CiDrep SickKids Foundation

FOR THE CURE AND CARE OF SICK (CHILDREN) KIDS™

APPLICATION FOR FUNDS AND ASSISTANCE

Please use the checklist below to help expedite your request.

BASIC REQUIREMENTS:

IMPORTANT: You must meet the following requirements before submitting your application.

☐ Income guidelines

☐ Child is age 18 or younger

☐ Request qualifies as a valid health care need

SUBMITTAL CHECKLIST:

IMPORTANT: Documents needed will vary depending upon the request.

Mandatory Documents:

☐ Complete application

☐ Letter from doctor (on letterhead) that includes the child's diagnosis, history of illness, specific request for funding and other relevant information

☐ First page of your most recent federal income tax return or W-2

☐ Child's photograph (this is optional)

Requests for treatment, surgery, medication, equipment, medical supplies or personal transport vehicle modifications:

☐ All documents listed in "Mandatory Documents" above

☐ Evaluation from specialist (Therapist, Audiologist, Pediatrician, Gastroenterologist etc. for the requested item)

☐ Letter from the provider on letterhead showing the original cost and price after discount (a hardship credit and/or discount must be given in order to receive assistance)

☐ Letter of denial from the insurance company or policy showing exclusion

Requests for travel or lodging:

☐ All documents listed in "Mandatory Documents" above

☐ Letter of medical necessity from a social worker on letterhead stating the frequency and duration of travel for the next 12 months (include the exact mailing address of the social worker and a statement that insurance does not cover the request)

CONTACT AND APPLICATION SUBMITTAL INFORMATION:

Application Submittal:

By Mail: 3340 Peachtree Road
Suite 1800
Atlanta, GA 30326

Contact:

Phone: 1 (470) 222-3120
Email: request@cidrepsickkids.org
Website: cidrepsickkids.org

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CHILD INFORMATION

Last name_____First name_____Age_____ Birth-Date (MM) _____ (DD) _____ (YYYY)

Male _____ Female _____ Citizenship_____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Hispanic

FAMILY INFORMATION

Guardian #1

Last name_____First name_____Occupation _____

Address_____City_____State _____ Zip_____Country _____

Home phone_____Cell phone_____E-mail address _____

Guardian #2

Last name_____First name_____Occupation _____

Address_____City_____State _____ Zip_____Country _____

Home phone_____Cell phone_____E-mail address _____

HOUSEHOLD INFORMATION

Child lives with_____Number of child guardians_____Number of dependent children in household _____

Does the household speak English? Yes_____No_____If no, what is the primary language _____

FUNDING INFORMATION

Health insurance name (Private)_____(Medicaid)_____Annual family income (prior year) $ _____

Last year's out-of-pocket medical expenses for the child $_____Amount requesting from CiDrep SickKids $ _____

Has funding been requested from additional sources? Yes_____ No _____ If yes, please list _____

If funding has been received, from whom?_____Amount $ _____

How did you hear about CiDrep SickKids? Family, Friend, Social Worker, Medical Professional, Website/Internet o r Other _____

MEDICAL INFORMATION *(Health care professionals providing current care)*

Physician's last name_____First name_____Title (DO, MD, etc.) _____

Social worker's last name_____First name_____Title_____

Child's clinical diagnosis_____Age illness started or was diagnosed _____

History of illness/health condition _____

_____

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Description of request (details on next page)_____

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*****COMPLETE ONLY THE SECTION(S) BEING REQUESTED*****

1. REQUEST FOR TREATMENT/SERVICES *(Surgeries, transportation/visits, procedures, therapy, etc.)*

Type of treatment _____

Number of treatments/visits_____Cost per treatment/visit $_____Price after discount $ _____

Company/provider that the check will be made out to_____Person at company receiving the check _____

Address_____City_____State _____ Zip_____Country _____

2. REQUEST FOR MEDICATION *(Attach additional pages listing medication if more than one is needed)*

Name of medication_____Dosage Frequency _____ Number of months needed Cost per month $_____Price after discount $ _____ Company/provider that the check will be made out to_____

_____Person at company receiving the check __ Address___City_____

_____State _____ Zip_____Country _____

3. REQUEST FOR EQUIPMENT/SUPPLIES *(Attach additional pages listing equipment or supplies if more than one is needed)*

Type of equipment/supplies_____Cost of equipment $_____Price after discount $ _____

Company/provider that the check will be made out to_____Person at company receiving the check _____

Address_____City_____State_____Zip_____Country _____

4. REQUEST FOR TRAVEL *(Please check with Angel Flight or major airlines for assistance.)*

Purpose of travel _____

Starting and ending cities/locations_____Number of individuals_____ Number of round trips Method of transportation:

☐ Car Estimated round-trip mileage (only if traveling bycar) _____

☐ Plane Ticket price per adult $_____Ticket price per child $ _____

☐ Train Ticket price per adult $_____Ticket price per child $ _____

☐ Public transportation Ticket price per adult $___Ticket price per child $_____If funding is granted, who should the check be made out to? (Parent/Guardian)_____*(Check will be mailed to social worker)* Attn social worker (name)_____Address_____City_____State Zip _____

5. REQUEST FOR LODGING *Is charitable housing an option? Yes____No _____*

Number of individuals_____Number of nights_____Type of lodging_____Discounted cost per night $ _____

If funding is granted, who will receive payment? (Company)_____Make to attention of _

Address_____City_____State _____ Zip_____Country _____

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REQUIRED—CONSENT TO RELEASE INFORMATION AND AFFIRMATION

I do hereby authorize all hospitals, financial institutions and insurance groups to release to CiDrep SickKids Foundation, or its duly authorized representatives, any information deemed necessary to complete its investigation of my application for financial assistance. In addition, I do hereby authorize all hospitals, financial institutions and insurance groups to release to CiDrep SickKids Foundation, or its duly authorized representatives, any information or itemized statements that pertain to the diagnosis and treatment of the child and related expenses. I further authorize CiDrep SickKids Foundation and its representatives to provide such information to those institutions as may be reasonably required to assist our family and our child. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

In order for *CiDrep SickKids Foundation*, a not-for-profit organization, to advance supplemental family support expenses in conjunction with the medical treatment of_____(child), the undersigned do hereby affirm as follows:

1. The undersigned are the parents or guardians of the child.
2. The term "non-medical expenses" is understood to mean lodging, food, gas, parking and transportation for children who require treatment incurred by the family or guardian of the above-named child in conjunction with that child receiving medical treatment. Financial assistance will be provided with the use of said funds to be specified by *CiDrep SickKids Foundation*.
3. The undersigned further agree(s) to return any unused funds immediately to *CiDrep SickKids Foundation* so that those funds can be utilized by the organization to benefit other families.
4. The undersigned acknowledge(s) and agree(s) to maintain records that will be made available to *CiDrep SickKids Foundation* upon reasonable request, detailing the expenditures made from the funds provided by the organization.

CiDrep SickKids Foundation reserves the right to distribute funds at its sole discretion. *CiDrep SickKids Foundation* may pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge. (Please refer to the checklist at the top of page one of the application and attach all required documentation prior to submitting the application.)

When awarding a grant, *CiDrep SickKids Foundation* is not advocating for the specific health care providers or medical equipment suppliers, but only providing the funds to enable you to access the services and equipment. You acknowledge and agree that accepting a grant from *CiDrep SickKids Foundation* is strictly voluntary. Furthermore, you agree that you will be responsible for any choices you make regarding the medical care, equipment or supplies, or for the failure, malfunction, repairs or ongoing maintenance of any equipment obtained as a result of the grant of funds.

Dated this_____day of_____, in the year _____

Mother/guardian signature_____Please print name _____

Father/guardian signature_____Please print name _____

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PUBLIC RELATIONS AND MEDIA RELEASE CONSENT

****Signing the media release form is not a requirement in order to receive assistance from CiDrep SickKids Foundation****

I hereby give my permission for CiDrep SickKids Foundation and/or its representatives to use photographs, audio tape recordings, letters, information or videotape of my child or myself and to use our names, information, these images or voice recordings in publications, slides, videotapes, motion pictures or on the Internet. I understand they will be used to inform families, volunteers, media and the general public about the CiDrep SickKids Foundation and its programs, services or events. I gladly give this authorization to support the efforts of CiDrep SickKids Foundation. I understand this authorization shall continue until terminated in writing.

Child's name (please print)_____DOB _____

Parent/guardian signature_____Date _____

Address_____City_____State _____ Zip Country _____