PROJECT 4031
STRENGTHENING END OF LIFE STORIES

Fulfilling Dreams Application

Project 4031 grants last Dreams for terminally ill children and adults with a current life expectancy of six months or less. We are a 501(c)(3) nonprofit organization founded in Fort Worth, Texas, and ONLY serve patients living in North Texas. We do our very best and make every effort to make Dreams come true for those unable to fulfill them on their own.

Who is eligible to apply?
Terminally ill children and adults with a life expectancy of six months or less that reside in the state of Texas are eligible for a last Dream. Before applying please ensure that your Dream request is a viable option given your current health conditions. Think about various options and have an alternate Dream request in mind that is entirely unrelated to the first Dream. We grant last Dreams, so it is not relevant if you have received a Dream/Wish in the past from another organization. Although we request this information be provided, it will not affect your application.

We cannot fulfill the following types of Dreams:

- Requests for patients OUTSIDE of the state of Texas
- Medical treatments/medical bills/prescription medications
- Posthumous requests from family members (travel arrangements to attend funeral)
- Property and home improvements
- Automobiles and lifts
- Reimbursements for completed Dreams
- Cash
- Legal assistance
- Inground pools
- Trips involving gambling
- Firearms
- Any Dream request deemed inappropriate or inconsistent with Project 4031 values

How to Apply:
Please click below to apply online now with any device or apply by downloading the PDF application. The PDF application must be uploaded below using our HIPAA Compliant system. All applications, forms, and supporting documents must be submitted or uploaded through our secure online portal and will not be accepted via email.
Medical Authorization Form

- This separate form must be completed by the referring hospice representative or medical professional with a hospice face sheet or official letter provided respectively. Please click below to submit the form online now with any device or download the PDF form. The PDF form and supporting document must be uploaded below using our HIPAA Compliant system.

If you have any questions, please contact our office before submitting your application. Call (817) 653-8976 or email info@project4031.org.

Please list names on application as they are on legal ID: Driver's License, State ID, Passport, or Birth Certificate.

Requirements:

- Signature of the patient or authorized caregiver/parent/legal guardian
- Supporting Documentation (if applicable)
  - Copies of photo ID for all participants if air travel is requested.
- Medical Authorization Form
  - This separate form is accessible online on the application page and must be completed by the patient's referring hospice representative or medical professional. Upon submission of the application, a reminder email about how to access the form online will be sent to the referring hospice representative or medical professional listed on the application.

Instructions for Application Submission:

1. Fill out this application entirely.
2. Gather all supporting documentation (if applicable).
3. Scan the completed application and all supporting documents with your smartphone or scanner.
4. Go to Project4031.org and go to the Fulfilling Dreams application page. Click the "Submit PDF Application Here" button.
5. Complete all required fields, upload the application and all supporting document files, and click "Submit".

Patient Name

First Name | Last Name

Name and Title/Relationship of person referring patient for services

First Name | Last Name | Title/Relationship

Contact Information of person referring patient for services

Phone Number | Email Address

How did you hear about Project 4031?

- ○ Hospice Representative
- ○ Medical Professional
- ○ Community Agency
- ○ Friend/Family Member
- ○ Project 4031 Website
- ○ Project 4031 Staff
- ○ Online/Social Media

Address of Patient

Street Address

Street Address Line 2

City State

Zip Code County

Primary Phone Number

Phone Number

Secondary Phone Number

Phone Number

Age

Date of Birth

Month Day Year

Gender

- ○ Male
- ○ Female

Ethnicity

Religious Preference

Would you like to be added to our prayer list?

○ Yes ○ No

Military Veteran

- ○ Yes
- ○ No

If yes, please list branch and dates of service.

Primary Language

- English
- Spanish
- Other

If primary language is not English, please provide information for a translator if possible.

Name of Translator and Relationship to Patient

First Name | Last Name | Relationship

Contact Information of Translator

Phone Number | Email Address

Name of Relative or Primary Caregiver and Relationship to Patient

First Name | Last Name | Relationship

Contact Information of Relative or Primary Caregiver

Phone Number | Email Address

Address of Relative or Primary Caregiver (if different from patient's)

Street Address

Street Address Line 2

City | State | Zip Code

Has the patient received services from Project 4031 before (Funding for Families or Fulfilling Dreams)?

- Yes
- No

If yes, please describe the request and date it was granted.

Has the patient received services from another organization?

- ○ Yes
- ○ No

If yes, please list name of organization(s), services received, and dates it was completed.

Is an application submitted/pending with any other agency/nonprofit?

- ○ Yes
- ○ No

If yes, please list name of organization(s) and describe the request(s).

Has the patient ever applied and been turned down by another organization?

- ○ Yes
- ○ No

If yes, please list name of organization(s) and reason(s) for denial.

Dream Information

Please explain your Dream request fully.

Please provide as much detail as possible (why it's important, timeframe/dates, where the most help is needed to fulfill the Dream, etc.)

Please provide an alternative Dream request.

Remember only one Dream can be granted. Please provide an alternative Dream request in case it is not possible to grant the first request due to circumstances outside our control.

Does the Dream request include travel or group activity?

- O Yes
- O No

If yes, please list the participants. The patient's immediate family (parent, spouse, caregiver, and children under the age of 18 living in the home) can participate. All others can participate in the Dream at their own expense.

Full Name	Age	Gender	Relationship to Patient

Does the patient or one of the participants in the Dream have a major credit card for a travel request?

- O Yes
- O No
- O N/A

Does the patient or one of the participants in the Dream have a valid driver's license/ID and car insurance for a travel request?

- Yes
- No
- N/A

Please list all physical limitations and/or medical requirements.

(ie. Wheelchair, oxygen use or other noteworthy information for the request)

Please Note: If applicable, copies of identification for each person traveling is required to be submitted with this completed application.

Upon submission, as the Patient/Authorized Caregiver/Parent/Legal Guardian, I hereby certify that the information contained in this application is true and accurate. If a travel Dream has been requested, I understand that a major credit card and proper identification is required.

Medical Release

Is the patient currently on hospice service?

- Yes
- No

If yes, provide contact information for your hospice representative below.

If no, provide contact information for your treating medical professional (Physician, PA, NP, or RN ONLY) below.

We will be in contact with your Hospice Representative or Medical Professional regarding your medical condition and receive a signed Medical Authorization which will enable us to serve you to the best of our abilities. Your application is incomplete until the signed Medical Authorization and supporting documentation is submitted.

Name and Title of Hospice Representative or Medical Professional

First Name | Last Name | Title

Name of Hospice Company or Hospital/Treatment Facility

Contact Information of Hospice Representative or Medical Professional

Phone Number

Email Address

Upon submission, as the Patient/Authorized Caregiver/Parent/Legal Guardian, I hereby authorize the Hospice Representative or Medical Professional to provide Project 4031 information necessary regarding this Fulfilling Dreams application.

HIPAA Privacy Authorization

TO:

Name of Hospice Representative or Medical Professional

Hospice Company or Hospital/Treatment Facility Address

Street Address

Street Address Line 2

City

State

Zip Code

RE:

Patient Name

First Name

Last Name

Patient's Date of Birth

Month

Day

Year

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I authorize the use and disclosure to Project 4031 of all protected health information about the patient as described below:

Information that may be used/disclosed: I authorize the release of my complete health records including but not limited to information regarding billing, condition, treatment and prognosis, as needed and or requested by Project 4031 in assessing:

1. Whether the patient is medically eligible for Project 4031's services.
2. If applying for a Dream, whether his/her request is medically appropriate. In addition, the Hospice Representative/Medical Professional is authorized to fill out, sign and provide forms to Project 4031 that may be required relating to medical eligibility, the requested services/Dream and medical considerations.

Persons authorized to use/disclose the information: The Hospice Representative/Medical Professional, as well as his/her authorized representatives.

Persons authorized to receive this information: Employees or other authorized representatives of: Project 4031 – 708 May St, Fort Worth, TX 76104, P 817.653.8976, F 817.841.8250, https://project4031.org

Purpose for which information will be used/disclosed: To enable Project 4031 to obtain:

A. Assessments regarding whether the patient is medically eligible to receive services/have a Dream granted by Project 4031 and, if so, whether the requested services/Dream is medically appropriate;
B. and relevant information relating thereto.

Effective time period: This authorization expires once the patient has received services/Dream has been granted by Project 4031 or a determination has been made that the patient is not eligible for services.

Right to revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person/entity named above.

I have read this form and agree to the uses and disclosures of the information as described. I understand that if the person/entity that receives the information described above is not a healthcare provider/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.

Upon submission, as the Patient/Authorized Caregiver/Parent/Legal Guardian, I hereby acknowledge my agreement to and affirmation of the above.

Media Release

The stories of the terminally ill children and adults we serve as told to the public allow us to raise funds in efforts to continue our mission. Sharing with the community how we have impacted people through our programs is vital as it allows us to continue our work strengthening end-of-life stories. We ask your permission to share with the media through print, video, television, radio, digital, internet, and social media, without limitation. Please indicate below if you give your permission for Project 4031 to share your story with the general public. The patient's full name will never be disclosed.

- ○ I, hereby **GIVE** my permission for Project 4031 to share stories and photographs in all of Project 4031's promotional materials.
- ○ I, hereby **DO NOT GIVE** my permission for Project 4031 to share stories and photographs in all of Project 4031's promotional materials.

Waiver and Release of Liability

The below signed Patient enters into this Waiver and Release of Liability (the "**Release**") as of the date set forth below. Pursuant to the terms set forth herein, and as consideration for the right to participate in the **Activity (as defined below)**, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this Release and hereby waive any and all rights, claims or causes of action

of any kind whatsoever arising out of my participation in the Activity, and do hereby release and forever discharge **Project 4031** (a Texas Nonprofit Corporation with its principal place of business in Fort Worth, Texas) and its affiliates, managers, members, directors, employees, agents, attorneys, staff, volunteers, representatives, predecessors, successors and assigns (collectively "Project 4031"), for any claim related to the Activity, including but

not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an event related to this Activity.

I acknowledge that this Activity may involve a test of a person's physical and mental limits and may carry with it the potential for death, serious injury, and property loss. The risks may include, but are not limited to, those caused by terrain, facilities, temperature, weather, lack of hydration, condition of participants, equipment, vehicular traffic and actions of others.

I am voluntarily participating in the aforementioned Activity and I am participating in the Activity entirely at my own risk. I am aware of the risks associated with participating in this Activity, which may include, but are not limited to, physical or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability (including paralysis), economic or emotional loss, and death. I understand that these injuries or outcomes may arise from my own or others' negligence, conditions related to travel, or the condition of the Activity location(s). Nonetheless, I assume all related risks, both known or unknown to me, of my participation in this Activity.

In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

I will, at all times while involved in the Activity, comply with (i) all local, state and federal laws (collectively, the "Laws") and (ii) any rules and regulations imposed by Project 4031 (collectively, the "Rules").

I acknowledge that Project 4031 and their directors, officers, volunteers, employees, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Project 4031.

In the event that claims are made against Project 4031 as a result of my actions or the actions of others accompanying me to the Activity, I acknowledge and agree to be held liable for any and all costs associated with any intentional, negligent or reckless acts. In the event a claim is made against Project 4031 arising out of the intentional, negligent or reckless acts, I agree to indemnify, defend (with counsel of Project 4031's choice) and hold Project 4031 harmless from any and all claims, suits, liabilities, damages, losses, costs, fines and expenses whatsoever including but not limited to reasonable attorneys' fees, whether the claims arise as a result of property damage, personal injury, wrongful death or otherwise. I further agree to indemnify, defend, and hold harmless Project 4031 against any and all claims, suits, liabilities, damages, losses, costs, fines and expenses whatsoever including but not limited to reasonable attorneys' fees, whether the claims arise as a result of property damage, personal injury, wrongful death or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs. I further agree to indemnify, defend, and hold harmless Project 4031 from my failure, whether intentional or negligent, to adhere to and comply with the Laws or the Rules and any claims, demands, damages and the like, including attorneys' fees, that may arise from such failure. My attempt to comply with any Laws or Rules shall not limit my commitments in this Paragraph. I understand that my obligations under this Paragraph shall survive the expiration or termination of this Release.

I understand that this Release is material and necessary to participate in the Activity and I acknowledge that I would not be granted the opportunity to participate in the activity absent the execution of this Release.

I acknowledge that I have carefully read this Release and fully understand that it is a release of liability. I understand that I have been granted the opportunity to have an attorney review this Release, and I have either had an attorney review this Release or consciously made the decision to move forward with the execution of this Release without consulting an attorney. I understand that in executing this Release I am expressly agreeing to release and discharge Project 4031 from any and all claims or causes of action related to the Activity, and I agree to voluntarily give up or waive any right that I otherwise have to bring a legal action against Project 4031 relating to the Activity.

This Release was entered into at arm's-length, without duress or coercion, and is to be interpreted as a release between two parties of equal bargaining strength. Accordingly, the normal rule of construction to the effect that any ambiguities are to be resolved against the drafting party shall not be employed in the interpretation of this Release. Both the Patient and Project 4031 agree that this Release is clear and unambiguous as to its terms, and that no

promises not contained herein have been made to induce Patient to enter into this Release. This Release contains the entire understanding between the parties with respect to the subject matter hereof. This Release may not be amended or modified except by written instrument executed by the parties.

This Release shall be governed and construed in accordance with the laws of the State of Texas without regard to the conflict of law provisions. I agree that the federal and state courts in TARRANT COUNTY, TEXAS have exclusive jurisdiction over any dispute that arises from this Release.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this Release shall be determined, by a court of competent jurisdiction, to be unlawful or otherwise unenforceable, the remainder of this Release shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this Release to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

In the event of an emergency, please contact the following person(s) in the order presented:

Emergency Contact Information 1

First Name	Last Name	Phone Number

Emergency Contact Information 2

First Name	Last Name	Phone Number

The "ACTIVITY" shall mean:

Provide a description of the request.

I hereby certify that I am the Patient/Authorized Caregiver/Parent/Legal Guardian named in this application and do hereby give consent for myself/the patient to participate in the Activity named above, without reservation to the foregoing on behalf of myself/this individual. I affirm that I am of the age of 18 years or older and I am freely agreeing to this Release. I have read this Release and certify that I fully understand its content and that this Release cannot be modified orally. I am aware this is a Release of Liability and a contract that I am agreeing to of my own free will.

By signing this document, I hereby certify all information contained in this application is true and accurate. I understand that providing incomplete, misleading, or false information may result in either delay or denial of services.

Signature of Patient/Authorized Caregiver/Parent/Legal Guardian ONLY

Name of Signer

First Name Last Name

Date

Month Day Year