Children's Cardiomyopathy Foundation™

Family Assistance Program

The **Children's Cardiomyopathy Foundation (CCF) Family Assistance Program** was established in 2011 through the generous donations of CCF family members. The fund was set up to assist children and their families with cardiomyopathy-related medical and non-medical needs when insurance and other financial resources have been exhausted.

QUALIFICATION

To qualify for the Children's Cardiomyopathy Foundation Family Assistance Program, a child's family should be facing financial challenges as a result of expenses incurred related to their child's diagnosis and treatment. In addition, the family's existing insurance plan will not cover the requested expenses or limits for the requested service have already been exceeded.

An application for financial assistance must meet the below funding criteria and financial guidelines to be considered.

Income

- The parent or legal guardian files a U.S. federal income tax return claiming the child as a dependent.
- The family's total adjusted gross income from their most recent tax return falls within the below categories. Adjusted gross income can be found on IRS form 1040 (line 37), form 1040A (line 21) or form IRS 1040EZ (line4).

Family Size (as reported on most recent tax return)	Adjusted Gross Income* (as reported on most recent tax return)
2	$45,390 or less
3	$57,270 or less
4	$69,150 or less
5	$81,030 or less
6	$92,910 or less
7	$104,790 or less
8	$116,670 or less

*300% of the 2013 Federal Poverty Level Guidelines for all states and the District of Columbia

Age & Residence

- The child is 18 years of age or younger.
- The child and parents or legal guardians currently reside in the United States, and each individual has a social security number.

Diagnosis & Medical Care

- The child has a diagnosis of cardiomyopathy requiring active medical attention (i.e. medication, surgery), although he or she does not need to be hospitalized at the time of the application.

- The child is under the care of a pediatric cardiologist at a pediatric cardiomyopathy specialty center in the United States, and receives care and medical items in the United States.
- To qualify for displacement expenses, the child has to have experienced displacement for treatment within the last six months.

Other

- A previous application has not been submitted for the family within the last 12 months.

COVERAGE

CCF's program provides assistance with medical expenses not covered by insurance and non-medical expenses incurred from the evaluation, treatment or care of a child diagnosed with cardiomyopathy.

Expenses Covered

- Treatment fees including clinical procedures and tests, medication, physical and occupational therapy, medical equipment and items, and medically necessary dietary supplements, special foods or formulas
- Displacement fees during a child's in-hospital treatment period including travel, lodging, child care, food, gas, parking, tolls and local transportation
- Living expenses such as mortgage, rent and utilities during a child's in-hospital treatment period
- Health insurance premiums, deductibles and co-pays
- Reimbursement of genetic testing of up to $1,000 per family

Expenses Not Covered

- Medical services and items not related to a diagnosis of cardiomyopathy
- Drugs not licensed by the U.S. Food and Drug Administration
- Alternative drugs, treatment or therapy that are considered controversial
- Individual or family screening without active medical treatment
- Psychological or counseling services
- Wheelchairs, assistive technology equipment, home care devices and wheelchair-accessible van purchases or vehicle modifications
- Auto payments and cell phone bills
- Autopsy, burial and funeral costs
- Credit card bills, loans and other forms of debt reduction
- Personal care, comfort or convenience items such as cardiac camps, tutoring programs and home modifications

APPLICATION PROCESS

- Families can apply directly to the program or through a healthcare professional at their child's place of treatment.
- A program application should be filled out by the child's parent, legal guardian or referring healthcare professional to provide information about the child's diagnosis and medical care, the family's financial situation, and the type of financial assistance needed.
- Applications for financial assistance will need to be verified by a healthcare professional (doctor, cardiac nurse, social worker or case worker) familiar with the child's care and family situation.
- To apply for funding, the below items need to be submitted to CCF:

Required Documents

- Signed application for assistance
- Child's photograph (optional)
- Most recent federal income tax return (form 1040, 1040-A, 1040EZ) listing child as a dependent
- Supporting letter from doctor or other healthcare professional (nurse, genetic counselor, social worker or case worker) overseeing child's care. Letter should cover child's medical condition, history of illness, impact of medical condition on child's life and required treatment including explanation for any special therapy or medical equipment needed
- Letter of denial or claim statement from insurance company showing applicant's and child's name, date of service and amount not covered
- Vendor and provider bills or receipts showing applicant's name, address, account number, date of expense and amount

REVIEW PROCESS

- Once an application and all supporting documents are received, a Foundation representative will review the application and verify the family's information with the child's healthcare professional. The Foundation may request additional information after the application is submitted.
- Applications are processed as they are received and reviewed monthly by the program committee. An applicant should hear from CCF within one to three months of submission.
- When a funding request is approved, checks are made payable to the vendor or provider within two weeks.
- The amount awarded can vary according to a family's situation, as well as the availability of CCF program funds. CCF reserves the right to distribute funding at its sole discretion. As such, the Foundation may deny a request or approve an amount lower than the amount requested.
- For each family, only one request for assistance will be considered every 12 months.
- Upon approval of your application, you will be asked for permission to share your family's story for marketing purposes. While this would be beneficial to cardiomyopathy families and the general public, you are not obligated to provide this information. Declining to participate will not have an effect on your current award or any future applications.

QUESTIONS

For questions about the Children's Cardiomyopathy Foundation Family Assistance Program, please contact Chris Colón, Patient Outreach and Support Manager, at 866.808.CURE ext. 905 or ccolon@childrencardiomyopathy.org.

The Children's Cardiomyopathy Foundation Family Assistance Program will be reviewed on an annual basis. The Foundation reserves the right to revise the program criteria, coverage, application guidelines and review process as needed over time.

Children's Cardiomyopathy Foundation™

Family Assistance Program

APPLICATION

Qualification Checklist

Please initial to acknowledge that you meet CCF's application requirements.

_____ I have read the application qualifications and understand the required documents.

_____ I am the parent or legal guardian of the child listed on the application.

_____ My child and I currently live in the United States, and both of us have a social security number.

_____ My child has been diagnosed with cardiomyopathy and is undergoing medical treatment.

_____ My child is 18 years old or younger.

_____ I file a U.S. federal income tax return, and my child is listed as a dependent.

_____ My family's adjusted gross income falls within the below categories.

Family Size (as reported on most recent tax return)	Adjusted Gross Income* (as reported on most recent tax return)
2	$45,390 or less
3	$57,270 or less
4	$69,150 or less
5	$81,030 or less
6	$92,910 or less
7	$104,790 or less
8	$116,670 or less

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Child's Information

_____
First Name Last Name

Gender: ❑ Male ❑ Female _____ _____
Date of Birth (mm/dd/yyyy) Social Security Number

Family's Information

Parent/Guardian 1:

_____
First Name Last Name

Relationship to child: ❑ Father ❑ Mother ❑ Guardian _____
Social Security Number

A Cause for Today... A Cure for Tomorrow

Address

City State Zip Code

Home Phone Work or Cell Phone

Email Address

Employer Position

Parent/Guardian 2:

First Name Last Name

Relationship to child: ❑ Father ❑ Mother ❑ Guardian

Social Security Number

Address

City State Zip Code

Home Phone Work or Cell Phone

Email Address

Employer Position

Child lives with: ❑ Both Parents ❑ Father ❑ Mother ❑ Guardian

Other children in the same household:

Name Age

Name Age

Name Age

Name Age

Name Age

Name Age

Child's Medical Information

Cardiomyopathy Diagnosis:

- ❑ Dilated cardiomyopathy
- ❑ Hypertrophic cardiomyopathy
- ❑ Restrictive cardiomyopathy
- ❑ Arrhythmogenic right ventricular cardiomyopathy
- ❑ Left Ventricular non-compaction cardiomyopathy

Age of diagnosis: _____

Please describe current treatment plan:

_____

_____

_____

_____

Pediatric Cardiologist:

_____
First Name Last Name

_____
Title

_____
Hospital/Medical Center

_____
Department

_____
Address

_____
City State Zip Code

_____
Phone number Email

Healthcare Professional *(nurse, genetic counselor, social worker or case worker)*:

_____
First Name Last Name

_____
Title

_____
Hospital/Medical Center

_____
Department

_____
Address

_____
City State Zip Code

_____
Phone number Email

Family's Financial Information

Number of people living in household: _____

Household Annual Gross Income *(salary, bonuses, interest on investments, income from rentals, pensions etc.):* $_____

Household Assets:

Bank accounts *(checking, savings)* $_____

Investments *(stocks, bonds, real estate, 401K, IRA)* $_____

Real estate $_____

Other *(specify)* $_____

Household Liabilities:

Loans *(mortgage, auto, education)* $_____

Debt $_____

Other *(specify)* $_____

Monthly Net Income: $_____ Monthly Expenses: $_____

Do you currently receive any other federal, state or private assistance funding? ❑ Yes ❑ No

If yes, please list from whom and amount provided monthly:

Assistance Request

Please provide details of medical and non-medical expenses that you are applying for financial assistance. Please be as specific as possible; this will assist in processing your application. A separate sheet may be attached if more room is needed. Proof of expense is required for each listing.

Medical Expenses

Medical services, medication, medical equipment or supplies as related to treatment

Provider or Vendor	Date of service or expense	Description	Amount requested

Non-Medical Expenses

Mortgage, rent, utilities, travel, lodging, food, local transportation as related to displacement

Provider or Vendor	Date of service or expense	Description	Amount requested

Total amount requested from CCF: $_____

Please provide an explanation for the expenses listed including why assistance is needed and how these expenses are related to your child's cardiomyopathy diagnosis.

Have you applied for financial assistance from CCF previously? ❑ Yes ❑ No

If yes, please specify when applied, whether received funding and the amount of funding awarded.

Are you applying or have you applied for financial assistance from other sources this year? ❑ Yes ❑ No

If yes, please list other sources and indicate whether funding has been awarded and the amount of funding awarded.

Verification & Consent

I verify that all of the information provided in this application is accurate and complete. I understand that during the course of the application review process, my child's healthcare provider will need to release information to the Children's Cardiomyopathy Foundation (CCF) to verify our need for financial assistance and I hereby authorize them to do so. I am aware that CCF may ask for my permission to share my family's story for marketing purposes, and declining to participate will not have an effect on my current award or any future applications. I also understand that all information shared with CCF is confidential and will not be released without my consent.

Signature of parent/guardian | Date | Relationship to child

Please mail this completed application with the below supplementary information to:
Children's Cardiomyopathy Foundation, P.O. Box 547, Tenafly, NJ 07626.

An application cannot be processed until all required items are received.

- ❑ Child's photo (optional)
- ❑ Most recent federal income tax return (form 1040, 1040-A, 1040EZ) listing child as a dependent
- ❑ Letter from doctor or other healthcare professional (nurse, genetic counselor, social worker or case worker) detailing child's medical condition, history of illness, impact of medical condition on child's life and required treatment including explanation for any special therapy or medical equipment needed
- ❑ Letter of denial or claim statement from insurance company showing applicant's and child's name, date of service and amount denied
- ❑ Vendor and provider bills or receipts showing applicant's name, address, account number, date of expense and amount