P.O. Box 90215
Staten Island, NY 10309
Phone (718) 644-4431 * Fax (347) 695-2458
Email ~ Butterflyhoh@gmail.com
Website ~ GiannaNicolesHeartOfHope.org

"We are OF the families, FOR the families"

Guidelines for families seeking financial assistance

ALL information requested must be submitted with your application

All applications are kept confidential. ***"Gianna Nicole's Heart of Hope Foundation"*** cannot meet every request and cannot provide large gifts for medical procedures. However, some assistance is generally available for things such as transportation, housing, medication, insurance premiums and other needs. Families may be prioritized by need, but no family will be ineligible because of their income level. ***"Gianna Nicole's Heart of Hope Foundation"*** reserves the right and the applicant hereby grants permission to share all information provided by the applicant to third parties on an as-needed basis.

* All applicants must complete the application ***COMPLETELY*** in order to be considered for review.

* Any applications that are not fully completed will be returned.

* Patient must be 21 years old or under to apply and currently receiving treatment for cancer.

*** All applications must include a letter from a social worker or treating doctor on letterhead explaining the child's diagnosis, family situation, and treatment plans for the next 60 days.**

* All families must demonstrate a financial need caused by the impact of the child's illness in order to receive financial assistance.

* In order to receive assistance for specific liabilities, ex. car, rent, heat, phone, electric, you must submit a copy of the specific bills that show proof of need for your top 5 priorities.

* If a family has received assistance from other organizations, please list the names of each organization, date and amount received from each organization.

* All applications are reviewed on a case-by-case basis and will be contacted in a timely manner.

CONSENT FOR RELEASE
OF PROTECTED HEALTH INFORMATION

THIS FORM MUST ACCOMPANY THE APPLICATION FOR FINANCIAL ASSISTANCE FOR GIANNA NICOLE'S HEART OF HOPE, INC.

Section 1 ~ Parent/Guardian Release

I, _____, am the **Parent ____ Guardian____ Legal Custodian ____**

of : _____,

whose **Social Security Number is _____and date of birth is_____,** authorize the

physicians and staff of the facility or medical practice treating _____, to

release information concerning and or discuss the treatment being provided to_____to:

Gianna Nicole's Heart of Hope, Inc.,
P.O. Box 90215
Staten Island, NY 10309

The aforementioned information is being released for the following purpose: to qualify for a grant/contribution from **Gianna Nicole's Heart of Hope, Inc.**, a registered Not for Profit organization. This release shall expire 120 days from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit information release. I also understand that I may revoke this consent in writing at any time unless action has already been taken on it. I freely and voluntarily give this consent.

I understand that the information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, know as Acquired Immune Deficiency Syndrome (AIDS). The information may also contain records which may include treatment, services and information concerning mental health disease(s) and/or disorder(s).

Date X_____ **Signature of Parent or Guardian X** _____

Section 2 ~ Physician Certification

I certify that the patient listed in this application is currently receiving treatment from:

_____

Name of hospital or treatment facility

Physician Signature: _____ ***Date***: _____

Section 3 ~ Application for families seeking financial assistance

THIS FORM MUST BE NEATLY PRINTED & PLEASE SUBMIT A COPY OF YOUR VALID DRIVERS LICENSE OR PROOF OF ID/ADDRESS WITH THIS APPLICATION

Grant requested for: ***Medical Expenses _____ Household Expenses _____ Other_____***

Please give description: _____

***Please PRINT all information in black or blue ink only*.**

Patient Information:

Patient Name: _____ Age: _____ DOB: _____ Male ___ Female ___

Birthplace: _____

Patient's Address:_____City:_____State:_____Zip: _____

Mother or Legal Guardian Information:

Relationship to child: Mother ____Other: _____ Marital Status: _____

Name: _____ Mother's Social Security #: _____

Address: _____ Home Phone:_____Cell Phone: _____

Work Phone: _____ Email: _____

Employer: _____ Address: _____Phone: _____

Father or Legal Guardian Information:

Relationship to child: Father _____Other: _____ Marital Status: _____

Name: _____ Father's Social Security #: _____

Address: _____ Home Phone: _____ Cell Phone: _____

_____ Work Phone: _____ Email: _____

Employer: _____ Address: _____Phone: _____

A. ***Patient's Medical Information:***

A letter from your social worker, nurse or doctor explaining the child's diagnosis, family situation, and treatment plans for the next 60 days is MANDATORY to complete this section.

Referring Hospital: _____ Hospital Main #: _____ Fax #: _____

Social Worker's Name: _____ Work Phone #: _____ Email: _____

Cell Phone #: _____ Fax #: _____

Mailing Address: _____ City: _____ State:_____Zip: _____

Name of Physician: _____ Phone #: _____ Fax #: _____

Diagnosis: _____ **Date of Diagnosis**: _____

Is the child still receiving treatment? _____

If not, please explain: _____

B. ***Insurance Information:***

Patients Name:_____

Is patient covered by private Health Insurance? Yes _____ No_____

If yes, please provide the following information:

Name of Insurance carrier: _____
Phone #: _____

Name of Policy Holder: _____
Self Parent Other

Is there a secondary insurance plan? Yes _____ No _____

If so, what is it? _____

Is patient covered by state funding insurance plan? (i.e. Medicaid)? Yes ____ No _____

Has the family completed an application for Medicaid? Yes ____ No _____

Does your insurance provide transportation? Yes _____ No _____

1. **Name of Child's Physician**: _____ Address: _____

Phone: _____

2. **Name of Child's Pharmacy**:

_____ Address: _____

Phone #: _____

3. ***Household Income and Assets:***

PLEASE PROVIDE THE FOLLOWING ADDITIONAL INFORMATION.

Has the applicant had any additional assistance form other organizations?

Please provide any documentation from all organizations.

Organization: _____Phone #: _____ Amount Received: $____Date: _____

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Organization: _____Phone #: _____ Amount Received: $____Date: _____

MONTHLY INCOME	*MONTHLY EXPENSES*	*ADDITIONAL MONTHLY EXPENSES RELATED TO YOUR MEDICAL/LIVING EMERGENCY*	
Gross Salary/Wages $_____	Mortgage/Rent $ _____	E-Z Pass $ _____	Medical Bills $ _____
Public Aid $_____	Gas/Heating $ _____	Medical $ _____	Medical $ _____
Pension $_____	Electric $ _____	Insurance $ _____	Equipment Co- $ _____
Disability $_____	Water $ _____	Medical Bills $ _____	Pays $ _____
Grants $_____	Telephone $ _____	$ _____	Prescriptions $ _____
Food Stamps $_____	Cable TV $ _____	Co-Pays $ _____	Lodging $ _____
Other Assistance $_____	Cell Phone $ _____	Prescriptions $ _____	Gas (Car) $ _____
Other Income $_____	Car Payments $ _____	Groceries $ _____	Parking $ _____
NET WORTH $_____	Car Insurance $ _____	Credit Card Balances $ _____	Other $ _____
This must be completed	Gas (Car) $ _____	Personal Loans $ _____	
	Parking $ _____	Other $_____	

YOU MUST SUBMIT WITH THIS APPLICATION, COPIES OF YOUR MOST RECENT BANK STATEMENTS, COPIES OF BILLS - ALONG WITH DOCUMENTATION DEMONSTRATING ADDITIONAL EXPENSES RELATED TO YOUR MEDICAL/LIVING EMERGENCY.

**** How did you hear about us?***

□ Internet Search □ Advertisement:_____(Please specify)

□ Recommended by:_____
(Please list name and phone number)

4. ***Authorization:***

I authorize that the information provided in this application is true and correct as of the date set forth and that any intentional misrepresentation of the information contained in the application will result in the loss of current and future assistance from The Gianna Nicole's
Parent/Guardian Signature:

Please submit your completed application and any other correspondence to:

Gianna Nicole's Heart of Hope Foundation
P.O. Box 90215
Staten Island, New York 10309
Tel: (718) 644-4431
or directly Fax to: (347) 695-2458

Please feel free to call us with any questions or concerns. We will be happy to assist you.

****APPLICATION CHECK LIST****

__ Completed Application
__ Copy of your valid Driver's License/Photo ID
__ Confirmation letter from Physician
__ Copies of your most recent Bank Statements
__ Copies of additional monthly medical/living expenses

FOR OFFICE USE ONLY:

APPLICATION # _____ Date Received _____ Date Approved/Denied _____ Grant Issued: _____

Approved by: _____

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Non-Mandatory Media Release Form*

I hereby give my permission for **The Gianna Nicole's Heart of Hope Foundation, Inc.** 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 **"Gianna Nicole's Heart of Hope Foundation"** programs, services or events.

I gladly give this authorization to support the efforts of **"Gianna Nicole's Heart of Hope Foundation."**

I understand this authorization shall continue until terminated in writing.

Child's Name _____

Parent/Guardian Signature_____Date _____

Address_____

City/State/Zip _____

Telephone # (_____)_____

*(*Signature not required to receive assistance)*