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 during their child's diagnosis and treatment. This financial aid program will cover expenses that a family's health insurance plan will not cover for their child's medical care. 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 or U.S. territory (in U.S. dollars) 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 (line 4).

Family Size (as reported on most recent tax return)	Adjusted Gross Income* (as reported on most recent tax return)
2	$49,380 or less
3	$62,340 or less
4	$75,300 or less
5	$88,260 or less
6	$101,220 or less
7	$114,180 or less
8	$127,140 or less

*300% of the 2018 Federal Poverty Level Guidelines for 48 contiguous states and the District of Columbia. Families residing in Alaska or Hawaii should contact CCF for separate poverty guidelines.

- If a child's treatment has caused a financial hardship in the current year and a family's reduced income is not reflected in the previous year's tax returns, an affidavit from the hospital social worker should be included to confirm that a family's income falls under CCF's adjusted gross income category.

Age & Residence

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

Diagnosis & Medical Care

- The child has received a diagnosis of cardiomyopathy and requires active medical attention (medication, surgery). He or she does not need to be hospitalized at the time of the application.

- A child who has received a heart transplant as a result of cardiomyopathy will be considered up to one year post transplant.
- The child is under the care of a pediatric cardiologist at a recognized medical center in the United States.
- To qualify for displacement expenses, a child's treatment should be within the last six months.

Other

- A previous application has not been submitted for the family within the last 12 months.
- Applicants must be registered members of the Children's Cardiomyopathy Foundation.
- A family can receive a maximum of two awards in total.

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 resulting from loss of income during a child's in-hospital treatment period
- Health insurance premiums, deductibles and co-pays
- Reimbursement of non-elective genetic testing up to $1,000 per family

Expenses Not Covered

- Medical services and items not related to a diagnosis of cardiomyopathy
- Long term care expenses associated with a heart transplant
- 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 should apply to the program through a social worker 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 and 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 should be verified by a social 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 (form 1040, 1040-A, 1040EZ) or U.S. territory (in U.S. dollars) tax return listing child as a dependent
- A hospital affidavit verifying a family's current income if the previous year's federal tax return does not show a financial hardship. A federal income tax return from the previous year should still be submitted with the affidavit
- Supporting letter from a doctor or healthcare professional (nurse, genetic counselor, social worker or case worker) familiar with the 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 any special therapy or medical equipment needed
- Letter of denial or claim statement from insurance company showing applicant/child's name, date of service and amount not covered
- Vendor and provider bills/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 two months of submission.
- When a funding request is approved, checks are made payable to the vendor or provider within two weeks.
- The amount awarded may vary according to a family's situation and depend on the availability of CCF program funds. The Foundation reserves the right to distribute funding at its sole discretion. As such, CCF 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, a family may be asked for permission to share their story. While this would be beneficial to others, a family is not obligated to participate in CCF's marketing initiatives. Declining to participate will not have an impact on a family's award or future applications.

QUESTIONS

For questions about the Children's Cardiomyopathy Foundation Family Assistance Program, please contact Gina Peattie, Director of Family Outreach and Support, at 866.808.CURE ext. 905 or gpeattie@childrenscardiomyopathy.org.

The Children's Cardiomyopathy Foundation reserves the right to revise the Family Assistance Program at any time, including its criteria, coverage, application guidelines, and review process.

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 a registered member of the Children's Cardiomyopathy Foundation.

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

_____ My child and I are legal residents of 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 or U.S. territory (in U.S. dollars) tax return, and my child is listed as a dependent.

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

_____ My family's income as reported on my federal income tax return or my current income as verified by a hospital affidavit 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	$49,380 or less
3	$62,340 or less
4	$75,300 or less
5	$88,260 or less
6	$101,220 or less
7	$114,180 or less
8	$127,140 or less

*300% of the 2018 Federal Poverty Level Guidelines for 48 contiguous states and the District of Columbia. Families residing in Alaska or Hawaii should contact CCF for separate poverty guidelines.

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	Affected/Unaffected
Name	Age	Affected/Unaffected
Name	Age	Affected/Unaffected
Name	Age	Affected/Unaffected
Name	Age	Affected/Unaffected
Name	Age	Affected/Unaffected

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 (bills, invoices, receipts) is required for each listing.

Medical Expenses

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

Provider or Vendor	Date of service or expense	Description	Amount requested

Non-Medical Expenses

Mortgage, rent, utilities resulting from loss of income due to child's medical care. Travel, lodging, food or local transportation 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, the amount of funding awarded and what expenses will be covered by the award.

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 submit this completed application with the below supplementary information via mail or email:

By mail: Children's Cardiomyopathy Foundation, PO Box 547, Tenafly, NJ 07670
By email: Gina Peattie, Director of Family Outreach & Support - gpeattie@childrenscardiomyopathy.org

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 the child as a dependent
- ❑ Signed affidavit, if qualifying based on current income
- ❑ Copies of recent paystubs, if qualifying based on current income
- ❑ 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, if applicable.
- ❑ Vendor and provider bills or receipts showing applicant's name, address, account number, date of expense and amount

Affadavit of Family Income

Children's Cardiomyopathy Foundation Family Assistance Program

A social worker at the child's place of treatment should complete this affidavit if a family is applying based on the current year's income. Please note that this affidavit does not replace the required letter from a healthcare professional verifying a child's diagnosis.

Date _____ Social Worker Name _____

Hospital _____

Child's Name _____

I affirm that the _____ family does not meet the income eligibility guidelines based upon last year's U.S. federal income tax return. However, they have experienced financial hardship caused by their child's diagnosis of cardiomyopathy this year, and their current income meets CCF's 2018 adjusted gross income requirement based on family size.

Per their most recent tax return, which are included in this application, the family's total adjusted gross income was $_____.

Based upon the family's most recent pay stubs, the family's present monthly income is $_____.

I attest to the family's need for financial assistance because their adjusted gross income for the year is estimated to be $_____ and this amount falls under CCF's eligible guidelines for assistance.

Family Size (as reported on most recent tax return)	Adjusted Gross Income* (as reported on most recent tax return)
2	$49,380 or less
3	$62,340 or less
4	$75,300 or less
5	$88,260 or less
6	$101,220 or less
7	$114,180 or less
8	$127,140 or less

*300% of the 2018 Federal Poverty Level Guidelines for 48 contiguous states and the District of Columbia. Families residing in Alaska or Hawaii should contact CCF for separate poverty guidelines.

Copies of the family's most recent pay stubs are included with this application. Details are listed below:

Employee name	Employer	Frequency (monthly, weekly)	Amount
Employee name	Employer	Frequency (monthly, weekly)	Amount
Employee name	Employer	Frequency (monthly, weekly)	Amount

Social Worker Signature _____ Date _____