Never Let Go Fund Grant Guidelines

The purpose of the Never Let Go Fund is to provide funds to qualified individuals to cover expenses related to the treatment of childhood cancer. Eligible expenses may include medical expenses not covered by insurance; travel or lodging needs when seeking treatment. Grant requests will be considered for no more than $2,000 per year, per child under the age of 18.

Application Requirements:

1. The applicant must be a resident of one of the following counties in Kansas: Chase, Coffey, Greenwood, Lyon, Morris, Osage and Wabaunsee counties.

2. <u>All of the following information</u> must be submitted with the application in order to be considered for a grant:

   (a.) A brief medical history, including condition of the patient with regard to cancer. (Examples: *When was the applicant diagnosed? What symptoms is he/she dealing with?)*

   (b.) A brief statement of financial need, including information about any medical insurance and expenses covered by the insurance policy. (*The attached form may be used as a release to give the caring physician/s. All of the information highlighted in yellow must be completed and given to the doctor to release the information about the applicant to the Foundation.*)

   (c.) A statement from applicant's medical doctor attesting to the medical conditions necessitating treatment.

   (d.) A listing of expenses, real or projected, for which the grant is being requested. (Examples: *Are you on a fixed income with increased expenses due to the child's diagnosis? Has diagnosis caused you to miss extended periods of work or to lose a job?*) Please include a list of expenses, real or projected, that have incurred due to the child's cancer diagnosis and tell us specifically what is being requested via this grant application (Example: *Gas money? Medical bills? Regular bills due to loss of income? Etc.*).

   (e.) A timetable for the expenditure of the grant. (*When is the assistance needed? When do you predict the assistance will be used?*)

3. Applications with attachments should be delivered or mailed to:
   Emporia Community Foundation
   527 Commercial St., Suite B
   Emporia, KS 66801

4. Questions? Contact the Foundation, 620-342-9304 or loni.heinen@emporiacf.org.

Never Let Go Fund

Assisting families who have a child with cancer

APPLICATION

Patient Information:

Name: _____ Last Four of SS Number: _____

Address: _____ Date of birth: _____

City/State/Zip: _____

Phone (Day): _____ Phone (Eve.) _____ Email: _____

Applicant Contact Person:

Name: _____ Relationship to Patient: _____

Address: _____ Date of birth: _____

City/State/Zip: _____

Phone (Day): _____ Phone (Eve.) _____ Email: _____

My child has been diagnosed with cancer and I am requesting assistance with costs associated with his/her treatment. I hereby give permission to the staff of the Emporia Community Foundation to contact the parties listed in this application or attachments thereto for purposes of verification.

_____ _____

Date *Signature of Applicant or Authorized Person*

Please attach the following information to this cover sheet: (*All items must be completed in order to be considered for a grant*.)

A. A brief medical history, including condition of the patient with regard to cancer. (Examples: *When was the applicant diagnosed? What symptoms is he/she dealing with?*)
B. A brief statement of financial need, including information about any medical insurance and expenses covered by the insurance policy. (*The attached form may be used as a release to give the caring physician/s. All of the information highlighted in yellow must be completed and given to the doctor to release the information about the applicant to the Foundation.*)
C. A statement from child's medical doctor attesting to the medical conditions necessitating treatment.
D. A brief statement telling us why assistance is needed. (Examples: *Are you on a fixed income with increased expenses due to the child's diagnosis? Has diagnosis caused you to miss extended periods of work or to lose a job?*) Please include a list of expenses, real or projected, that have incurred due to the cancer diagnosis and tell us specifically what is being requested via this grant application (Example: *Gas money? Medical bills? Regular bills due to loss of income? Etc.*).
E. A timetable for the expenditure of the grant. (*When is the assistance needed? When do you predict the assistance will be used?)*

Submit all application documents to:

Emporia Community Foundation
527 Commercial St., Suite B
Emporia, KS 66801

Questions? Contact the Foundation, 620-342-9304 or loni.heinen@emporiacf.org.

AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

PATIENT NAME	BIRTHDATE	SOCIAL SECURITY NO.
Patient Address		Patient Telephone

CHECK ONE:

☐ I HEREBY AUTHORIZE PROVIDER TO USE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT

☒ I HEREBY AUTHORIZE ALL OF MY HEALTH PROVIDERS, INCLUDING, BUT NOT LIMITED TO, _____ TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO: **The Emporia Community Foundation (ECF) its officers, directors, and grant-making committees for the purpose of determining the eligibility of the patient for grants administered by ECF.**

_____

For Treatment date(s): _____

Specify date(s) – this line MUST BE completed

For the following purposes(s): At the request of patient and for all purposes connected with the above referenced grant request

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED
(Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider unless records were prepared on behalf of Provider)

	Entire Record (will not include Billing Records or records not prepared by or on behalf of Provider unless those items also are selected) Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records.	☐	Patient Demographic Information	☐	Cardiac Studies
		☐	Emergency Room Records	☐	Physician Progress Notes
		☐	Admission History & Physical	☐	Physician Orders
		☐	Consultation Reports	☐	Discharge Summary
		☐	Operative/Procedure Reports	☐	Nursing Notes
☐	Other _____	☐	Lab Test Results	☒	Billing Records or verification of financial need
		☐	Imagining/Radiology Reports	☒	Physician letter to confirm diagnosis

This authorization shall remain in effect **as long as the above-referenced grant request is pending and while I am receiving the grant** at which time this authorization to disclose the identified health information expires.

I understand that the records to be used or disclosed pursuant to this authorization may contain information that is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. § 65-5601 et seq., and K.S.A. § 65-6001 et seq. I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization by checking the box(es) below:

☐ Records relating to participation in any federally assisted drug and alcohol abuse program
☐ Information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition
☐ Information relating to HIV testing, HIV status, or AIDS

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of record as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to the designated privacy officer of the provider to whom this authorization is sent. (Note: Revocation is not effective for disclosures that have already been made.)

_____ _____

Date *Signature of Parent or Authorized Agent/Representative*

_____ _____

Printed Name of Parent/Authorized Agent/Representative *Authorized Agent/Representative's Relationship to Patient*

_____ _____

Address of Parent/Authorized Agent/Representative *Telephone # of Parent/Authorized Agent/Representative*

_____ _____

Date *Signature of Medical Personnel*