Jonathan Powell Hope Foundation, Inc.

Application for Financial Assistance

Financial assistance provided by the Jonathan Powell Hope Foundation, Inc. is made possible because of generous donors. It is important that these funds be available for families experiencing the greatest financial need. If your family meets the JPHF guidelines for financial assistance and has financial needs related to your child's cancer diagnosis, the Jonathan Powell Hope Foundation may be able to help.

You may obtain additional information about the Foundation a www.jonathanshope.org.

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, advocacy, 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 relapse after their 18th birthday are not eligible for services.
2. Children must be citizens or lawful, permanent residents of the U.S. 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 (front and back) of their I551 card (green card).
3. If a family possesses liquid assets in excess of $5,000, the JPHF reserves the right to request a partial or complete spend-down prior to the approval of financial assistance.
4. All sections of the application must be completed thoroughly and accurately in order 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 facsimile, email or postal service and should include the following:
   - Child's full name, date of birth and diagnosis
   - Past treatment information
   - Treatment plan for the next 60 days
   - Type of financial assitance requested
   - Other community resources being utilized
6. Financial assistance is provided for a maximum of up to 90 calendar days and up to $1000 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. JPHF will only send monies directly to the treatment provider or third party vendor and will not send monies directly to the reciepient family.

After you complete the application, please forward it to The Jonathan Powell Hope Foundation. This may be mailed or faxed to:

The Jonathan Powell Hope Foundation
~~320 Courthouse Road~~ PO Box 5527
Princeton, WV 24740

or Fax 304-425-4155

Rev. 12/01/2005

OFFICE USE ONLY
Date Received ______

PERSONAL INFORMATION - *Please PRINT and complete all sections accurately*

Patient Name (first, middle, last) ______ ✱ Male ✱ Female
Date of Birth ______ Place of Birth (state/country) ______
Social Security Number ______
Parents'/Guardians' Name(s) ______
Does Guardian speak English? ✱ yes ✱ no If no, primary language? ______
Permanent Address ______
City/State/Zip ______ Email address: ______
Permanent Phone #(   ) ______ Cell Phone #(   ) ______
Temporary Address (Name of Facility) ______
Address ______
City/State/Zip ______ Temp Phone #(   ) ______
How did you hear about The Jonathan Powell Hope Foundation? ✱ Hospital Professional ✱ Friend ✱ Other ______
Emergency Contact Name ______ Relationship ______ Phone # (   ) ______

MEDICAL INFORMATION - *This section to be completed by hospital personnel (social worker, nurse or doctor)*

A letter from a social worker, nurse or doctor explaining the child's diagnosis, family situation, and the assistance being requested is needed in addition to the completion of this section. See guidelines for necessary Information.

Name of Hospital ______ Main Hospital # (   ) ______
Social Worker (first and last name) ______ Phone #(   ) ______
Pager # (   ) ______ Email ______
Mailing Address ______ Dept. ______
City/State/Zip ______
Name of Physician (first and last name) ______ Phone #(   ) ______
Diagnosis ______ Date of diagnosis ______
Number of relapses ______ Is the child currently in remission? ______
Other treatment facility involved in child's care ______
Social Worker (first and last name) ______ Phone #(   ) ______
Address ______ Dept. ______
City/State/Zip ______

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Patient Name ____________________

Insurance Information

Is patient covered by private insurance? * Yes * No   Is patient covered by a state funded insurance plan (i.e. Medicaid)? * Yes * No

What is the name of the plan? ____________________

Policy Number ____________________ What is the percentage of coverage? ____________________

Address of Insurance Company ____________________

City/State/Zip ____________________ Phone # (   ) ____________________

Does insurance provide assistance with meals, transportation, or lodging expenses? * Yes * No

Is there a secondary Insurance? * Yes * No

If yes, what is the name of the plan? ____________________

If the child does not have health insurance, has the family completed an application for Medicaid? * Yes * No

Household Income and Assets

Employment ____________________

Father/Guardian ____________________ Net Annual ____________

Employer ____________________ Salary ____________

Phone # (   ) ____________________

Is Father/Guardian on unpaid leave? * Yes * No

Mother/Guardian ____________________ Net Annual ____________

Employer ____________________ Salary ____________

Phone # (   ) ____________________

Is Mother/Guardian currently on unpaid leave? * Yes * No

Other Income: SSI __________ Child Support __________ TANF __________ Other __________

Patient Name ______________________

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 your application, please include a copy of your most recent statements for all of the accounts below. If a family possesses liquid assets in excess of $5,000, the JPHF reserves the right to request a partial or complete spend-down prior to the approval of financial assistance.

Type of account ______________________ Type of account ______________________
Value ______________________ Value ______________________

Type of account ______________________ Type of account ______________________
Value ______________________ Value ______________________

Principal Residence

Do you own or rent? * Own * Rent What is the monthly payment? ______________________

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

What is the mortgage loan balance? ______________________

Fundraising

Has money been raised on behalf of the applicant? * Yes * No

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

Are there any restrictions on the account? * Yes * No

If yes, please state restrictions: ______________________

BankAcct.# ______________________

Address ______________________

City/State/Zip ______________________

Phone # (__) ______________________ Fax # (__) ______________________

Assistance from Other Organizations

If you have applied for or received assistance from another organization, please list.

Organization ______________________ Type of Assistance ______________________
Organization ______________________ Type of Assistance ______________________
Organization ______________________ Type of Assistance ______________________

Patient Name ______________________

Request For Assistance 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 reimbursment for meals for parents and dependant family members***

________ ***Transportation: JPHF will consider payment or reimbursment for transportation to and from treatment. Please state the round trip mileage ________***

________ ***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 the facility.***

________ ***Long Distance Phone Cards: We provide long distance phone cards when the immediate family is separated due to the child's treatment and/or the treatment center is long distance from the family home.***

________ ***Medical Insurance Premiums: We will consider providing assistance with medical insurance premiums when tje parent providing the coverage is on leave due to a child's treatment. You must provide documentation that confirms your montly payment. Please make certain taht you thoroughly complete the Insurance Section on Page 4.***

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

- Bone Marrow Transplant
- Donor Search
- Donor Harvest
- Other cancer treatment procedures. Specify: ______________________
- Pharmaceuticals/Supplies. Specify: ______________________

An applicant may be eligible for assistance with medical expenses if the treatment has been denied by the hospital due to a 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 a copy of the insurance policy may be requested if a procedure/treatment has been denied by Medicaid or a private insurance company.

****Note: Requests for medical assistance may be put before The Jonathan Powell Hope Foundation Board of Directors for approval.***

Additional 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.

Patient Name: ______________________________

Approved applicants will be required to execute the enclosed prepared statement by The Jonathan Powell Hope Foundation affirming use of funds granted.

The JPHF will 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.

______________________	________	______________________	________
Signature of Mother/Guardian	Date	Signature of Father/Guardian	Date

You will not be discriminated against or denied aid because of your 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 based 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 is confidential.

CONSENT TO RELEASE INFORMATION

I do hereby authorize all Hospitals, Financial Institutions and Insurance Groups to release to The Jonathan Powell Hope Foundation, 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 transplant and related expenses.

Signature of Parent or Guardian	Signature of Parent or Guardian
Printed Name	Printed Name
Social Security Number	Social Security Number
Address	Address
City/State/Zip	City/State/Zip
Date	Date

AFFIRMATION

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

1. The undersigned are the natural parents or 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 that 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 Jonathan Powell Hope Foundation towards the specific ancillary expenses within the designated time period. Any unused funds will be returned immediately to The Jonathan Powell Hope Foundation for use by others.
4. Upon reasonable request, the undersigned agrees to produce receipts or other records to verify the appropriate use of said funds.

Dated this ______________________ day of ______________ , in the year ______________

Mother/Guardian Signature	Please Print Name
Father/Guardian Signature	Please Print Name

WITNESS: ____

MEDIA RELEASE FORM

I hereby give my permission for The JPHF and/or its representatives to use photographs, audio tape record or videotape of my child or myself and to use our names, these images or voice recordings in publications, slides, videotapes, motion pictures or on the internet.

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

I gladly give this authorization to support the efforts of The Jonathan Powell Hope Foundation. I understand this authorization shall continue until terminated in writing.

Signing the consent form is not a requirement in order to receive assistance from The JPHF.

Child's Name ______________________________

Parent/Guardian Signature ______________________ **Date** ____________

Address ______________________________

____

Telephone # ( ) ______________________