively under the laws of the State of Ohio without regard to its conflicts of laws principles. Any dispute arising out of or related to this Application and these Terms must be commenced (if at all) and prosecuted in the courts located in the State of Ohio, Montgomery County. The parties agree to submit to the jurisdiction and venue of such courts.
10. I represent that I have carefully reviewed and understand the Application and these terms. This Application and any Grant by WHIF constitute the entire agreement between me and the WHIF concerning my Grant Request. This Application supersedes any and all prior or contemporaneous agreements, whether oral or in writing, between the parties with respect to the subject matter. No change, amendment or modification of this Application will be valid unless it is in writing and signed by the party to be charged.
11. I may not assign in whole or in part, or subcontract, my rights or obligations under this Application.

Sign: _____ Date: _____

Name: _____

Title: Grantee

YOU MAY PRINT, FILL-OUT AND RETURN IN HARD COPY OR SCAN DOCUMENTS AND EMAIL, ***WHICHEVER IS MORE CONVENIENT FOR YOU.***

Return grant form to:

WHIF Individual Grant Program, PO Box 292602, Kettering, OH 45429

Email: grants@womenshealthinitiatives.org

DOUBLE CHECK: Please make sure you have all these elements before mailing out your application: Doctors letter; Income verification: W-2 or other government verification; Household bills, medical invoices or other evidence of outstanding debt related to your medical condition; Testimonial; Completed, signed and dated application and Optional $25.00 Pay-It-Forward Donation made payable to Women's Health Initiatives Foundation. Please do not send cash.

Please note, your application must be submitted with requested documentation in ONE package otherwise, your application will be considered incomplete and cannot be reviewed.

Please be patient and allow for the allotted time for the application to be reviewed.

If you have any questions or require additional information:

Call or Text: 937-371-4838

Email: grants@womenshealthinitiatives.org

Web: www.womenshealthinitiatives.org

[FOR WHIF PURPOSES ONLY]

Grant Approved:

Amount of Grant: _____

Conditions to Grant: _____

WOMEN'S HEALTH INITIATIVES FOUNDATION

By: _____ Date: _____

Name: _____

Title: _____