

Help Fill A Dream Foundation
PO Box 8136
Victoria, BC
V8W 3R8



Email: info@helpfilladream.com
Telephone: 250-382-3135
Fax: 250-382-2711
Toll Free: 1-866-382-2711

Dream Application Package

Please find enclosed an application form to Help Fill a Dream of a child.

Details of this form must be completed in full and signed by parents and/or guardian.

Relay your intentions to your child's doctor and ask him/her to send us written confirmation of your child's diagnosis and prognosis. Please provide as many details as possible. This will avoid delay.

Enclose a picture of your child (if possible), for our records.

Also, review your passports if the dream is outside Canada.

May we take this opportunity to say thank you for allowing us to share the dream of your wonderful child.

Please note: we cannot commence processing a dream request until we receive the above items, "D" and "R". Help Fill A Dream is a Victoria B.C. Based charity operating within the Vancouver Island Health Authority Footprint. As such, the dream application must be for a child who primarily resides on Vancouver Island.

Privacy

The Help Fill A Dream Foundation is committed to protecting the privacy of the personal information of our Dream children, their families, our donors, our employees, our members and volunteers, and other stakeholders. The Help Fill A Dream Foundation acts in accordance with the privacy principles found in the federal Personal Information Protection and Electronic Documents Act. These principles address the collection, use, storage and disposal of personal information.

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Individual Information

Help Fill A Dream collects personal information to facilitate the delivery of our programs to children with life threatening illnesses. Collection and disclosure of personal information is authorized by the recipient's custodial parent(s) or legal guardian by signed approval at the time of collection. In the absence of express written permission, disclosure of such personal information to third parties is limited to information that is necessary to allow those third parties to deliver the program to the children and their families.

Safeguards

Help Fill A Dream ensures that all personal information collected, retained and destroyed is protected against loss, theft, unauthorized access and inadvertent or inappropriate release.

Procedures have been established to ensure that the personal information is collected used, stored and destroyed in a sensitive manner. This information is considered and treated as highly confidential.

Privacy Officer

Help Fill A Dream Foundation's Privacy Officer can be contacted for any inquiries regarding the appropriate collection, use, disclosure, retention, and destruction of personal information. Program recipients and donors can request access to their own personal information through the Privacy Officer as well.

Contact Information:

Attn.: Privacy Officer
Help Fill A Dream Foundation
PO Box 8136
Victoria, BC V8W 3R8

Tel: 250.382.3135
Fax: 250.382.2711
Email: privacy@helpfilladream.com

Website: www.helpfilladream.com

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APPLICATION FORM

Applicant's name: _____

Address: _____

Age: _____ D.o.B.: _____

Phone: _____ Email: _____

Physician's name: _____ Phone: _____

Type of illness: _____

(Please provide a short detailed description of the child's medical condition)

Dream request: _____

All applications will be held in strict confidence within the Foundation.

Each applicant will be handled on a personal basis, with the assistance of the parent(s) and the physician.

I hereby give my permission to the Help Fill A Dream Foundation of Canada to conduct whatever investigations that may be necessary to fulfill this dream.

NOTE: A letter from the child's physician must accompany this application. Help Fill A Dream is a Victoria B.C. Based charity operating within the Vancouver Island Health Authority Footprint. As such, the dream application must be for a child who primarily resides on Vancouver Island.

Date of Application: _____ Parent(s) Signature: _____

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ADDITIONAL INFORMATION

Father's name: _____ D.o.B.: _____

Address: _____

_____ Phone: _____

Mother's name: _____ D.o.B.: _____

Address: _____

_____ Phone: _____

How many brothers? _____

Name: _____ D.o.B.: _____

Name: _____ D.o.B.: _____

Name: _____ D.o.B.: _____

How many sisters? _____

Name: _____ D.o.B.: _____

Name: _____ D.o.B.: _____

Name: _____ D.o.B.: _____

Do you have current passports? _____

When do you want to go? _____

Child's interests, hobbies, favorite sports/players, celebrities: _____

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QUESTIONNAIRE

1) The Help Fill A Dream Foundation is able to help fulfill dreams based on the generosity of our corporate and private donors. By giving us your permission to publish your child's first name and pictures of your child or your family, you will be helping us raise public awareness for the many families that the Foundation assists. Can we count on your support? Yes No

2) Are there any special medical requirements such as: medication, wheelchair, and/or stretcher? If so, please state below: Yes No

3) Have you ever received funds from any organization such as Help Fill A Dream, Children's Wish, etc? If yes, please provide details. Yes No

4) Is this the dream of the child or parent(s)? Child Parent

5) Would this dream be possible if you were not financially assisted or sponsored by Help Fill A Dream? Yes No

6) Are you and your family, in any way, related through blood or marriage to any members or associates of this Foundation? Yes No

The parent(s) or guardian(s) will not hold Help Fill A Dream Foundation, or it's officers, staff, members, or volunteers responsible for any accidents, acts of God or unforeseen illness that should occur during this dream or trip.

Dated this ____ day of _____, 20__.

Signed: _____ Signed: _____
Parent(s) or Guardian(s) Help Fill A Dream Foundation