ROYAL ARCH MASONS
CHILDREN'S HEART FOUNDATION INC.

APPLICATION PACKET

MAY 27, 2019

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

Index

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

PART A
FOREWORD

The purpose of the Royal Arch Masons Children's Heart Foundation, a Charitable Institution, is to aid in financing medical and surgical care for children who have heart defects; and whose parents are financially unable to assume the entire cost of these expensive operations· without great and undue sacrifices being suffered by the family.

IN ALL CASES, THE APPLICATION WHEN COMPLETED, WILL BE PROCESSED BY THE TRUSTEES OF THE FOUNDATION.

This charity makes NO DISTINCTION AS TO RACE, COLOR, CREED OR DENOMINATION and is limited to children under the age of eighteen (18) years. The Royal Arch Masons Children's Heart Foundation shall consider those children, whose parents or legal guardians are residents of the State of Washington for a PERIOD OF NOT LESS THAN SIX MONTHS prior to date of application or operation, whichever comes first. Upon completion of the application, the Foundation will consider financing the hospital, medical and transportation services only.

The Heart Foundation will pay for TWO (2) CARDIAC CATHERTERIZATIONS of a child who has a heart defect as diagnosed. The Heart Foundation will pay for ONE (1) PACEMAKER if needed for the success of the original operation. If in the future, the child needs another Pacemaker, the Board of Trustees will review such requests. If an application for assistance has been approved by the Board of Trustees, and surgery for the applicant has been postponed for one year, the entire application and financial status of the family shall be updated and reviewed subject to approval of the Board of Trustees.

THE ROYAL ARCH MASONS CHILDREN'S HEART FOUNDATION WILL NOT BE LIABLE FOR THE EXPENDITIJRE OF ANY FUNDS UNLESS APPROVED BY THE BOARD OF TRUSTEES. ANY AMOUNT IN EXCESS OF THE INITIAL $10,000 LIMIT MUST HAVE FURTHER APPROVAL OF THE BOARD OF TRUSTEES.

The Royal Arch Masons Children's Heart Foundation may, upon receipt of a proper paid receipt from the family, pay directly to the family for transportation to the hospital, other than private vehicle. This will be judged by the Board of Trustees on a case by case basis. The Foundation will not pay for blood taken from a blood bank. All payments from the Foundation will be made directly to the hospital, physicians and anesthesiologists. Payments paid to physicians or the hospital by the family will not be reimbursed by the foundation.

It is essential that the full name ROYAL ARCH MASONS CHILDREN'S HEART FOUNDATION be used on all matters pertaining to the Foundation, since the word MASONS refers to the order which distinguishes it from other charitable organizations.

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

PART B
INSTRUCTIONS

1. The Chapter assigned to investigate should accept sponsorship of the application at a regular stated Convocation. IF THE CHAPTER IS DARK, ANY ONE OF THE THREE ELECTED OFFICERS together with the SECRETARY OF THE CHAPTER have the power to act on the application, so the application does not become dormant when the Chapter is dark. Make sure the Chapter's seal is affixed to the Chapter section of the application and proper signatures are affixed.

2. The Chapter is responsible to appoint an Investigating Committee.

3. It is the responsibility of the Investigating Committee to fill out the application in the presence of and with the information provided by the family. This is to be done at the scheduled interview. Correctness of the information should be verified by the family.

4. It is essential that the Investigating Committee familiarize themselves with the **FOREWORD PART A** and **INSTRUCTIONS PART B** of the application prior to meeting with the family, so that they may make certain notes pertaining to information while for filling out the application. PLEASE PRINT OR TYPE ALL INFORMATION to questions on the form. Please use BLACK INK PEN ONLY when printing.

5. Prior to completion of the application and placing the signatures, **review** the entire application to ascertain if any items have been omitted or need to be altered.

6. **ONCE THE APPLICATION REACHES THE SECRETARY OF THE FOUNDATION, THE INFORMATION RECORDED WILL STAND. REMEMBER, IT IS ESSENTIAL THAT ALL QUESTIONS BE ANSWERED.**

7. **Inform the parties mentioned on the application, PARAGRAPH #4 and #5 of the FOREWORD PART A AND THIS MUST BE ADHERED TO.**

8. **Ask the parents or guardian for a PHOTO of the child named on the application. A COPY OF THE CERTIFIED BIRTH CERTIFICATE IS REQUIRED. (Note: If you have a smart phone, you can take a picture of the child and the birth certificate. If your smart phone has a scanner application, then scan the birth certificate as a PDF. However, make sure you send a legible copy of both with your report either in print or by email.)**

9. **Section 4, PHYSICIANS REPORT, is to be left for the family to take to their family doctor or physician, together with the stamped envelope provided (addressed to the Area Trustee). It must be stressed that the APPLICATION IS NOT COMPLETE UNTIL THE TRUSTEE RECEIVES THIS FORM.**

10. Section 2A & Section 2B deals with the Financial Status of the Applicant. We need complete information in each subsection. If the applicant indicates have a particular financial account or assets, write N/A. The applicant should know that falsifying information will invalidate the application.

11. Section 2C deals with information regarding the patient's surgery, transportation, etc. Please make sure the applicant understands that any future surgery dates are needed. If there isn't any, write N/A.

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

PART B
INSTRUCTIONS

12. Section 2D is where the applicant certifies the information is true. The certification needs the signature of both parents if the household has both parents. If the patient has two legal guardians in the household then both of their signatures are required. If the household only has one parent or legal guardian, then only one signature is needed. Regarding the signature of the witnesses, we need two of the Investigating Committee to certify the applicant(s) has signed this section.

13. Inform the parent or guardian that we must have, for our records, copies of ALL MEDICAL AND HOSPITAL records of the patient, and that they sign the release forms SECTION 5 A and B in the presence of the Investigating Committee. After they have affixed their signatures to the form, and the Investigating Committee affixes their signatures in the presence of the parent or guardian, we will have a LEGAL DOCUMENT to present to the hospital and the insurance provider.

14. Inform the parent(s) or legal guardian(s) that we will cover what is not covered by their medical insurance, private or public.

15. Upon completion of the interview with the applicant, advise the parent or legal guardian that they will be notified by the Secretary or President of the action taken by the Board of Trustees.

16. EXPEDITE THE APPLICATION AS SOON AS POSSIBLE. Upon completion, make sure that the Investigating Committee's signatures and date are affixed to the application. A COVER LETTER BY THE INVESTIGATING COMMITTEE SHOULD CONTAIN PERSONAL REMARKS OF THEIR FINDINGS. The application when completed is to be given to the AREA TRUSTEE, together with the Investigating Committee Investigation Report, BIRTH CERTIFICATE AND PHOTO.

17. WHEN THE AREA TRUSTEE HAS RECEIVED THE APPLICATION, together with the Investigation Committee report, birth certificate and photo, and when he has received the PHYSICIANS REPORT, he will then add HIS INVESTIGATION REPORT and send the COMPLETE APPLICATION TO THE FOUNDATION'S SECRETARY.

18. The Investigating Committee or Area Trustee will completely fill out Section 1 (History of Patient & Applicant) which should contain all the information in the patient and the parent(s) or legal guardian(s).

If the family has Life Insurance, ask for the cash value. Annotate the amount in the section.

Do not change nor edit the RAMCHF Application Number.

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 1 - HISTORY OF PATIENT AND APPLICANT

RAMCHF APPLICATION # _____(office use only)

Full Name of Patient: _____
(Last) (First) ((Middle)

Present Address of Patient: _____
(Number & Street) (City) (State) (Zip)

Date of Birth: _____/ _____/_____ Place of Birth: _____
(Month/Day/Year)

Phone Number Where You Can Be Reached: ( ) _____ Email Address: _____

How Long Legal Resident of Washington State? _____
(Father or Legal Guardian) (Mother) (Child)

Medical Condition: _____

Status of Parents: ___Married ___Not Married ___Separated ___Divorced ___Deceased (___Both ___Father ___Mother)

Full Name of Father & Age:_____
(Last) (First) (Middle) (Age)

Father Address: _____
(Number & Street)

City: _____ State: _____ Zip: _____ Phone ( ) _____

Full Name of Mother or Legal Guardian & Age:_____
(Last) (First) (Middle) (Age)

Mother or Legal Guardian's Address:_____
(Number & Street)

City: _____ State: _____ Zip: _____ Phone ( ) _____

Has applicant applied for assistance through another agency or institution other than RAMCHF? ____Yes ____No

_____
(Government CCS) (Children's Hospital) (State Medical Assn.) (Other Agencies)

Is patient receiving treatment now? ____Yes ___No If Yes, where? _____
(Hospital or Place of Treatment)

Name of Physician: _____ How long treatment? _____

Date form completed by Investigating Committee? _____
(Investigating Committee Comments Use Section VIII)

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 2A - Financial Status of Applicant

RAMCHF APPLICATION # _____(office use only)

EMPLOYMENT

Father or Legal Guardian's Employment: _____ Position: _____

Length of Employment: _____ Annual Income: $ _____

Source(s) of Other Income: _____ Annual Income Other Sources: $ _____
(Jobs, Investments, Grants, Etc.)

Member of a Union: ___Yes ____No If YES, Name of Union: _____

Mother's Employment: _____ Position: _____

Length of Employment: _____ Annual Income: $ _____

Source(s) of Other Income: _____ Annual Income Other Sources: $ _____
(Jobs, Investments, Grants, Etc.)

Member of a Union: ___Yes ____No If YES, Name of Union: _____

PROPERTIES (Use additional paper if you have more properties than you can place on this application)

Property: _____

Own: ___ Yes ___No Rent: ___Yes ___No Monthly Payments or Rent: $_____

List any and all properties, owned or buying, real or personal

_____
(Location / Market Value / Payments / Equity)

_____
(Location / Market Value / Payments / Equity)

VEHICLES

List any and all vehicles owned: (Use additional paper if you have more than you can place on this application)

_____
(Year / Make / Model / Approximate Value / Amount Still Owed / Payment)

_____
(Year / Make / Model / Approximate Value / Amount Still Owed / Payment)

_____
(Year / Make / Model / Approximate Value / Amount Still Owed / Payment)

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 2B - Financial Status of Applicant

RAMCHF APPLICATION # _____(office use only)

BANK ACCOUNTS AND SECURITIES (Use additional paper if you have more accounts than you can place on this application)

Bank or Credit Union Name: _____ Location: _____

Checking Account Balance: $ _____ Savings Account Balance: $ _____

Stocks, Bonds or Mutual Funds ___Yes ___No If Yes, Amount $ _____ Type _____

Other Securities of Liabilities ___Yes ___No If Yes, Amount $ _____

Type: _____

INSURANCE POLICY (Use additional paper if you have two or more policies with the information required)

Insurance Policy or Policies: ___Yes ___No Type ___Life ___Term

Name of Insurance Company: _____

Address Insurance Company: _____

How long has this policy been in effect? _____ **Cash Value:**

Insurance Policy or Policies: ___Yes ___No Type ___Life ___Term

Name of Insurance Company: _____

Address Insurance Company: _____

How long has this policy been in effect? _____ **Cash Value:**

MEDICAL INSURANCE (Use additional paper if you have more than two medical policies with the information required)

Any Medical Insurance? ___Yes ___No If Yes, Name of Medical Insurance: _____

How long has Medical Insurance been in effect? _____

Any Medical Insurance? ___Yes ___No If Yes, Name of Medical Insurance: _____

How long has Medical Insurance been in effect? _____

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 2C - Financial Status of Applicant

RAMCHF APPLICATION # _____(office use only)

Transportation of Patient

How was patient transported to the hospital or outpatient clinic? _____

If by ambulance or medical transport, which company? _____

Surgery

Date of Surgery: Month: _____ Day: _____ Year: _____

In what hospital or outpatient clinic was surgery performed?

_____
(Name)

_____
(Address)

_____
(City) (State) (Zip)

Was surgery successful? ___Yes ___No

Does the patient require further surgery? ___Yes ___No

Date form completed by Investigating Committee: _____/ _____/ _____

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 2D - Financial Status of Applicant

RAMCHF APPLICATION # _____(office use only)

CERTIFICATION OF INFORMATION GIVEN

I / We, the parent(s) or legal guardian(s) of the applicant do herby certify that the information presented in Sections 1, 2A, 2B and 2 C of this application for assistance is true to the best of my / our knowledge.

I / We understand that any misrepresentation of facts or information may result in the immediate disapproval or cancellation of any and all financial assistance provided by the Royal Arch Masons Children's Heart Foundation, Inc.

I / We understand that in the event of I / We having medical insurance coverage, the Royal Arch Masons Foundation Inc. will cover any medical bill, in accordance with our by-laws and up to the maximum the by-laws allows, after the medical insurance pays the medical provider or I / We receive any payment for services covered by the by-laws of the Royal Arch Masons Children's Heart Foundation Inc.

I / We agree that In the event that I / We receive any payment from or payments are made directly to the medical providers from my / our medical insurance coverage and payments have been received by the medical providers from the Royal Arch Masons Children's Heart Foundation Inc. for the same service, I / We will promptly refund the Royal Arch Masons Children's Heart Foundation, Inc. the full amount of the payment of said service received from them.

Parent or Legal Guardian Signature

Signature: _____

Date Signed: _____/_____/_____

Parent or Legal Guardian Signature

Signature: _____

Date Signed: _____/_____/_____

Witness
Print Name: _____ **Date Signed** _____/_____/_____

Signature: _____

Witness
Print Name: _____ **Date Signed** _____/_____/_____

Signature: _____

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 3A - Certification Sponsoring Chapter

RAMCHF APPLICATION # _____(office use only)

The attached application was received by _____ Chapter No. ____

Located at _____, _____, WA

On (Month) _____ (Day) _____ (Year) _____, by _____.
(Member's Name)

The application was presented to the Companions at a regular Stated Convocation held on the following date:

(Month)_____ (Day) _____ (Year) _____.

The application ____passed ____was rejected at the Stated Convocation.

Attest:

_____
(High Priest)

[CHAPTER SEAL]

_____
(Secretary)

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 3B - Certification Investigating Committee

RAMCHF APPLICATION # _____(office use only)

On this date, _____ _____, _____, we the Investigating Committee met with the applicant
(Month) (Day) (Year)

named hereon and his parent(s) or legal guardian(s). We have completed an interview with the family, and do now affix our signatures to this certification, that all the facts and information given and recorded are true to the best of our knowledge and have transferred this application to the AREA TRUSTEE _____on
(Name of Trustee)

_____ _____, _____.
(Month) (Day) (Year)

Fraternally submitted

_____
(Print Name) (Signature) (Date)

_____
(Print Name) (Signature) (Date)

_____
(Print Name) (Signature) (Date)

APPLICANT'S INFORMATION (From page one)

Name of patient: _____

Name of Parent(s) and or Guardian(s) patient is living with:

_____ _____
(Mother or Guardian) (Father or Guardian)

Address patient is living at:

_____
(Number) (Street) (City) (Zip)

Phone for contact: ( ) _____ ( ) _____ ( ) _____
(day phone) (night phone) (cell phone)

Email: _____

Date of Birth: _____ / _____ / _____ Date of Death: _____ / _____ / _____

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 4 - Physician's Certification

RAMCHF APPLICATION # _____(office use only)

Patient's Name: _____ Sex: ___ Age: _____

Brother's Name: _____ Age: ____ Sister's Name: _____ Age: ____

Brother's Name: _____ Age: ____ Sister's Name: _____ Age: ____

Brother's Name: _____ Age: ____ Sister's Name: _____ Age: ____

Brother's Name: _____ Age: ____ Sister's Name: _____ Age: ____

Family History (if pertinent)

_____

_____

_____

Short History of Patient's Condition: _____

Diagnosis: _____

Date of Diagnosis: _____

Past Illness? _____

Remarks of Physician: _____

_____

_____

_____

Name of Physician: _____, M.D. Date: _____/ _____/ _____

Signature: _____ Phone: ( ) _____

Address: _____
(Number & Street) (City) (State) (Zip)

Email Address: _____@ _____. _____

(If additional space is needed, use other side of this page.)

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 5A - Authorization for Release of Payment Information

RAMCHF APPLICATION # _____(office use only)

Re: **Patient's Name** _____

Policy Number _____

Subscriber _____

To whom it may concern:

This is to authorize my Insurance Company (or Agency) _____ to furnish to the Royal Arch Masons Children's Heart Foundation Inc. whose address and phone number are indicated above any and all information regarding payments to Hospitals, Doctors, Ambulances and other Health Providers related to the treatment for dates of

_____ **to** _____

1. Duration of Waiver – This authorization shall be valid for a period of one (1) year from the date hereof.
2. Copy in lieu of original – A copy of the original authorization for release of medical information shall have the same force and effect as the signed original.

_____ _____
Signature of patient or patient's authorized representative Date

_____
(Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 5B - HIPAA Authorization for Use and Disclosure of Information

I _____hereby authorize the use and/or disclosure of
(Name of Parent or Legal Guardian)

_____individually identifiable health information (the "Information") as follows:
(Name of Patient)

1. In connection with the information requested for the assistance application of the Royal Arch Masons Children's Heart Foundation Inc. from the child's or patient's physician(s).
2. When submitting payment information to the Royal Arch Children's Heart Foundation Inc. for payment related to cardiac surgery, treatment, etc. claims.

I authorize my health care providers to disclose to the Royal Arch Masons Children's Heart Foundation Inc. to whom the Claim may be submitted, all Information related to the Claim, for the specific purposes of facilitating the processing and/or payment of the Claim by the Royal Arch Masons Children's Heart Foundation Inc. and communicating with the Royal Arch Masons Children's Heart Foundation Inc. and the Payor about the Claim.

This authorization is specifically limited to the individually identifiable health information related to the Claim.

I further understand and agree:
1. This authorization will expire upon the termination of the payment limits rendered by the Royal Arch Masons Children's Heart Foundation Inc., as indicated in their by-laws, and the parent(s) or Legal Guardian(s) of the patient named above.
2. I may revoke this authorization at any time by notifying the Royal Arch Masons Children's Heart Foundation Inc. in writing (although the revocation will not have any effect on any actions taken before receiving the revocation).
3. I may see and copy the information described on this form if I ask for it.
4. The information that is used or disclosed under this authorization may be re-disclosed by the receiving entities, but only for the specific purposes authorized.
5. Copy in lieu of original – A copy of the original authorization for release of medical information and/or disclosure of payment shall have the same force and effect as the signed original.

Parent(s)/Guardian(s) Name(s):_____

If I am signing this Authorization as a Patient's Representative, I certify that I have the authority to act on behalf of the Patient and that the information provided below to verify my identity is correct.

_____ _____
Signature of Parent(s), Legal Guardian or Claimant's Representative — Signature of Parent(s), Legal Guardian or Claimant's Representative

Date : _____ Date: _____

Name of Claimant's Representative, if applicable: _____

Representative's DOB:_____ Relationship to the Patient _____

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 6 - Area Trustee Certification

RAMCHF APPLICATION # _____(office use only)

Area Trustee

I, _____, an AREA TRUSTEE of the Board of Trustees of the Royal Arch.,
(Name of Area Trustee)

Children's Heart Foundation, Inc Have on this date _____ _____, _____ received this application from the
(Month) (Day) (Year)

Chapter Investigating Committee and have interviewed the applicant and have found all items and information listed correctly to the best of my knowledge and have placed my comments on this application in Section 8.

Signature Area Representative: _____

Date Signed: _____ / _____ / _____
(Month) (Day) (Year)

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 7 - Investigating Committee Report

RAMCHF APPLICATION # _____(office use only)

Please make your own assessment of the family in question and enter your remarks on this section. If you need more space, attach another sheet of paper to Section 6 before turning it over to the Area Trustee.

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 8 - Area Trustee Investigating Report

RAMCHF APPLICATION # _____(office use only)

Make your own assessment of the family circumstances and enter your comments in this section.
REMEMBER, ALL SECTIONS MUST BE COMPLETELY ANSWERED BEFORE YOU RETURN THE APPLICATION TO THE FOUNDATION'S SECRETARY, INCLUDING COVER LETTER AND PHYSICIAN'S REPORT.

ROYAL ARCH MASONS
Children's Heart Foundation Inc.

PO Box 223 Marysville, WA 98270-0223
Phone: (360) 658-4581 (800) 813-9900
Email: ramchf@comcast.net

APPLICATION FOR ASSISTANCE

SECTION 9 – Board Resolution

Decision of the Board of Trustees

Application received on _____ / _____ / _____

____Approved ____Disapproved

Remarks:

_____

_____

_____

Date of Decision: _____
(Month) / (Day) / (Year)

_____
(Signature of Secretary)

[Seal of Foundation]

_____
(Signature of President)