FOR OFFICE USE ONLY:

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 7 and 8 of the application must be signed before a Notary Public.
- All required documentation, including financial history and income verification, detailed on Page 9 *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.

ELLIE’S ARMY FOUNDATION
12000 BISCAYNE BLVD STE 407
NORTH MIAMI, FL 33181-2725
OFFICE: 305-756-0068
EMAIL: INFO@ELLIESARMY.ORG
WWW.ELLIESARMY.ORG

SECTION 1—REQUEST FOR ASSISTANCE

DATE: ____________________

Please explain your current financial situation and how it led to your need for assistance.

____

____

____

____

What specific assistance are you seeking from Ellie's Army? What expenses do you need help with?

____

____

____

SECTION 2—PATIENT INFORMATION

PATIENT NAME ______________________________ DIAGNOSIS ______________________

DATE OF BIRTH ____________ AGE ______ SOCIAL SECURITY NUMBER ______________________

EMAIL ADDRESS ______________________________ GENDER: ☐ FEMALE ☐ MALE

STREET ADDRESS ______________________________ PHONE ______________________

CITY ________________ ST ________________ ZIP ________________

HAVE YOU APPLIED TO ELLIE'S ARMY FOUNDATION IN THE PAST? ☐ NO ☐ YES DATE: ____________

WHERE DID YOU LEARN ABOUT ELLIE'S ARMY? ______________________________

HAVE YOU RECEIVED ASSISTANCE FROM OTHER FOUNDATIONS? ☐ NO ☐ YES DATE: ____________

IF YES, WHERE? ______________________________

IS THE PATIENT CONSIDERED A DEPENDENT OF ANOTHER INDIVIDUAL FOR FEDERAL INCOME TAX PURPOSES, AS DEFINED ON IRS FORM 1040? YES ☐ NO ☐

PATIENT DEMOGRAPHIC INFORMATION - CHECK ALL THAT APPLY*		
RACE:		**ETHNICITY:**
☐ NATIVE AMERICAN / ALASKAN NATIVE	☐ NATIVE HAWAIIAN / PACIFIC ISLANDER	☐ HISPANIC / LATINO
☐ ASIAN	☐ WHITE	☐ NOT HISPANIC / LATINO
☐ BLACK / AFRICAN AMERICAN	☐ OTHER ____________________	

** Demographic information is collected for reporting purposes only. Your responses will be used solely for statistical analysis and will not impact your eligibility.*

PATIENT EMPLOYMENT INFORMATION *Complete this section only if the patient is employed*

EMPLOYER ______________________________ HIRE DATE ______________

ADDRESS ______________________________ PHONE ______________

CITY ______________________________ ST ________ ZIP ____________

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 ____________________

DATE OF BIRTH ____________________ SOCIAL SECURITY NUMBER ____________________

EMAIL ADDRESS ____________________ HOME PHONE: ____________________

STREET ADDRESS ____________________ CELL PHONE ____________________

CITY ____________________ ST ____________________ ZIP ____________________

EMPLOYMENT INFORMATION

EMPLOYER ____________________ HIRE DATE ____________________

ADDRESS ____________________ PHONE ____________________

CITY ____________________ ST __________ ZIP ____________________

SECONDARY PARENT/GUARDIAN INFORMATION

NAME ____________________ RELATIONSHIP TO PATIENT ____________________

DATE OF BIRTH ____________________ SOCIAL SECURITY NUMBER ____________________

EMAIL ADDRESS ____________________ HOME PHONE: ____________________

STREET ADDRESS ____________________ CELL PHONE ____________________

CITY ____________________ ST ____________________ ZIP ____________________

EMPLOYMENT INFORMATION

EMPLOYER ____________________ HIRE DATE ____________________

ADDRESS ____________________ PHONE ____________________

CITY ____________________ ST __________ ZIP ____________________

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 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: ____

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): $ __________

PUBLICITY CONSENT AND RELEASE FORM

I ____ ("you"), a minor, hereby irrevocably grant to the Ellie's Army Foundation and its licensees, successors, and assigns, the right, license, and privilege to use my name, likeness, voice, performance, essays, personal story, personal characteristics, photograph, and biography, in whole or in part, throughout the universe, in all formats and media now known or hereafter devised, in such manner as Ellie's Army Foundation shall deem appropriate for the purpose of promoting, advertising and publicizing Ellie's Army Foundation and its charitable activities.

I ____ ("you"), the parent or legal guardian of the undersigned minor, hereby consent to the execution of this Publicity Consent and Release and the grant of rights herein. I hereby certify that no other consents, authorizations, or payments are necessary to permit the full use and enjoyment by Ellie's Army Foundation of the rights granted herein.

The undersigned hereby release and agree to indemnify Ellie's Army Foundation and its licensees, affiliates, successors, and assigns, from and against any and all liability, costs, and expenses, including reasonable attorneys' fees, arising out of the exercise of the rights granted hereby. In no event, shall any of the undersigned have any right to seek or obtain injunctive or other equitable relief with respect to Ellie's Army Foundation. The parties submit any disputes arising out of or related to this Publicity Consent and Release cannot be terminated, rescinded, or amended hereafter except by a written agreement, signed by all parties. This Publicity Consent and Release shall be exclusively governed by and construed in accordance with the laws of the State of Florida, without regard to conflicts of laws principles.

Executed as of the ______day of ______________________________, 20______.

ACCEPTED AND AGREED TO BY:

MINOR:		PARENT/LEGAL GUARDIAN:	
SIGNATURE:	______________________________	SIGNATURE:	______________________________
PRINTED NAME:	______________________________	PRINTED NAME:	______________________________
		ADDRESS:	______________________________
			______________________________

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.

____ 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 **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 current condition from patient's treating physician
2. Letter from a social worker outlining the patient's current situation and needs
3. Proof of United States Citizenship
4. Copies of all bills for which you are requesting assistance (If requesting housing assistance, please submit a copy of the mortgage statement, lease, or most recent account statement)
5. **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)
6. Latest IRS 1040 Form, plus associated W-2 and/or 1099 Forms (if applicable)
7. The latest paycheck stubs for patient/parent(s)/guardian(s) (if applicable)
8. Pertinent proof of out-of-pocket expenses (if applicable)
9. Medicaid or Title V denial (if applicable)
10. 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 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