



APPLICATION FOR ASSISTANCE

Use this checklist to help expedite your request.

REQUIREMENTS:

You must meet the following requirements before submitting an application.

- Income guidelines
- Child is age 18 or younger (special consideration for children ages 19–21)
- Request qualifies as a valid health care need

SUBMITTAL CHECKLIST:

Documents needed will vary depending upon the request.

All requests:

- Complete application
- Letter from doctor (on letterhead) that includes the child's diagnosis, history of illness, specific request for funding and other relevant information
- First page of your most recent federal income tax return or W-2
- Child's photograph (this is not a requirement)

Requests for treatment/services, medication, equipment/supplies or vehicle modifications:

- All documents listed in "All requests" above
- Evaluation from specialist (therapist, audiologist, etc. for the requested item)
- Letter from the provider on letterhead showing the original cost and price after discount (discount must be given in order to receive assistance)
- Letter of denial from the insurance company or policy showing exclusion

Requests for travel or lodging:

- All documents listed in "All requests" above
- Letter of medical necessity from a social worker on letterhead stating the frequency and duration of travel for the next 12 months (include the exact mailing address of the social worker and a statement that insurance does not cover the request)

CONTACT AND APPLICATION SUBMITTAL INFORMATION:

Application Submittal:

Upload: www.firsthandfoundation.org/upload
Fax: (816) 571-1569
Mail: 2800 Rockcreek Parkway
Kansas City, MO 64117

Contact:

Phone: (816) 201-1569
Email: firsthandfoundation@cerner.com
Website: www.firsthandfoundation.org/funding



CHILD INFORMATION

Last name _____ First name _____ Age _____ Birth date (MM) _____ (DD) _____ (YYYY) _____
Male _____ Female _____ Citizenship _____ Hispanic? Yes _____ No _____
Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Other

FAMILY INFORMATION

Guardian #1

Last name _____ First name _____ Occupation _____
Address _____ City _____ State _____ Zip _____ Country _____
Home phone _____ Cell phone _____ E-mail address _____

Guardian #2

Last name _____ First name _____ Occupation _____
Address _____ City _____ State _____ Zip _____ Country _____
Home phone _____ Cell phone _____ E-mail address _____

HOUSEHOLD INFORMATION

Child lives with _____ Number of guardians in household _____ Number of dependent children in household _____
Does the household speak English? Yes _____ No _____ If no, what is the primary language _____

FUNDING INFORMATION

Health insurance name (Private) _____ (Medicaid) _____ Annual family income (prior year) \$ _____
Last year's out-of-pocket medical expenses for the child \$ _____ Amount requested from First Hand \$ _____
Has funding been requested from additional sources? Yes _____ No _____ If yes, please list _____
If funding has been received, from whom? _____ Amount \$ _____
How did you hear about First Hand? Family _____ Friend _____ Social worker _____ Health care professional _____ Internet _____ Other _____

MEDICAL INFORMATION *(Health care professionals associated with current care)*

Physician's last name _____ First name _____ Title (DO, MD, etc.) _____
Social worker's last name _____ First name _____ Title _____
Child's clinical diagnosis _____ Age illness started or was diagnosed _____
History of illness/health condition _____

Description of request _____



COMPLETE ONLY THE SECTION(S) BEING REQUESTED

1. REQUEST FOR TREATMENT/SERVICES (Surgeries, clinic visits, procedures, therapy, etc.)

Type of treatment _____
Number of treatments/visits _____ Cost per treatment/visit \$ _____ Price after discount \$ _____
Company/provider that the check will be made out to _____ Person at company receiving the check _____
Address _____ City _____ State _____ Zip _____ Country _____

2. REQUEST FOR MEDICATION (Attach additional pages listing medication if more than one is needed)

Name of medication _____ Dosage _____ Frequency _____
Number of months needed _____ Cost per month \$ _____ Price after discount \$ _____
Company/provider that the check will be made out to _____ Person at company receiving the check _____
Address _____ City _____ State _____ Zip _____ Country _____

3. REQUEST FOR EQUIPMENT/SUPPLIES (Attach additional pages listing equipment or supplies if more than one is needed)

Type of equipment/supplies _____ Cost of equipment \$ _____ Price after discount \$ _____
Company/provider that the check will be made out to _____ Person at company receiving the check _____
Address _____ City _____ State _____ Zip _____ Country _____

4. REQUEST FOR TRAVEL (Please check with Angel Flight or major airlines for assistance.)

Purpose of travel _____
Starting and ending cities/locations _____ Number of individuals _____ Number of round trips _____
Method of transportation:
[] Car Estimated round-trip mileage (only if traveling by car) _____
[] Plane Ticket price per adult \$ _____ Ticket price per child \$ _____
[] Train Ticket price per adult \$ _____ Ticket price per child \$ _____
[] Public transportation Ticket price per adult \$ _____ Ticket price per child \$ _____
If funding is granted, who should the check be made out to? (Parent/Guardian) _____ (Check will be mailed to social worker)
Attn social worker (name) _____ Address _____ City _____ State _____ Zip _____

6. REQUEST FOR LODGING Is charitable housing an option? Yes _____ No _____

Number of individuals _____ Number of nights _____ Type of lodging _____ Discounted cost per night \$ _____
If funding is granted, who will receive payment? (Company) _____ Make to attention of _____
Address _____ City _____ State _____ Zip _____ Country _____



REQUIRED—CONSENT TO RELEASE INFORMATION AND AFFIRMATION

I do hereby authorize all hospitals, financial institutions and insurance groups to release to the First Hand Foundation, or its duly authorized representatives, 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 First Hand Foundation, or its duly authorized representatives, any information or itemized statements that pertain to the diagnosis and treatment of the child and related expenses. I further authorize the First Hand Foundation and its representatives to provide such information to those institutions as may be reasonably required to assist our family and our child. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

In order for the First Hand Foundation, a not-for-profit organization, to advance supplemental family support expenses in conjunction with the medical treatment of _____ (child), the undersigned do hereby affirm as follows:

1. The undersigned are the parents or guardians of the child.
2. The term “non-medical expenses” is understood to mean lodging, food, gas, parking and transportation for children who require treatment incurred by the family or guardian of the above-named child in conjunction with that child receiving medical treatment. Financial assistance will be provided with the use of said funds to be specified by First Hand Foundation.
3. The undersigned further agree(s) to return any unused funds immediately to the First Hand Foundation so that those funds can be utilized by the organization to benefit other families.
4. The undersigned acknowledge(s) and agree(s) to maintain records that will be made available to the First Hand Foundation upon reasonable request, detailing the expenditures made from the funds provided by the organization.

The First Hand Foundation reserves the right to distribute funds at its sole discretion. The First Hand Foundation may pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge. (Please refer to the checklist at the top of page one of the application and attach all required documentation prior to submitting the application.)

When awarding a grant, the First Hand Foundation is not advocating for the specific health care providers or medical equipment suppliers, but only providing the funds to enable you to access the services and equipment. You acknowledge and agree that accepting a grant from the First Hand Foundation is strictly voluntary. Furthermore, you agree that you will be responsible for any choices you make regarding the medical care, equipment or supplies, or for the failure, malfunction, repairs or ongoing maintenance of any equipment obtained as a result of the grant of funds.

Dated this _____ day of _____, in the year _____

Mother/guardian signature _____ Please print name _____

Father/guardian signature _____ Please print name _____

MEDIA RELEASE CONSENT

****Signing the media release form is not a requirement in order to receive assistance from the First Hand Foundation****

I hereby give my permission for the First Hand Foundation and/or its representatives to use photographs, audio tape recordings, letters, information or videotape of my child or myself and to use our names, information, these images or voice recordings in publications, slides, videotapes, motion pictures or on the Internet. I understand they will be used to inform families, volunteers, media and the general public about the First Hand Foundation and its programs, services or events. I gladly give this authorization to support the efforts of the First Hand Foundation. I understand this authorization shall continue until terminated in writing.

Child's name (please print) _____ DOB _____

Parent/guardian signature _____ Date _____

Address _____ City _____ State _____ Zip _____ Country _____
