Financial Assistance Application

Dear Grant Applicant:

We would like to thank you for your interest in contacting the Nathan C. Splant Foundation to request assistance for your premature child. Attached are all the forms the Foundation requires to review your application. ***Please return the original copy by mail . You may fax in your application to 219.513.2033, but the original must be received by the Foundation before any assistance can be performed.*** Mail the completed grant applications to the following address:

Nathan C. Splant Foundation – Grant
15500 109th Avenue
Dyer, IN 46311

Only completed applications will be considered. The following checklist will help you submit a complete application packet:

☐ You must sign and have a witness sign the Consent Agreement

☐ You must sign the Authorization for Release of Protected Medical Information Form.
Please complete and sign one for the primary care doctor and at least one for the child's specialty care doctor or facility as it relates to prematurity, if different.

☐ You must complete and sign Application Form

Once we receive the above information, the foundation will review your request for assistance. If the foundation determines that we may be able to assist you, you will be contacted and asked to provide the following supporting documents in order to make a final eligibility determination.

DO NOT submit the following supporting documentation with your application, but have them available:

☐ Provide Proof of Income (submit all that apply)
- Last two paycheck stubs (If married, we need check stubs from both)
- Self-Employed -Filed tax return for the previous year (including Schedule C)
- Tax return from the prior year
- Supporter Statement (If you and/or your spouse and child are being supported by someone other than you and/or your spouse or if you and/or your spouse are supported by cash)-**THIS FORM MUST BE SIGNED AND NOTARIZED**
- Unemployment Verification (If receiving unemployment payments)
- Workman's Comp Verification (If receiving Workers Compensation payments)
- Other (Other proof of income as applicable)

☐ Health Insurance (or equivalent) Verification, if applicable.

☐ Proof of your Identity. A copy of your current driver's license/state ID, passport, or student photo ID. If the address on the proof of identity is not current or missing, include copy of a current utility bill).

☐ Proof of Child's Identity: A copy of the child's birth certificate. If this is not available a letter from the child's doctor.

☐ Disclosure of Assets (for each household member, provide all documents that apply: Current statement from Checking and Savings Account(s), Certificate(s) of Deposit, Money Market Fund, Trust Fund or Brokerage Statement

Do not hesitate to contact the foundation at (219) 365-5800 should you require help with the application.

Sincerely,

Nathan C Splant Foundation

NATHAN C. SPLANT FOUNDATION
Assistance Application
Guidelines, Policy, and Release of Liability

Mission Statement

Dedicated to helping local children and families affected by prematurity.

PROGRAM DESCRIPTION

Eligibility Requirements: Any person or family throughout Northwest Indiana (Lake and Porter County) and Cook County of Illinois facing a burden resulting from a premature birth (14 weeks gestation to 36 weeks gestation). Assistance will be provided solely for the purpose of improving the child's quality of life. This may include, offsetting direct medical costs or advanced medical equipment, post medical care (i.e. therapy) or a financial hardship directly resulting from a premature birth.

Applications: Those seeking assistance from the Foundation, can receive an application by calling us or from our website: www.ncsplantfoundation.org. Applicants may request assistance for a child, in which, they are the legal guardian or parent only. A member of the Board of Trustees may also request assistance for a family, individual or charitable institution in need. **Completed applications should be placed in a sealed envelope and mailed to Nathan C. Splant Foundation - Grant, 15500 109th Avenue, Dyer, IN 46311.** The Board of Trustees may contact the applicant if additional information is needed, including information not specifically asked for on the application, to determine eligibility for services.

Assistance Policy : Financial assistance will not be made directly to the applicant. The Foundation will make such assistance payable to, and deliver directly to, the institution, business or entity, to accomplish the need for which the applicant is requesting. If the applicant is requesting food or groceries, the foundation will make available a method to allow the applicant to acquire food or groceries using a non-monetary method (for example a store gift card). The Foundation will not provide assistance for the use of alcohol, tobacco or any illegal or illicit item. If other arrangements are needed, additional approval must be obtained, by the board of the foundation. Adequate documentation will be necessary to process payment of funds.

In being the best stewards of this fund, an attempt will be made to help as many children as possible; therefore all requests may not receive full funding. Only one application per child and household will be considered within a 12-month period. If there is more than one child in a family, the additional children will be considered part of the same household.

All applications will be reviewed on their individual merit and awards will be based solely on need, and shall be free from discrimination based on race, color, national origin, sex, religion, age, disability, sexual orientation, marital or familial status, political beliefs, parental status, or protected genetic information. The identity of the applicant's medical provider or any donor's contributions will in no way influence the eligibility of an application. Assistance to the child will be awarded independent of donor contributions and all eligibility determinations will be determined using objective criteria. Applicants would not be prohibited from changing medical providers during the determination period or while receiving assistance from the foundation. The Board of Trustees of the Nathan C Splant Foundation will make the final determination of the approval or disapproval of each application.

Privacy: Only the Nathan C. Splant Foundation will be aware of the name and information of the applicant, the child and any entity associated with the applicant and child. At NO time will this information be revealed to anyone privately or publicly without the consent of the applicant. You may request a copy of the Foundation's complete Privacy Policy at any time.

Release of Liability

The Nathan C Splant Foundation is a 501c(3) non-profit corporation. All individuals involved in the operations of the foundation donate their time on a voluntary basis. The services being provided might not be available but for the efforts of the foundation volunteers. These individuals are not obligated to do so, but are doing so on a voluntary basis.

The Nathan C Splant Foundation has the right, in its sole discretion, to refuse to provide service or withdraw service in the event it determines that misrepresentation regarding information on the client's application form have been made. In addition, the foundation may refuse or withdraw assistance for any other reason.

CONTRIBUTIONS

The Nathan C. Splant Foundation is funded solely on donations made by generous contributors and fundraising efforts. Contributions can be made via the Internet at www.ncsplantfoundation.org or by mail to the Nathan C. Splant Foundation, 15500 109th Avenue, Dyer, IN 46311.

No Donor will exert control over the foundation or its use of donor contributions. Donors will not be provided information that would allow them to correlate contributions with funds dispersed for services the foundation provides or in any way that would compromise the confidentiality of the foundations beneficiaries. To ensure proper stewardship of the foundation's funds, utilization of the foundation's resources will be monitored in order to maximize the impact to foundation beneficiaries and the community.

REPORTING AND ACCOUNTABILITY

Maintenance of Records: Since contributions are made to the foundation, it is important that proper reporting and accountability be assured. Completed applications are retained in a confidential and secure manner by the Nathan C. Splant Foundation.

Reporting: Accountings of funds received and disbursed are reported by the Nathan C. Splant Foundation using the current IRS and states codes requirements. At no time, unless authorized by the applicant, are the names of the applicants or recipients revealed.

15500 109th Avenue,
Dyer, Indiana 46311
TEL: (219) 365-5800 FAX: (219) 513-2033

APPLICATION FORM

Please fill in as much information as possible, however, missing information may lead to a delay in determination and/or a denial of assistance. Please print or type:

Date: _____ / _____ / _____

CHILD'S INFORMATION:

Name of Child in need of assistance:

_____
(Last) (First) (Middle Initial)

Gender ☐ M ☐ F Date of Birth ____/____/_____

How Many Weeks Premature: _____ Social Security #: _____ - _____ - _____

HOUSEHOLD INFORMATION:

Your Name: _____ Relationship to Child: _____

Spouse or Partners Name*: _____ Relationship to Child: _____

* If you are divorced or separated and have custody of the child you do not need to put this information in.

Divorced: ☐ Yes ☐ No

Legally Separated ☐ Yes ☐ No

If Divorced, Do you have: ☐ Sole custody of the child ☐ Joint Custody of the child

Total number of all individuals in your household you are responsible for : _____

Address of you and your Child:

_____
(Street)

_____
(City) (State) (Zip)

Home # (___) ___- _____ Work # (___) ___- _____ Other # (___) ___- _____

Cell # (___) ___- _____ Email: _____

Household Type:

□ Two Parent Family Married
□ Two Parent Family Unmarried
□ Female Single Parent
□ Male Single Parent
□ Foster Parent(s)
□ Non -custodial Caregiver
□ Grandparent and Child
□ Other: _____

Type of Living Situation:

□ Owns Home
□ Hotel/Motel
□ Rental House/Apartment
□ Living with Friends
□ On the street
□ Transitional Housing
□ Hospital
□ Emergency Shelter
□ Living with Family
□ Subsidized Housing

Actual or Pending Eviction? : □ Yes □ No If yes, date of eviction _____

Shelter Name if in a Shelter: _____

FINANCIAL INFORMATION

Monthly Income (combine both parents/guardians):

Gross Pay	$_____	Soc. Security	$_____
AFDC/TANF	$_____	SSI	$_____
Unemployment	$_____	SSDI/Disability	$_____
Child Support	$_____	Alimony	$_____
SNAP/Food Stamps	$_____	Pension	$_____
Self Employment	$_____	Rental Income	$_____
Workers Compensation	$_____	401K/IRA	$_____
Public Assistance	$_____	Other	$_____

If you have no income, check this box ☐

If you checked the box above, check one of the following boxes:

☐ I/We and my child are being supported by someone.
You will be asked, later, to provide a signed Supporter Statement from this individual

☐ I/We have no income and we have no support

Your Employment Status:

□ Full time
□ Part time
□ Retired
□ Seasonal work
□ Unemployed

Hours of work per week _____

Spouse or Partner's Employment Status:

□ Full time □ Part time
□ Retired □ Seasonal work
□ Unemployed

Hours of work per week _____

Monthly Expenses:

Rent/Mortgage	$_____	Utilities	$_____
Health Insurance	$_____	Medical Bills	$_____
Child Support	$_____	Alimony	$_____
Other _____	$_____	Other _____	$_____
Other _____	$_____	Other _____	$_____

MEDICAL INFORMATION:

Is the child insured: Yes No

Child's Primary Doctor's Name: _____

Doctor's Address: _____

Doctor's Telephone #: _____

Child's Additional Doctor's Name: _____

Doctor's Address: _____

Doctor's Telephone #: _____Reason for Treatment by this doctor: _____

Child's Additional Doctor's Name: _____

Doctor's Address: _____

Doctor's Telephone #: _____Reason for Treatment by this doctor: _____

If there are any conditions the child is being treated for, please list here:

_____

_____

_____

CHILD'S NEED REQUEST

I am requesting financial assistance for the following*:

□ Medical Equipment
□ Physical Therapy (PT) Services
□ Doctor's Bill
□ Rent Payment
□ Telephone
□ Food or Groceries
□ Other _____

□ Medical Services
□ Occupational Therapy (OT) Services
□ Insurance Premium Payment
□ Mortgage Payment
□ Electric or Gas Utilities Payment
□ Other _____

* In many cases the foundation will only be able to provide assistance for one of the items being requested. Please decide what services you require most assistance with when completing this section.

If you checked, Medical Equipment, Medical Services, PT Services, OT Services or other, has your child's doctor recommended it?: ☐ Yes ☐ No

Is one of the items, checked above, going to be shut off or discontinued if payment is not made? (if so, please indicate below): ☐ Yes ☐ No

Please provide specific information about the assistance you are requesting. Include the amount for the service, item or payment. Include how far behind you are in a bill or payment Include the specific name and cost of the medical equipment or service and how much your insurance is willing to pay. Provide as much information as you are able to if you feel it will help in determining your eligibility for services.

Your signature below authorizes use of the above information by the Nathan C Splant Foundation to determine eligibility for services. This information will be kept in the strictest confidence and will only be used for program qualification/eligibility purposes.

Your Signature **Date**

Spouse or Partner's Signature (if applicable) **Date**

Consent Agreement

I, _____, fully understand the conditions of the Nathan C Splant Foundation's Guidelines, Assistance Policy and Release of Liability.

I, _____, understand that by signing this form I am giving up my right to assert any claim or demand for damages of any type arising out of the services provided to me through the effort and assistance of the Nathan C Splant Foundation. In consideration for being permitted to receive the services provided, by signing below, I do forever release, hold harmless and discharge the Nathan C Splant Foundation, its officers, directors, agents, volunteers, sponsors, employees, successors and assigns from any and all claims, causes of action, damages, demands or liability arising out of or connected in any manner arising out of my receipt of services.

By signing below, I acknowledge and agree that the Foundation's agreement to offer limited assistance does not obligate the Foundation to provide additional assistance for any other services.

By signing below, I acknowledge and agree that the Nathan C Splant Foundation has the right, in its sole discretion, to refuse to provide or withdraw assistance in the event it determines that misrepresentations regarding my intake information have been made. In addition, failure to comply with updating financial and demographic data when requested can result in a withdraw of assistance.

I have carefully reviewed this agreement and am signing it of my own free will and not under duress or coercion of any kind. I am competent to sign this waver.

This release is made and intended to bind me as well as my heirs, executors, administrators, and assigns. This agreement is made in Indiana and is intended to be construed under Indiana law.

_____(Your Name Printed)

_____(Your Signature)

_____Date

_____(Spouse or Partner's Name Printed, if applicable)

_____(Spouse or Partner's Signature)

_____(Date)

_____(Witness's name Printed)

_____(Witness's Signature)

_____(Date)

15500 109th Avenue, Dyer, Indiana 46311
Phone: (219) 365-5800
Fax: (219) 513-2033

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Release for Medical Records:

When you obtain services from the Nathan C Splant Foundation, certain uses and disclosures of your child's health information are necessary and permitted by law in order to assist you. You may request a copy of the Foundation's Privacy Policy at any time. You have the right to request that we restrict how protected health information about your child is used.

Please use full and accurate names and addresses below.

I _____ , parent or legal guardian of, _____, a minor child, who's date of birth is ____/____/____, give permission to the following doctor or medical facility: _____, whose address is _____ to disclose, consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rules and Regulations, all or any part of my child's medical record for treatment, payment or health care operations. This permission includes the release of medical and financial information relating to my child's diagnosis, health, treatment and/or hospitalization for prematurity. In addition I allow any health care provider, including any physicians and facilities to which my child may be transferred, to provide medical and financial information to the Nathan C Splant Foundation upon request, concerning my child's care, condition, and treatment, for quality improvement, risk management or verification purposes.

This authorization will expire at the end of my services with the Nathan C Splant Foundation, unless I revoke the consent prior to that time or state a date of termination. Date of termination of authorization: _____

Guardian or Parent Signature: _____ Date: _____

_____
(Printed name of Parent or Legal Guardian)

15500 109th Avenue, Dyer, Indiana 46311
Phone: (219) 365-5800
Fax: (219) 513-2033

Supporter Statement

Child's Name (Print): _____

Parent(s) or Guardian(s) Name (Print): _____

Address of Above – Street, City, State and Zip Code (Print):
_____

The above named applied for financial assistance to the Nathan C Splant Foundation and has advised us that you either contribute substantially to their support or you are their sole means of support. Please complete this form, have it notarized and return it the Nathan C Splant Foundation by: _____.

Thank you

The type of support I/we provide is: (please complete all that apply)

☐ Room and Board, since (date) _____

☐ Allowance of $ _____

☐ Every Week ☐ Every 2 Weeks ☐ Every Month ☐ Other (please explain) _____

I/We, (print) _____ have been the sole/substantial support for the child and the parent(s) or guardian(s) named above and, to the best of my/our knowledge, declare that this person has no other primary means of support.

_____
Signature 1

_____
Signature 2 (if jointly providing support)

_____
Relationship to child and parent(s) or guardian(s)

_____
Address: Street, City, State, Zip

_____ _____
Telephone Date

Subscribed and sworn before me this _____ day of _____, A.D.

_____, Notary Public.