



1425 Grand Rd., Winter Park, FL 32792 321-236-0520

**Wingmen Foundation
Request for Financial Services
SPORTS & FITNESS FINANCIAL ASSISTANCE**

Application Requirements:

- Must be a United States resident
- Medical Verification Form
- Signed Certification and Release

Please type or print in ink all information requested. Signed applications and supporting materials must be received by **25th of each month**. The Wingmen Foundation Financial Services Department will review applications at the end of each month, and funds, if any, will be dispersed the beginning of the following month.

Funds will be dispersed directly to the organization and not to the applicant.

Financial Assistance Requests Include:

- Sports Equipment
- Membership Fees to any individual or group activities that support physical fitness (i.e. Gym Membership, Martial Arts, Organized Sports Application Fees, Swim Lessons, etc.)
- Travel Team Expenses

Please email your complete financial services application documents to:

FS@wingmenfoundation.org

For questions, please email FS@wingmenfoundation.org.

Application Checklist

- Completed, signed and dated **Application**
- Letter of **Verification** from physician or treatment center. Treatment center or physician-signed "travel" letter is acceptable
- Signed and dated **Release**

Application Form - page 1

Personal Information:

Last Name _____ First Name _____ Middle Initial _____

Address _____ Home Phone _____

_____ Cell Phone _____

Email Address _____

Date of Birth _____

Male Female

Medical Condition _____

Severity (if applicable) Mild Moderate Severe Inhibitor

Physician Name and Phone Number _____

Hemophilia Treatment Center (if applicable) _____

Services:

How did you hear of the Financial Services Program offered by Wingmen Foundation?

Facebook

Direct mailing

Online Listing (please name) _____

Wingmen Foundation personnel (please name) _____

Chapter or Foundation (please specify) _____

HTC Personnel (please name) _____

Other (please specify) _____

Certification and Release

Applications received by the Wingmen Foundation Financial Services Program will be reviewed and approval for request of financial assistance will be reviewed by the Financial Services Department at the end of each month, and funds, if any, will be dispersed at the beginning of the following month. All decisions made are final. It may be necessary for someone from the Financial Services Department to contact you directly for a personal interview or to qualify any information contained in this application.

Funds will be dispersed directly to the organization and not to the applicant. Applicant must show accountability by participating in a continuous manner if funds dispersed are for an ongoing activity. Wingmen Foundation will continue to follow up to ensure applicant is compliant with the financial request accountability. If applicant is not compliant in continuing the activity, assistance will be extinguished. Please notify Wingmen Foundation if individual is having medical issues and/or is having gaps of attendance due to medical reasons and not able to continue the sports activity or is in need of a leave of absence. Wingmen Foundation will not pay for any missed sessions unless reason was for a medical emergency of individual or family member.

I have personally signed this Wingmen Foundation Financial Services application. I certify that all statements contained in the foregoing application are true and correct.

Printed Name

Signed Name

Date

If applicant is under age 18, please include a parent or guardian's signature

Parent or Guardian Printed Name

Phone Number

Parent or Guardian Signed Name

Date

Basis of Authorization

MEDICAL VERIFICATION FORM Physician or Treatment Center

Dear Applicant: Please fill out your name and address and give this form to your physician or hemophilia treatment center. A copy of a letter signed by your physician or treatment center (such as a travel letter) verifying your bleeding disorder may be substituted for this form. It is your responsibility to see this form is submitted by the **25th of the month.**

Name of Applicant _____

Address of Applicant _____

To be completed by applicant's Physician or Nurse

What type of bleeding disorder has this scholarship applicant been diagnosed with?

Hemophilia A Hemophilia B Severity: Mild Moderate Severe

Inhibitor: Yes No

von Willebrand Type 1 Type 2 Type 3 Severity _____

Other (please specify) _____

Physician/Nurse Signed Name _____ Date _____

Physician/Nurse Printed Name _____ Phone number _____

Treatment Center or Medical Facility _____

Treatment Center or Medical Facility Address _____

Please return this form to the patient by the **25th of the month.**