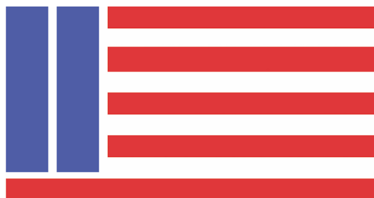


RAY PFEIFER FOUNDATION

Award Application

Please fill out the application completely

Applicant Name: ____

Spouse Name: ____

Street address: ____

City: ________________________ State: __________ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________

Email Address: ____

Agency and Unit Worked for on 9/11: ______________________________

Employment Status on 9/11: ☐Active ☐Retired

Date of Employment: ______________ Date of Retirement: ______________

Dates worked at 9/11 Rescue/Recovery Area: __________________________

Location of NYC 9/11 Rescue/Recovery Area where you worked (Ground Zero, Staten Island Landfill, Office of the Chief Medical Examiner or New York City):

____

List World Trade Center Certified Illnesses:__________________________

Are you currently receiving treatment for your WTC certified illnesses? If yes, please explain: ____

Are you receiving a disability pension? ☐ Yes ☐ No

If yes, from which agency? ____________________________________

Are you collecting Social Security Disability? ☐ Yes ☐No

Are you enrolled in the World Trade Center Health Care Program? ☐ Yes ☐ No

Are you receiving Workman's Compensation Benefits? ☐ Yes ☐No

Are you enrolled in the September 11 Victim Compensation Fund? ☐ Yes ☐ No

Have you received your 100% award from your 9/11 Victim Compensation fund?

☐ Yes ☐ No

Who is your September Victim Compensation Fund Lawyer?

____

Are you currently employed? ☐ Yes ☐ No If so, by whom?________________

What medical equipment are you requesting from The Ray Pfeifer Foundation?

____

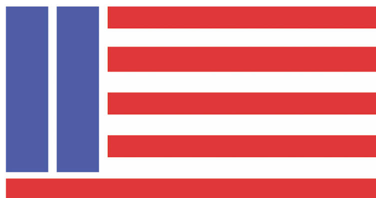
Primary Insurance Company? ____________________________________

Have you tried to obtain the requested equipment from your medical insurance company? ☐ Yes ☐ No If yes, please explain the outcome: ______________

____

Please explain how the medical equipment requested will aide your condition/quality of life.

____



Award Application

Please list 2 references who were with you during the rescue/recovery efforts during the 9/11 response/recovery. (By providing this information, you consent to The Ray Pfeifer Foundation Inc. and/or its advisors contacting these references.)

Name:	Name:
Agency:	Agency:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone Number:	Phone Number:

With this application please provide the following information:

1. Certification papers of your 9/11 illnesses.
2. Medical Disability retirement papers, if applicable.
3. Provide documentation from your medical insurance provider that it will not cover the equipment requested free of charge for you to use.
4. Any other documentation that will help the Review Board award you the medical equipment needed.

We reserve the right to request additional documentation, including but not limited to, pay stubs; official personnel rosters; signed employer statements; and/or site credentials. A failure to provide requested documentation may serve as the basis for the rejection of your application.

The Ray Pfeifer Foundation Inc. does not discriminate on the grounds of race, color, religion, gender, national origin, age, sexual orientation, marital status, disability or status as a covered veteran in accordance with applicable federal, state and local laws.

CERTIFICATION: I hereby certify that the information provided in this Application is complete and accurate to the best of my knowledge. I understand that if any such information is found to be false, I may be denied assistance, and I may be required to return, or repay the value of, any assistance that I receive based on the false information. I acknowledge the receipt of the Ray Pfeifer Foundation's Notice of Privacy Practices and **by signing this Application I waive any and all protections, rights and remedies which I may have under the Health Insurance Portability and Accountability Act of 1996 or any equivalent state law**, to the extent the same exist. I authorize The Ray Pfeifer Foundation Inc. to disclose the information which I have provided in connection with this application, including but not limited to information regarding my medical condition, to the Review Board and to third parties, including but not limited to advisors of The Ray Pfeifer Foundation Inc. in connection with the review and consideration of this application and the making of any award herein. I have made this authorization voluntarily, and understand that I have the right to revoke this authorization by writing to The Ray Pfeifer Foundation Inc.

Applicant Signature: ____

Applicant Name Print: ____

Date: ______________________

Please email the application back to the Ray Pfeifer Foundation contact you have spoken to or send to: info@theraypfeiferfoundation.org

You may also mail the application to:
The Ray Pfeifer Foundation

827 Route 82
Suite 10210
Hopewell Junction, NY 12533
United States