

APPLICATION FOR ASSISTANCE

Use this checklist to help expedite your request

ou must meet the following requirements before submitting an application. For more information about funding and the application proces
please visit firsthandfoundation.org/funding.
\square Fall within the income guidelines found at firsthandfoundation.org/funding
\Box 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:
irst 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
☐ First page of your most recent federal income tax return or W-2 *If you have not filed taxes, please submit three months of bank statements and/or a letter from your employer
☐ Child's photograph (this is not a requirement) *Please see the media release on Page 4
\square Letter from parent detailing any other awards granted/fundraising completed
f applying for treatment/services, equipment/supplies or vehicle modifications, the following documentation must be submitted:
\square 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)
\square Letter of denial from the insurance company or policy showing exclusion
f applying for travel or lodging, the following documentation must be submitted:
☐ Letter of medical necessity from a social worker on letterhead stating the frequency and duration of travel for the next 12 months
PONTACT AND ADDITION SURMITTAL INFORMATION:

CONTACT AND APPLICATION SUBMITTAL INFORMATION:

Application Submittal. Contact:

Upload: www.firsthandfoundation.org/upload **Phone:** (816) 201-1569

Fax: (816) 571-1569 Email: firsthandfoundation@cerner.com
Website: www.firsthandfoundation.org/funding

Kansas City, MO 64117

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.



PLEASE COMPLETE THIS PAGE IN ITS ENTIRETY

CHILD INFORMATION	I				
Last name	First name		_ Birth date (M	M) (DD) (YYYY)	
Male Female Co	ountry of citizenship				
Race: ☐ American Indian/Ala	ska Native 🗆 Asian 🗆 Black/African American	n 🗆 Native Hawaii	an/Other Pacific	: Islander 🗆 Caucasian 🗆 Other	
GUARDIAN INFORMA	TION				
Last name	First name	Relations	ship to child		
Address	City	State	Zip	Country	
	E-mail address				
	First name				
Address	City	State	Zip	Country	
Primary phone	E-mail address		Occupation		
	ION Does the child have health insurance? Y				
Health insurance name (Priva	ate) (Medicaid)	Annual family income (prior year) \$			
•	dical expenses for the child \$				
	from additional sources? Yes No				
If funding has been received	, from whom?		Amour	nt \$	
How did you hear about First	Hand? Family Friend Social work	er Health ca	re professional	Internet Other	
MEDICAL INFORMAT	ION (Health care professionals associated w	vith current care)			
Physician's last name	First name		_Title (DO, MD,	etc.)	
Social worker's last name	First name		_ Organization _		
Social worker's email addres	s		_ Phone numbe	r	
Child's clinical diagnosis			_ Age illness st	arted or was diagnosed	
Description of request					



COMPLETE ONLY THE SECTION(S) BEING REQUESTED

Minimum of one section must be completed in its entirety

1. REQUEST FOR T	REATMENT/SERVIC	EES/MEDICATION (Surger	ies, clinic visits, proc	edures, therapy, medication, etc.)
Number of treatments/vis	sits Cost	per treatment/visit \$	Price at	fter discount \$
2. REQUEST FOR E	QUIPMENT/SUPPLI	ES (Attach additional pages lis	ting equipment or su	upplies if more than one is needed)
Type of equipment/supplie	es			
		_ Price after discount \$		
3. REQUEST FOR L	ODGING Is charitable ho	ousing an option? Yes No	o (Include a q	uote from hotel/charitable housing)
Number of individuals	Number of nights	Type of lodging	Discount	ed cost per night \$
4. REQUEST FOR T	RAVEL (Please check wi	th Angel Flight or major airlines	for assistance)	
·				N. observation and the co
			Number of Individual	s Number of round trips
•		in	f traveling by air, a qu	note/itinerary must be provided.)
PAYMENT INFORM	ATION			
		following payment information	n:	
If you completed Boxes 1	1, 2 or 3 above, fill out the	e following payment informatio		he check
If you completed Boxes 1 Check payable to (compare	1, 2 or 3 above, fill out the ny/provider)	Person at	company receiving t	he check Country
If you completed Boxes 1 Check payable to (compar Address	1, 2 or 3 above, fill out the ny/provider) City	Person at	company receiving t	Country
If you completed Boxes 1 Check payable to (compar Address If you completed Box 4 a	1, 2 or 3 above, fill out the ny/provider) City	Person at	company receiving t	Country
If you completed Boxes 1 Check payable to (compar Address If you completed Box 4 a Check payable to (parent/	1, 2 or 3 above, fill out the ny/provider) City bove, fill out the following	Person at payment information (First H	company receiving to 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 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
Marilla Company		DI
Mother/guardian signature		Please print name
Father/guardian signature		Please print name
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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