Native Daughters of the Golden West
Childrens Foundation
543 Baker Street
San Francisco, California 94117-1405

Email: CFCaseManager@ndgw.org

Phone: (415) 563-9091
Fax: (415) 563-5230

Website: www.ndgw.org

INSTRUCTIONS FOR COMPLETING CONFIDENTIAL APPLICATION FORM

APPLICATIONS WILL NOT BE ACCEPTED FOR SERVICES IN THE PROCESS OF BEING PERFORMED OR FOR REIMBURSEMENT OF BILLS PREVIOUSLY INCURRED OR PAID.

The Native Daughters of the Golden West Childrens Foundation, hereinafter called "Foundation", provides financial assistance to children living within the State of California. All services for which the Foundation provides funding must be administered within the State of California. An application may be submitted for a child, from birth to the eighteenth birthday, by the child's parent(s) or guardian. A doctor, dentist, orthodontist, nurse, a Member of a Subordinate NDGW Parlor or any other person who has reason to know of the child's need may submit an application to a member of the Foundation Committee or to the Case Manager of the Foundation Committee as noted below. **The application shall not be submitted to a NDGW Parlor.** Decisions are made exclusively by the Foundation and are determined by supporting information provided by the individual(s) submitting the application. Submitting an application is not a guarantee of receiving the grant. All financial assistance granted by the Foundation shall be paid directly to the provider of the service within 6 months, and not to the parent or guardian. Financial assistance ceases when the child reaches his/her eighteenth birthday.

THE APPLICATION MUST BE COMPLETELY FILLED OUT. Copies of the last two (2) years Federal Income Tax Returns **must** be submitted with the application. In addition, a photograph and statement about the child **must** be included. A medical, dental or orthodontia request must be accompanied by a statement from the child's doctor or dentist/orthodontist, giving both a diagnosis and prognosis and **must** include a full statement of the charges to be incurred. If an Individual Education Plan (I.E.P.) has been done, include a copy with the application.

Please attach a brief written statement about the child applicant setting forth his/her strengths, likes, achievements, etc. Describe how the child applicant will benefit personally from receiving the requested grant. Ask the child applicant, if he/she is able, to also prepare a personal statement.

REQUESTS FOR ORTHODONTIA ARE CONSIDERED FOR THE DOWN PAYMENT ONLY

In addition to completing pages one (1) through three (3) of the application, please note instructions on supplement to the application for orthodontia treatment, page four (4). If the application is for an orthodontia grant, the dentist/orthodontist must complete the information requested on page four (4). Both the dentist/orthodontist and parent(s)/guardian must sign page four (4). **In addition,** photographs/x-rays in support of the child's need for orthodontia treatment **must be** included with the application. **Active treatment must commence within six (6) months from the date of the grant.**

EMERGENCY GRANT: An emergency need is considered on an individual basis by contact with a member of the Foundation. An application **must** be completed. The maximum allowance for an emergency grant shall be FIVE HUNDRED DOLLARS ($500).

Bills incurred for services rendered prior to the submission and approval of an emergency application shall not be paid.

FORWARD THE COMPLETED APPLICATION, DOCUMENTS, X-RAYS AND SERVICE QUOTES TO:
NDGW Childrens Foundation
Attention: Case Manager
543 Baker Street, San Francisco, CA 94117-1405

Or by Email to: CFCaseManager@ndgw.org

Revised 2/2025

NATIVE DAUGHTERS OF THE GOLDEN WEST CHILDRENS FOUNDATION APPLICATION

Date _____ Referred by: _____ Parlor (If Applicable) _____

Name of the Child Applicant _____ Date of Birth _____Sex _____

Address: _____ City _____ Zip _____ Phone( ) _____

Names and ages of siblings of child applicant residing in the family home (List additional siblings on extra page)

Name: _____ Age: _____ Name: _____ Age: _____

SCHOOL: If this child is in a special program, please submit latest annual test results and/or IEP report

School attends: _____ Grade ____ Private ___ or Public ___ Teacher _____

School address: _____ City _____ Zip _____ Phone( ) _____

INSURANCE: Is the applicant covered by any group insurance, prepaid health plan, Medi-Care, or Medi-Cal?
Yes _____ No_____ If yes, complete the following: Name of insured: _____

Group Insurance Company or plan's name _____

Address of Insurance Company: _____ City _____ Zip: _____

Major Medical coverage? Yes ____ No ____Amount of coverage $_____ Deductible $_____

Prescription coverage? Yes ___ No ___ Dental Plan? Yes ___ No ___ Vision Care Plan? Yes ___ No ___

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CONFIDENTIAL – THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER

for orthodontia services, also complete supplement page four (4)

Type of service requested: _____ Disability: _____

Diagnosis: _____ Prognosis: _____

Full cost of Service: $_____ Recommendation: _____

Length of time required: _____ Is an agency in the area providing this service? Yes _____ No _____
If yes, the name of the agency providing the service: _____

Physician's name _____ Signature: _____

Address: _____ City _____ Zip:_____ Phone( ) _____

Is there a service covering this request in your community? _____No _____Yes
If so, attach a sheet giving complete details regarding who you have contacted, requirements for services, etc.
Attach information that will clarify your request and assist in processing this application.

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COMPLETE THE FOLLOWING FOR A NON-MEDICAL REQUEST - INCLUDE A QUOTE

Remittance is made by check payable to the service provider

Type of service requested: _____ Cost: $ _____

Name of the service provider: _____ Phone( ) _____

Address of the service provider: _____

NATIVE DAUGHTERS OF THE GOLDEN WEST CHILDRENS FOUNDATION APPLICATION

HOUSEHOLD INFORMATION AND FINANCES

PHOTO COPIES OF YOUR FEDERAL INCOME TAX RETURNS FOR THE LAST TWO YEARS MUST ACCOMPANY THE APPLICATION

MONTHLY INCOME

	FATHER'S INFORMATION	MOTHER'S INFORMATION
Name		
Age		
Employer		
Employer's Address City and State		
Type of work		
Gross Monthly Income		
"Take Home" Income		
Are you the natural parent of the child, Yes or No ?		

If there are others residing in the household, please indicate name, age, relationship and amount contributed each month to the family income.

Name: _____ Age: _____ Relationship: _____ Income: $_____

Does the household receive any other income, such as alimony, child support, or local, state or federal assistance (IHSS, SSI or SSDI)? Yes _____ No _____ If yes, please indicate from whom and the monthly amount.
PLEASE NOTE: All local, state and federal assistance received must be verified by issuing agency.

Name of agency: _____ Person receiving check: _____Amount: $_____
(ex. Social Security)

TOTAL GROSS MONTHLY INCOME	$	TOTAL "TAKE HOME" INCOME	$

MONTHLY EXPENSES

Rent or Mortgage Payment: $ _____ Insurance: Household: $_____ Medical: $_____

Utilities: electric, water, gas, phone: $_____ Auto expense: Loan: $_____ Maintenance: $_____

PLEASE LIST ANY OTHER MONTHLY PAYMENTS AND OUTSTANDING ACCOUNT BALANCES

(include any medical expenses not presently covered by insurance)

Name: _____ Monthly payment: $ _____ Balance Due: $ _____

Name: _____ Monthly payment: $ _____ Balance Due: $ _____

If there are other family members dependent for support, not residing in the household, please indicate name and monthly support amount required, age and relationship.

Name: _____ Age: ____ Relationship: _____ Monthly support amount: $____

TOTAL MONTHLY EXPENSES	$

NATIVE DAUGHTERS OF THE GOLDEN WEST CHILDRENS FOUNDATION APPLICATION

Please use the space provided below or attach any additional information that may be helpful to the Childrens Foundation Committee in reviewing this application, such as financial or medical circumstances, or any additional information you may wish to relate to the Committee:

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I/We certify that the information on this application is true and correct to the best of my/our knowledge. I/We authorize the release of any medical information necessary to process this application.

I/We understand this application is submitted for consideration and that the Native Daughters of the Golden West Childrens Foundation Committee is not obligated in any way.

I/We do hereby release the Native Daughters of the Golden West or the Native Daughters of the Golden West Childrens Foundation Committee and its members personally from any liability which might be incurred by them and/or any of them in the course of administering the Childrens Foundation Program.

I/We agree that the Native Daughters of the Golden West Childrens Foundation will be reimbursed should I/We become eligible for duplicate funds from any public or private agency.

IF BOTH PARENTS ARE IN THE HOME, EACH MUST SIGN BELOW

Signature of Parent or Guardian	Signature of Parent or Guardian
Printed Name of Parent or Guardian	Printed Name of Parent or Guardian
Address	Address
City, State, Zip Phone	City, State, Zip Phone
Email	Email

SUPPLEMENT - TO BE COMPLETED FOR ORTHODONTIA CASES ONLY

Active treatment must be started within six (6) months of the date of acceptance for orthodontia treatment. Applications for orthodontia grants must be accompanied by photographs/x-rays of the child applicant that support the need for the treatment.

An orthodontia grant is valid if the banding occurs after the date the orthodontia grant is awarded.

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STATEMENT OF DENTIST/ORTHODONTIST

DIAGNOSIS: _____

_____

TREATMENT PLAN: _____

_____

I agree to accept treatment of the above-named child applicant knowing that only the down payment "not to exceed" ONE THOUSAND DOLLARS ($1,000) will be paid by the Native Daughters of the Golden West Childrens Foundation. I further understand that banding cannot take place until the orthodontic grant has been approved and I have been notified by the Foundation of the action taken. I also understand that any treatment prior to the approval of this application for the above-named child applicant will not be reimbursed by the Foundation.

Full cost of treatment: $_____ Down payment: $ _____ Monthly payment: $ _____

_____ _____

Signature of Dentist/Orthodontist Print name of Dentist/Orthodontist

_____

Date of signature

Address: _____ City: _____ Zip: _____ Phone( )_____

PARENTS' or GUARDIAN'S STATEMENT

I/we agree to accept only the down payment, "not to exceed" ONE THOUSAND DOLLARS ($1,000) from the NATIVE DAUGHTERS OF THE GOLDEN WEST CHILDRENS FOUNDATION and assume responsibility for the remainder of the cost of the orthodontia treatment.

_____ Date of Signature: _____

Signature of Parent or Guardian

_____ Date of Signature: _____

Signature of Parent or Guardian