



Rainbow of Help, Inc.
Fundraising Benefit Application
(Each application will be reviewed on an individual basis)

"Volunteers dedicated to assisting others in fundraising efforts to offset the cost of unforeseen medical situations"

www.rainbowofhelp.com
rainbowofhelp@gmail.com

Date: _____

Requesting Sponsors Name _____

Address: _____ City: _____

Phone Number: _____

Benefactors Name: _____

Address: _____ City: _____

Phone Number: _____ Age: _____

1) Niagara County Resident? Yes _____ No _____

2) Medical Insurance? Yes No

3) Has Social Services been contacted? Yes _____ No _____

If yes, briefly describe the outcome:

4) Please describe the medical circumstances (cancer, paralysis, etc.) **Please be as accurate as possible.**

Disposition: Accepted _____ Declined _____ Reason _____

Date application was received: _____

5) Purpose for fundraiser: (i.e. medical bills, handicap van, home renovations for medical reasons etc.)
Be specific:

6) We understand that the Rainbow Of Help, Inc. requires 100% participation from the family and friends of the benefactor. _____ (initial)

Applicant acknowledges that the Rainbow of Help, Inc. does not "put on" an event but assists in coordinating and planning a fund raising event. The recipient must provide people the day of the event to work with the Rainbow members.

7) Consumption of alcohol and/or illicit drugs on premises is strictly prohibited.

I (print name) _____, certify that all funds raised during this benefit will be used solely for the purpose only as referenced in item #5 above.

Date: _____ Signed _____.

How did you hear about the Rainbow Of Help?

All applications must be filled out completely in order for an interview to be conducted.

Please mail completed application to:
Rainbow Of Help, Inc.
P.O. Box 206
Newfane, N.Y. 14108

For Office use only:

Date application was received: ____/____/____

Disposition: Accepted _____ Declined _____ Reason _____