Rally4Reilly & Friends
Physical Therapy Wellness Fund Application

Who We Are:

Rally4Reilly & Friends ("Rally4Reilly","we", "us", or "our") is a San Diego-based nonprofit organization founded in 2017 to address gaps in aid for individuals and families affected by a spinal cord injury. Our inspiration was and continues to be little Reilly. In an instant, Reilly suffered a severe spinal cord injury, unimaginably rendering him unable to move from the shoulders down.

Our mission is to organize fundraising events, mobilize do-gooders of all kinds, and facilitate scholarship opportunities — all to help support individuals and families affected by spinal cord injuries. Although we started by helping children only, we will not turn anyone away simply because of their age. We believe in helping hands and open hearts.

What The Fund Is:

The Rally4Reilly Wellness Fund (the "Fund") allows us to provide financial support to individuals and families affected by spinal cord injuries. Approved applicants, many of whom have no insurance coverage or inadequate coverage, will receive a Fund Amount that will be paid directly to a said vendor as needed to cover Therapy Needs.

How The Fund Works:

1. **Complete this application and submit all supporting documentation** (*applications will be accepted on a rolling basis but recipients are only chosen quarterly*).
2. **Submit supplemental documentation, if necessary** (*upon receiving your application, we will notify you if we need supplemental information*).
3. **If approved, you will receive an allowance amount for twelve (12) month period or until the fund is exhausted** After your Funds ends or if your application was not approved, you may re-apply as many times as you like.

Wellness Fund Application

APPLICANT & INJURY INFORMATION

If the applicant is a competent adult over the age of 18:

Applicant First Name: _____ Applicant Last Name: _____

If the applicant is a minor under the age of 18 or has a conservatorship or guardian:

Guardian First Name: _____ Guardian Last Name: _____

Applicant Address: _____ Guardian Address (if applicable): _____

_____ _____

Briefly describe the injury: _____

_____

_____

Briefly describe your P/T History to date

_____

_____

When did the injury occur? _____

Briefly describe the remaining bodily function as of today: _____

_____

_____

PHYSICIAN & INSURANCE INFORMATION

Is the applicant presently covered by a medical insurance plan or assistance program? ◯ Yes ◯ No

If yes, what is the name of the insurance provider or assistance program? _____

_____

If an insurance provider, what is the policy and/or group number? _____

_____ (*Please also provide a copy of the medical insurance card with this completed application*).

List the applicant's physician(s) and/or specialist(s) since the injury occurred, their phone number, and describe the nature of their work with the applicant:

Name & Phone Number:	*Nature of Work*:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NOTICE: In order to verify the applicant's injury information, diagnosis, and related medical needs, please submit all applicable medical records, reports, labs, and similar documents (either in physical format with this completed application or in electronic format by promptly emailing to mark@rally4reilly.org).

The applicant and/or the applicant's conservator or guardian understands that these medical documents are required to assess the applicant's needs in relation to the Fund, and that said medical records will **only** be used for verification and Wellness Fund approval purposes. Rally4Reilly strictly adheres to the applicable medical privacy laws, including without limitation, HIPAA, CMIA, and the Lanterman-Petris-Short Act.

By signing below, the applicant or his or her authorized conservator or guardian agrees to voluntarily provide said medical documents to Rally4Reilly for the limited purposes described above. In addition, the applicant or his or her authorized conservator or guardian represents and warrants that he or she has completed the "Authorization for Use/Disclosure of Medical Information" form, which is attached hereto **Exhibit "A"**, should Rally4Reilly need to contact the applicant's medical professional directly for any reason.

Signature of Applicant or Authorized Conservator or Guardian: _____

Printed First and Last Name: _____ Date: _____

If the applicant is covered by a medical insurance plan or assistance program, are there any procedures, treatments, or other benefits not covered by that plan or program? ◯ Yes ◯ No ◯ N/A

If yes, briefly describe the procedures, treatments, or other benefits not covered by that plan or program:

_____

_____

_____

_____

Briefly describe why the procedures, treatments, or other benefits not covered by that plan or program are necessary: _____

_____

_____

INCOME & FINANCIAL NEED

If the applicant is of legal working age, is he or she employed? ◯ Yes ◯ N0

If the applicant has a conservator or guardian, is that person employed? ◯ Yes ◯ No

How many people are in the applicant's household? (*Including the applicant*) _____

What is the total estimated, monthly income for the applicant's household? (*Income from a marital or divorce proceeding, such as alimony and child support, need not be included*) _____

Proof of Income: (*With this completed application, please provide supporting documentation of the above estimated, monthly income, which may include paystubs for the last 3 months, last year's W-2 tax form(s), last year's 1099 tax form(s), or any other supporting documentation*).

The applicant and/or the applicant's conservator or guardian understands that this income documentation is required to assess the applicant's needs in relation to the Wellness Fund, and that said income documentation will **only** be used for verification and Fund approval purposes. Moreover, by voluntarily providing this income documentation, the applicant and/or the applicant's conservator or guardian is representing and warranting that said income documentation is valid, accurate, and freely given to Rally4Reilly.

Signature of Applicant or Authorized Conservator or Guardian: _____

Printed First and Last Name: _____ Date: _____

Briefly describe why the applicant needs the financial assistance of this Wellness Fund:: _____

_____

_____

_____

_____

_____

_____

_____

_____

Terms & Conditions

I. ***Incorporation & Entire Agreement***. This application and all of its pages and Exhibits bearing the same Version Number are hereby incorporated by this reference. In addition, any approval and/or denial notification, letter, communication, or note regarding this Grant, which is given, sent, or otherwise transmitted to the applicant and/or the applicant's conservator or guardian (collectively "Applicant") from Rally4Reilly shall be governed by these terms, and shall hereby be incorporated by this reference. Finally, if the Applicant is approved for the Fund and submits fund requests from their Fund allowance, each of those requests shall also be governed by these terms, and shall hereby be incorporated by this reference. These terms constitute the entire agreement between the parties herein and no amendment or modification of any kind to these terms shall be effective except by a writing duly executed by the parties herein.

II. ***Confidentiality***. Rally4Reilly and Applicant (hereinafter collectively "Parties") herein understand and agree that, since this application and its supporting materials may contain sensitive health, financial, or personal information, confidentiality is of the utmost importance. The Parties shall not report, advertise, or disclose in any fashion whatsoever the terms contained in this application or its incorporated documents, nor any supporting materials may contain sensitive health, financial, or personal information, to any third party or entity, including without limitation, publications, journals, or websites, unless expressly authorized in writing or compelled by law.

III. ***Governing Law & Disputes***. The Applicant and Rally4Reilly hereby agree that California law shall govern the construction, interpretation, and enforcement of this Wellness Fund application and any Fund term resulting therefrom, without giving effect to principles of conflict of laws. The Parties herein expressly agree that they shall attempt, in good faith, to resolve any dispute regarding this Wellness Fund application and any Fund term resulting therefrom in an informal manner amongst themselves. Any dispute regarding this Wellness Fund application and any Fund term resulting therefrom which is unable to be resolved in an informal manner, the Parties agree shall first be submitted to formal mediation to be conducted by a third party neutral mediator jointly selected by the parties to be conducted in the County of San Diego, State of California. Thereafter, if the dispute remains unresolved, the Parties may file an action in court if they choose. The venue for such claim will be San Diego, California.

IV. ***Attorney's Fees***. The prevailing party of any such action arising from this Wellness Fund application and any Fund term resulting therefrom shall be entitled to their reasonable attorney's fees and costs from the other party(ies).

V. ***Forfeiture of Grant***. Should Applicant materially breach these terms, including without limitation, submitting invalid or incorrect information or documentation to Rally4Reilly or any of its officers, directors, vendors, employees, or agents, whether deliberately or not, then Rally4Reilly may immediately suspend, cease, cancel, or deny Applicant's application, receipt of Wellness Fund funds, and/or any benefit from Rally4Reilly whatsoever. Moreover, in the event of any breach of these terms by Applicant, Rally4Reilly shall be entitled to pursue all available remedies available to it under the law, including without limitation, injunctive relief, liquidated damages, punitive damages, attorney's fees and costs.

VI. ***Severability and Non-Waiver***. The Parties herein do hereby agree that if any provision, or portion thereof, of these terms or any of the incorporated document(s), shall for any reason be held to be invalid or unenforceable or to be contrary to public policy or any law, then the remainder of the terms shall not be affected thereby and shall be enforced as if the invalid provision or portion thereof were not a part of the terms. Should any provision or portion thereof be held unenforceable for any reason, then such provision or portion thereof shall be enforced to the maximum extent permitted by law. Nothing in this Section or in any other provision of the terms shall, or is intended to limit any other rights or remedies the parties herein may have by virtue of the terms or otherwise.

VII. ***Counterparts***. The Parties herein do hereby acknowledge that this application, all incorporated documents, and supporting materials, may be executed in counterpart originals with like effect as if executed in a single original document. The Parties herein also agree that a facsimile or scanned copy of these signed documents shall have the same force and effect as an original.

***NOTICE*:** By signing below, the Applicant agrees that all information disclosed in this application and in any related documentation is freely and voluntarily given. The undersigned Applicant represents and warrants, as a material term, that all such disclosures herein are valid and accurate.

Applicant or Conservator/Guardian Signature: _____

Applicant or Conservator/Guardian Printed Name: _____

Date: _____

Preferred Method(s) of Contact (*check and fill out all that apply*):

☐ Home Phone: _____

☐ Mobile Phone: _____

☐ Email: _____

☐ Address: _____

☐ Facsimile: _____

Exhibit "A"

AUTHORIZATION OF USE/DISCLOSURE OF MEDICAL INFORMATION

1. ***Authorization***. I, _____, hereby voluntarily consent to and authorize my health care provider, _____, to use or disclose my medical information during the term of this Authorization to the recipient(s) that I have identified below.

2. ***Recipient(s)***. I authorize my medical information to be released to the following recipient(s): Rally4Reilly & Friends, a California nonprofit public benefit corporation, whose mailing address is P.O. Box 189, La Mesa, California 91944, and any of its officers, directors, employees, or authorized agents.

3. ***Purpose(s)***. I authorize the release of my medical information for the following purpose(s): To allow the above-referenced recipient(s) to assess the existence, nature, extent, and

treatment of my spinal cord injury and any related medical conditions, for the purpose of me being eligible for financial assistance from said recipient(s).

4. Information to be Disclosed. I authorize the release of the following medical information:

☐ All of my medical information that the health care provider has in his, her, or its possession, including information relating to any medical history, mental or physical condition, and any treatment received by me. (*Note: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.*)

☐ Other (*describe*): _____

5. ***Term***. I understand that this Authorization will remain in full force and effect from the date of this Authorization until the passing of twelve (12) consecutive months from said date.

6. ***Redisclosure***. I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

7. ***Right to Revoke***. I understand that I can revoke this Authorization by providing a written notice of revocation to the above-referenced health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

First Name: _____ Last Name: _____

Signature: _____ Date: _____

Witness First Name: _____ Witness Last Name: _____

Signature of Witness: _____ Date: _____

If the individual is unable to sign this Authorization, please complete the information below:

Representative/Guardian Name: _____

Representative/Guardian Signature: _____

Relationship to Individual: _____

Date: _____

Witness First Name: _____ Witness Last Name: _____

Signature of Witness: _____ Date: _____