Jonathan Powell Hope Foundation

APPLICATION FOR FINANICAL ASSISTANCE

The Jonathan Powell Hope Foundation
Guidelines for Financial Assistance

A mission of The Jonathan Powell Hope Foundation (JPHF) is to improve the quality of life for children with cancer by promoting children's health through financial and in-kind assistance, support services and education.

General Guidelines for Financial Assistance:

1. Any child diagnosed with cancer on or before his/her 18th birthday and treated before his/her 25th birthday is eligible for consideration. Adults not previously assisted by JPHF who relapsed after their 18th birthday are not eligible for services.

2. Children must be citizens or lawful permanent residents of the US who have maintained an uninterrupted residency for 12 months without prior history of the current illness. Non-citizen residents must have and provide JPHF with a photocopy of their green card.

3. If a family possesses liquid assets in excess of $5000, the JPHF reserves the right to request a partial or complete spend-down prior to approval for financial assistance.

4. All sections of the application must be completed thoroughly and a accurately for the organization to review the request. Failure to provide complete and truthful information is basis for denial.

5. In order to review the request for financial assistance, a hospital professional (Doctor, Nurse, or Social Worker) must send a letter of support. This may be sent via email or postal service and should include the following:

    a. Child's full name, date of birth and diagnosis
    b. Past treatment information
    c. Treatment plan for next 60 days
    d. Type of Financial Assistance requested
    e. Other community resources being utilized.

6. Financial assistance is provided for a maximum of 90 calendar days and up to $1500 for approved applications. After this period, additional letters of request from a hospital professional may be submitted to the JPHF if further assistance is needed.

7. Requests cannot be processed until all information is received. JPFH may send monies directly to treatment provider or third-party vendor.

After you complete the application, please forward to:

The Jonathan Powell Hope Foundation
PO Box 5527
Princeton, WV 24740
Or
jonathanshope@suddenlink.net

Personal Information-Please PRINT and complete all sections

Patient Name (First, Middle Last) _____ Gender: M or F (Circle one)

Date of Birth: _____ Place of Birth (State/Country): _____

Last 4#'s of Social Security Number: __ __ __ __

Parents'/Guardians' Name(s): _____

Do/Does Guardians speak English? Yes No (Please Circle One). If No, primary language? _____

Permanent Address: _____

Primary Phone # _____ If not cell, please provide cell number; _____

Email Address: _____

Temporary Address while obtaining treatment: _____

How did you hear about JPHF? Please Check: ____Hospital ___ Friend ____ Other

Medical Information-to be completed by Hospital Professional (Dr/Nurse/Social Worker)

A letter from a Doctor, nurse or social worker explaining the child's diagnosis, family situation and the assistance being requested is needed in additional to the completion of this section.

Name of Hospital _____ Name Hospital Phone #: _____

Social Worker (First and Last name): _____ Phone #: _____

Mailing Address: _____

Name of Physician (First and Last): _____ Phone #: _____

Diagnosis: _____ Date of Diagnosis: _____

Number of relapses_____ Is the child currently in remission? Yes or No (Circle One)

Is child covered by Insurance? Yes or No (Circle One) Name of Plan: _____ Policy #: _____

Insurance Company Address: _____
Insurance Company Phone Number: _____

Is child covered by State-Funded plan or Medicaid? Yes or No (Circle One) Name of Plan? _____

Does Insurance provide assistance with meal, transportation or lodging expenses? Yes or No (Circle One).

Is there secondary insurance? Yes or No (Circle One). If yes, what is name of plan? _____

If child does NOT have health insurance, has family completed application for Medicaid? Yes or No (Circle One)

Household Income and Assets

Please explain current Employment situation of parents/guardians:_____

_____

_____

_____

_____

Name of Employer Parent/Guardian #1: _____

Phone Number: _____ Salary/Pay: _____

Name of Employer Parent/Guardian #2: _____

Phone Number: _____ Salary/Pay: _____

Is either Parent/Guardian on unpaid leave? Yes or No (Circle one) Please explain: _____

_____

_____

Other Income: SSI _____ Child Support _____ TANF _____ Other _____

Investments (Please include information for money markets, CDs, mutual funds, stocks, and other investments. Do NOT include IRA's or other retirement accounts.)

To expedite processing, please include copy of your most recent statements for all accounts below. If a family possesses liquid assets in excess of $5000, the JPHF reserves the right to request partial or complete spend down prior to approval of financial assistance.

Type of Account _____ Type of Account _____

Value: _____ Value: _____

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Value: _____ Value: _____

Principal Residence:
Do you own or Rent? Own Rent (circle one) What is the monthly payment? _____

If you own, what is the approximate value of the home? _____

What is the mortgage balance? _____

FUNDRAISING

Has money been raised on behalf of applicant? Yes or No (circle one)

If yes, how much? _____ How much is currently in the account? _____

Are there any restrictions on the account for how the money can be used? Yes or No (circle one) If so please explain: _____

_____

_____

Back Account Number for fundraising money: Routing # _____ Account # _____

Bank Name and address: _____

Bank Phone Number: _____

Assistance from other Organization. If you have received or applied for assistance from other organizations, please list:

Organization: _____ Type of Assistance: _____

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Organization: _____ Type of Assistance: _____

REQUEST FOR ASSITANCE WITH SUPPLEMENTAL FAMILY SUPPORT

An applicant may be eligible for supplemental family support for a child with cancer for expenses related to treatment. Supplemental family support includes food, travel, lodging phone cards and medical insurance premiums.

Please check all that apply:

___ Meals: JPHF will consider payment or reimbursement for meals for parents and dependents.

___ Transportation: JPHF will consider payment or reimbursement for transportation to/from treatment.
Please state round trip mileage: _____ Tolls: _____

___ JPHF will pay for lodging during treatment.

___ JPHF also strives to make treatment for children as comfortable as possible. In that regard, we will consider payment for toys, games, activities, and entertainment that the child desires, including activity away from facility.

___ Medial Insurance Premiums: JPHF will consider providing assistance with medical insurance premiums when the parent providing coverage is on leave due to a child's treatment. You must provide documentation that confirms your monthly payment. Please make certain that you thoroughly complete the Insurance section on page 4.

Request for Assistance with Medical expenses
for treatment/procedures denied by hospital due to lack of funding.

(Please circle all that applies)
Bone Marrow Treatment
Donor Search
Donor Harvest
Other Cancer Treatment Procedures. Please Specify: _____
Pharmaceuticals/Supplies: Please Specify: _____

An applicant may be eligible for assistance with medical expenses if the treatment has been denied by the hospital due to lack of funding and the treatment is FDA approved. JPHF may not assist with expenses already incurred. JPHF may not assist with co-pays or deductibles. If requested, please include the following with your application:

1. A letter from the physician detailing the child's diagnosis, treatment history and recommended procedure.

2. A letter from the hospital detailing all costs and the hospital's official position on treating a patient without means to pay.

3. A letter of denial and copy of the insurance policy may be requested if procedure/treatment has been denied by Medicaid or private insurance company.

*Note: Requests for medical assistance may be put before the JPHF Board of Directors for approval.

ADDITONAL REQUESTS

Assistance may be requested for up to three months or 90 calendar days. At the end of this time if additional assistance is needed, consideration will be given to those requests submitted in writing by a hospital professional. A new application is only necessary when the length of time between requests exceeds one year.

IMPORTANT NOTICE—PLEASE READ!

The JPHF is a charitable organization dependent upon the public for support. The JPHF tries to maximize the limited resources available. These guidelines are a statement of the JPHF's general policy, and the JPHF reserves the right, in its sole discretion, to modify the same at any time without notice.

Child's Name: _____

Approved applicants will be required to execute the enclosed prepared statement by the JPHF affirming use of funds granted.

I have read the Guidelines for Financial Assistance and I declare that the information furnished on this application form, including attached sheets, is true an correct to the best of my knowledge:

_____ _____ _____ _____

Signature of Mother/Guardian #1 Date Signature of Father/Guardian #2 Date

The JPHF does not discriminate against or deny aid because of applicant's race, religion, color, national origin, sex or political affiliation.

All financial applications will be reviewed on a case-by-case basis and final determination will be made upon other applications submitted and the availability of funds.

The JPHF reserves the right to deviate from the Guidelines when special needs arise.

All information disclosed on this form will be kept confidential.

CONSENT TO RELEASE INFORMATION

I do hereby authorize all hospitals, financial institutions and insurance groups to release to the JPHF, or its duly authorized representative, 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 the JPHF or its duly authorized representative, any information or itemized statements that pertain to bone marrow and related expenses.

_____ _____

Signature of Parent or Guardian #1 Signature of Parent or Guardian #2

_____ _____

Printed Name Printed Name

_____ _____

Social Security # Social Security #

_____ _____

Address Address

AFFIRMATION

As an inducement to the JPHF, a non-profit organization, to advance supplemental family expenses in conjunction with the medical treatment of _____ (Child) the undersigned do hereby affirm as follows:

1. The undersigned are the natural parents/guardians of the child.
2. The term "Supplemental Family Support" is understood to mean those reasonable and necessary expenses incurred by the family or guardian of the above-named child in conjunction with the child receiving medical treatment. Said expenditures shall be deemed to include, but not be limited to, reasonable and necessary costs for travel, lodging, food and daily expenses.
3. The undersigned agree to utilize all funds received from the JPHF towards specific ancillary expenses within the designated time period. Any unused funds will be immediately returned to the JPHF for use by others.
4. Upon reasonable request, the undersigned agrees to produce receipts of other records to verify the appropriate use of said funds.

Dates this the _____ day of _____, in the year _____.

_____ _____
Mother/Guardian Signature Please Print Name

_____ _____
Father/Guardian Signature Please Print Name

_____ _____
Witness Signature Please Print Name

Media Release Form

I hereby give my permission for the JPHF and/or its representative to use photographs, audio tape record or video of my child or myself and to use our names, these images and/or recordings in publications, slides, videos, and social media.

I understand that these visual images or recordings will be used to inform families, volunteers, the media and/or general public about the JPHF programs, services or events.

I gladly give this authorization to support efforts of the JPHF. I understand this authorization shall continue until terminated in writing.

I understand that signing this consent is NOT a requirement to receive assistance from the JPHF.

Child's Name: _____

_____ _____

Mother/Guardian Signature Please Print Name

_____ _____

Father/Guardian Signature Please Print Name

Address: _____

Phone: _____