For Office Use Only:
File Name

Assisting Children and Young Adults with Critical Illnesses

Ellie's Army Foundation Grant Application

Please read the following carefully:

Please complete this application in its entirety and provide all requested documents in a timely fashion. If a section does not apply to your situation, please note "N/A" in that area.

Assistance is only available to US citizens under the age of 30. Requested financial and/or income documentation *must* be submitted so that the application may be fully reviewed. Information may be submitted via email or regular US Mail.

For clarification of any section of this application, please contact Ellie's Army Foundation at 305-756-0068 or via email at info@elliesarmy.org.

Ellie's Army Foundation
1051 NE 93rd Street
Miami Shores, FL 33138
Office: 305-756-0068
Email: info@elliesarmy.org
www.elliesarmy.org

DATE: _____

SECTION 1—Request for Assistance

Please describe your current financial situation and the circumstances which led to your requiring assistance:

_____

_____

_____

_____

_____

Please describe the *specific* assistance requested at this time from Ellie's Army Foundation:

_____

_____

_____

_____

SECTION 2—Patient Information

Patient Name: _____ Diagnosis _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Age: _____ Date of Birth: _____

Social Security Number: _____ Gender: Male ☐ Female ☐

Have you submitted an application to Ellie's Army Foundation previously? Yes ☐ No ☐

If yes, please supply the date. _____

Employment Information (Patient) *Complete this section only if the patient is employed:*

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Telephone: _____ Employed Since: _____

Is the patient a dependent of another individual, as defined for IRS tax reporting purposes on the IRS Form 1040? Yes ☐ No ☐

SECTION 3—Parent/Guardian Information

Complete the following section only if you are a parent or guardian applying on behalf of a dependent patient.

Primary Parent/Guardian Information

Name: _____

Relationship to Patient: _____ Telephone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Telephone: _____ Employed Since: _____

Secondary Parent/Guardian Information

Name: _____

Relationship to Patient: _____ Telephone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Telephone: _____ Employed Since: _____

SECTION 4—Health Insurance Information

ALL APPLICANTS MUST COMPLETE THIS SECTION.
Please complete questions for <u>all</u> insurance carriers. If you do not have insurance coverage, please indicate "NO INSURANCE". Please include, on separate page if necessary, all information regarding Medicare, Medicaid/State Children's, or other relevant programs.

1. Primary Insurance Carrier

Health Insurance Carrier: _____

Policy ID _____ Group Number _____

Company Contact (if any): _____ Telephone: _____

Subscriber Name: _____

Date of Birth: _____ Social Security Number: _____

Annual Deductible: Individual $_____ Family $_____

Annual Out-of-Pocket Limit $_____

Have you reached your out-of-pocket limit? Yes ☐ No ☐

Is this policy employer provided? Yes ☐ No ☐

Does this policy cover prescription drugs? Yes ☐ No ☐

Is there a separate/different deductible? Yes ☐ No ☐ (If yes, please indicate. $_____)

Has this insurer ever denied a drug claim? Yes ☐ No ☐

If yes, please explain: _____

Does this policy pay for durable medical equipment (nebulizers, compressors, etc.)? Yes ☐ No ☐

2. Secondary Insurance Coverage

Health Insurance Carrier: _____

Policy ID _____ Group Number _____

Company Contact (if any): _____ Telephone: _____

Subscriber Name: _____

Date of Birth: _____ Social Security Number: _____

Annual Deductible: Individual $_____ Family $_____

Annual Out-of-Pocket Limit: $_____

Have you reached your out-of-pocket limit? Yes ☐ No ☐

Is this policy employer provided? Yes ☐ No ☐

Does this policy cover prescription drugs? Yes ☐ No ☐

Is there a separate/different deductible? Yes ☐ No ☐ (If yes, please indicate. $_____)

SECTION 4—Health Insurance Information (Continued)

Has this insurer ever denied a drug claim? Yes ☐ No ☐

If yes, please explain: _____

Does this policy pay for durable medical equipment (nebulizers, compressors, etc.)? Yes ☐ No ☐

3. Public Program Eligibility

Are you currently eligible for any of the following public programs?

Medicare: Yes ☐ No ☐ Other: Yes ☐ No ☐ (If yes, please indicate _____)

Medicaid: Yes ☐ No ☐

Supplemental Prescription Drug Coverage

Which carrier currently covers your prescription drugs? _____

Are you required to use a specific pharmacy? Yes ☐ No ☐

Name/Type of pharmacy: _____

SECTION 5—Medical Provider Information

Name of physician treating the patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

SECTION 6—Financial Information

ALL APPLICANTS MUST COMPLETE THIS SECTION

Household gross income last calendar year $_____ Year _____

Has your annual family income changed significantly this year? Yes ☐ No ☐

If yes, please explain: _____

Number of dependent children in the family: _____

Annual out-of-pocket medical expenses (expenses incurred not reimbursed by insurance) last calendar year.

Hospital(s):	$ _____	Doctor(s):	$ _____
Prescription Drugs:	$ _____	Health Insurance Premiums:	$ _____
Other (including deductibles):	$ _____		

AUTHORIZATION FOR BANKING AND FINANCIAL RECORDS

Miami, Florida

Date: _____

Re: Determination of Eligibility of Financial Assistance from Ellie's Army Foundation

To Whom It May Concern:

This authorizes all banking, financial institutions, credit bureaus, creditors, and any other individuals and/or entities in possession of any financial information related to me to furnish full and complete records to:

Ellie's Army Foundation
1051 NE 93rd Street
Miami Shores, Florida 33138
Tel: (305) 756-0068

This further authorizes the examination of all banking and financial records that will aid representatives of the foundation to determine whether I am eligible for financial assistance from Ellie's Army Foundation.

You are directed to disclose financial information to no other party.

_____ Birth Date: ____/____/_____
Signature

_____ Social Security Number: _____-_____-_____
Print Name

_____
Date

SWORN TO AND SUBSCRIBED before me this the ____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as identification.

NOTARY PUBLIC

My Commission Expires:

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
(HIPAA Compliant)

I, _____ , hereby authorize **Ellie's Army Foundation,** its agents, employees, and associates, to release and obtain my protected health information (PHI). This medical authorization hereby authorizes physicians, hospitals, and any medical attendant or records custodian to furnish full and complete medical records, applications and information to **Ellie's Army Foundation: 1051 NE 93rd Street, Miami Shores, Florida 33138, {Tel: (305) 756-0068}** or to any representative from said foundation. Should you have questions with this request, please call us and reference our client's name or date of accident.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the authorized receipt and may no longer be protected by state and federal law.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire six (6) months from the signature date below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. I understand that I may refuse to sign this authorization. Should I choose to sign this authorization, I understand that I have the right to request access to my protected health information that may be used or disclosed to individuals that are not subject to HIPAA regulations. I understand that once the PHI is disclosed, it may be re- disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, and insurance companies and even may become public record if filed with a court of law.

I understand that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release has not been coerced by a health care entity or any of its business associates.

This authorization for the protected health information also includes examination reports, hospital records, x-ray /CT-scan films, questionnaires, applications, and the furnishing of any other information including opinions.

I have authorized **Ellie's Army Foundation** to collect my medical records in connection with _____.

Your full cooperation with **Ellie's Army Foundation**, is hereby requested. Please do not disclose any medical information to any insurance adjuster or any other person without written authority from myself.

_____ Birth Date: ____/____/_____
Signature

_____ Social Security Number: _____-_____-_____
Print Name (Identify Capacity if P.R.)

_____
Date

SWORN TO AND SUBSCRIBED before me this the _____ day of _____,

20_____, by _____, who is personally known to me or has produced

_____ as identification.

NOTARY PUBLIC

My Commission Expires:

SECTION 7—Documentation Needed

PLEASE NOTE:

YOUR APPLICATION <u>WILL NOT BE REVIEWED</u> UNTIL WE HAVE RECEIVED <u>ALL</u> OF THE BELOW-REQUESTED INFORMATION

Please submit a copy of the following information with your application:

1. Proof of patient diagnosis and condition from treating physician
2. Letter from social worker outlining situation
3. **<u>All financial transaction history from the most recent three (3) months</u>, including but not limited to**: loan information, notes, bills, statements for any and all checking accounts, savings accounts, credit card accounts, and all other financial accounts (such as PayPal, Venmo, CashApp, etc.) belonging to patient/parent(s)/guardian(s)
4. Latest IRS 1040 Form, plus associated W-2 and/or 1099 Forms (if applicable)
5. The latest paycheck stubs for patient/parent(s)/guardian(s) (if applicable)
6. Pertinent proof of out-of-pocket expenses (if applicable)
7. Medicaid or Title V denial (if applicable)
8. Insurance Denial (if applicable)

SECTION 8—Declarations

I verify that the information provided in this application is complete and accurate. I further understand that reported financial information may be verified by an audit as deemed necessary by Ellie's Army Foundation. I understand that assistance will terminate if the Foundation becomes aware of any documented case of fraud or of medication/services no longer being prescribed for me/the patient on whose behalf this application was completed. I understand that the Foundation reserves the right at any time and without notice to (1) modify the Application Form (2) modify or discontinue any or all the programs and related eligibility criteria, or (3) terminate assistance at any time.

I authorize Ellie's Army Foundation to obtain my/the patient's information from the prescribing physician, insurance coverage information from my employer or insurance company, and other information related to treatment as may be necessary to complete the application process or to verify the accuracy of any information provided in this application. Ellie's Army Foundation retains the right to periodically monitor and assess the recipient's continued compliance with the goals of the Foundation.

Signature _____ Date_____

Email or mail your completed application and supporting documentation, along with a signed copy of SECTION 8 (*above*) to:

Ellie's Army Foundation
1051 NE 93rd Street, Miami Shores, FL 33138
Email: info@elliesarmy.org