APPLICATION FOR ASSISTANCE

Please fill out the application based on where care will be provided

You must meet the following requirements before submitting an application. For more information about funding and the application process please visit firsthandfoundation.org/funding.

☐ Fall within the income guidelines found at firsthandfoundation.org/funding

☐ Child is age 18 or younger (special consideration for children ages 19–21)

☐ Request qualifies as a valid health care need

SUBMITTAL CHECKLIST:

Every application must have the following documentation to be processed:
**First Hand must receive all required documentation before processing your application.*

☐ Complete application with signature on Page 4

☐ Letter from doctor (on letterhead) that includes the child's diagnosis, history of illness, specific request for funding and other relevant information

☐ Proof of income

☐ Child's photograph (this is not a requirement)
**Please see the media release on Page 4*

☐ Letter from parent detailing any other awards granted/fundraising completed

If applying for treatment/services, equipment/supplies or vehicle modifications, the following documentation must be submitted:

☐ 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

If this is your first time submitting this form, please contact the Case Grant team at firsthandfoundation@cerner.com.

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

First Hand reviews applications on the first Wednesday of each month. To be considered during a given month, you must submit all documentation by the last Wednesday of the previous month. All non-US applicants must receive care from a First Hand trusted provider.

PLEASE COMPLETE THIS PAGE IN ITS ENTIRETY

CHILD INFORMATION

Last name ______________ First name ______________ Birth date (MM) _____ (DD) _____ (YYYY) _____

Male _____ Female _____ Country of citizenship ______________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Caucasian ☐ Other

GUARDIAN INFORMATION

Last name ______________ First name ______________ Relationship to child ______________

Address ______________ Country ______________

E-mail address ______________ Occupation ______________

Last name ______________ First name ______________ Relationship to child ______________

Address ______________ Country ______________

E-mail address ______________ Occupation ______________

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 *Does the child have health insurance? Yes _____ No _____*

Health insurance name ______________ 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 ______________ Organization ______________

Social worker's email address ______________ Phone number ______________

Child's clinical diagnosis ______________ Age illness started or was diagnosed _____

Description of request ______________

*****COMPLETE ONLY THE SECTION(S) BEING REQUESTED*****

Minimum of one section must be completed in its entirety

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

Type of treatment ____________________

Number of treatments/visits __________ Cost per treatment/visit $ __________ Price after discount $ __________

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2. 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 $ __________

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3. 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 ☐ Plane ☐ Train ☐ Public transportation

(A detailed breakdown of travel needs should be included in a social worker letter. If traveling by air, a quote/itinerary must be provided.)

PAYMENT INFORMATION

Please provide wire information on health care entity letterhead. Include the following:

☐ Bank Name

☐ Bank Address

☐ Hospital / Entity Name

☐ Hospital / Entity Address

☐ Bank Account Number

☐ Swift Code

☐ IBAN:

***Please note your entity must be able to accept wire transfers from the United States.*

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 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, 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 ____________________