



# ELLIE'S ARMY FOUNDATION

*Assisting Children and Young Adults Battling Life-Threatening Illnesses*

## GRANT APPLICATION

### BEFORE YOU BEGIN, PLEASE NOTE CAREFULLY:

- ★ Financial assistance is only available to US citizens under the age of 30 who have been diagnosed with a life-threatening illness.
- ★ This application must be completed in its entirety; if a section does not apply to your situation, please write "N/A". Pages 6 and 7 of the application must be signed before a Notary Public.
- ★ All required documentation, including financial history and income verification, detailed on Page 8 *must be submitted before an application will be reviewed.*
- ★ Applications and supporting documentation may be submitted either via email or regular US Mail.

For clarification of any section of this application, please get in touch with Ellie's Army Foundation at 305-756-0068 or via email at [info@elliesarmy.org](mailto:info@elliesarmy.org).

### **ELLIE'S ARMY FOUNDATION**

12000 BISCAYNE BLVD STE 407  
NORTH MIAMI, FL 33181-2725  
OFFICE: 305-756-0068  
EMAIL: [INFO@ELLIESARMY.ORG](mailto:INFO@ELLIESARMY.ORG)  
[WWW.ELLIESARMY.ORG](http://WWW.ELLIESARMY.ORG)

## SECTION 1—REQUEST FOR ASSISTANCE

DATE: \_\_\_\_\_

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

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Please describe the *specific* assistance you are requesting from Ellie's Army Foundation:

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## 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 applied to Ellie's Army Foundation previously? Yes ☐ No ☐

If yes, please provide 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 all insurance carriers. If you do not have insurance coverage, please indicate “NO INSURANCE”. Please include, on a 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: \_\_\_\_\_

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## SECTION 5—MEDICAL PROVIDER INFORMATION

Name of physician treating the patient: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

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## 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  
12000 BISCAYNE BLVD STE 407  
NORTH MIAMI, FL 33181-2725  
(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.

\_\_\_\_\_  
Signature

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Print Name

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

\_\_\_\_\_  
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: 12000 Biscayne Boulevard, Suite 407, Miami, Florida 33181-2725, [Tel: (305) 756-0068]** or to any representative from said foundation. Should you have questions about this request, please call us and reference our client's name.

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 who 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 healthcare provider and that this release has not been coerced by a healthcare 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 other person without written authority from me.

\_\_\_\_\_  
Signature

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Print Name (Identify Capacity if P.R.)

Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

\_\_\_\_\_  
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 **WILL NOT BE REVIEWED** UNTIL WE HAVE RECEIVED **ALL** OF THE BELOW-REQUESTED INFORMATION

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

1. Proof of patient diagnosis and condition from the treating physician
2. Letter from the social worker outlining the situation
3. **All financial transaction history from the most recent three (3) months, including,** but not limited to, statements for all checking accounts, savings accounts, credit card accounts, loan information, notes, bills, 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)

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## 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 SIGNED AND NOTARIZED APPLICATION  
AND SUPPORTING DOCUMENTATION TO:**

ELLIE'S ARMY FOUNDATION  
12000 BISCAYNE BLVD STE 407  
NORTH MIAMI, FL 33181-2725  
EMAIL: INFO@ELLIESARMY.ORG