Safety Net Grant Program

Description:

The National Pediatric Cancer Foundation's ***Safety Net Grant Program*** assists cancer patients (children under the age of 18) with advanced cancer treatment related costs.

This is an "on-line grant program" for "reimbursable event related support" – meaning, the grant does not support unpaid expenses, only expenses validated with a current / original invoice & payment receipt for said expense. Receipts are required to be submitted with the grant application.

Support is restricted to the following reasons:

1. Durable home based medical supplies/equipment/mobility aids
2. Medication - prescription and over-the-counter
3. Transportation costs to and/or from treatment
4. Insurance co-payments & out-of-pocket plan deductibles

Eligibility:

- Patient must be currently undergoing treatment in relation to a cancer related clinical trial or advanced form of cancer therapy treatment
- Patient must be a legal citizen of the USA and be under the age of 18 as of the day of treatment
- Patient's treatment must be validated (signature on application) by a licensed healthcare provider providing said treatment and by supporting parent/legal guardian
- Financial assistance by the NPCF is considered "last resort" funding
- Applicants must demonstrate financial need on the patient application. Financial needs will be assessed based on numerous factors including household income, and size as compared to the cost of basic needs by county.
- Patients must be alive at the time that the grant is issued. Financial assistance related to postmortem expenses or expenditures incurred after death will not be considered for reimbursement
- Applicants may apply at six-month intervals – limited to two per calendar year. The maximum grant amount per application is $500.00
- Number of annual grants – current program awards one $500 grant per six month period

Application Requirements:

1. Application is complete and signed by both the patient's guardian and the Recommending healthcare provider.
2. In the case of attached receipts and support documentation, we should receive the following:
    a. Transportation: Attach a description of required travel for treatment including treatment dates, to/from destination and either gas receipts for respective dates or mileage amounts for each specific reimbursement date being requested. If mileage is requested, we will reimburse at a rate of $.19 per mile which is the approved IRS rate for medical mileage. We will either reimburse for mileage or gas receipts but not a combination of the two.
    b. Medical Supplies: Include description of supplies or equipment being requested and corresponding receipt evidencing payment of equipment.
    c. Medication: Include corresponding receipts for prescribed medication or over the counter medication needed. We will reimburse any out of pocket costs not covered by insurance.
    d. Insurance Co Payment and Deductibles: Attach receipts for payment of any co-payment and/ or deductibles either for doctor visits, hospital stays, or medical care incurred for patient.
3. All receipts should fall within the treatment dates shown in the application.
4. Household Income Information – Attach latest Income Tax return for said household.

Process**:**

1. To apply for support, **mail** the application below to: NPCF, Attn: Safety Net @ 5550 West Executive Drive., suite 300, Tampa, FL 33609 or **email**: safetynet@nationalpcf.org

2. In some situations, NPCF may choose to institute a grant cap &/or close or suspend the program. Information will be posted on the NPCF website. NPCF also reserves the right to institute changes to grant maximums.

3. The decision to provide assistance in response to any given application or request is at all times subject to the sole and absolute discretion of NPCF. The NPCF Safety Net Program is not an entitlement program. There is no "right" to a grant or financial assistance, either initially or for any given period. NPCF reserves the right to modify or withdraw at any time any commitment as to any grant or financial assistance. Without limiting the foregoing, a finding of eligibility does not give rise to entitlement to financial assistance which, upon other variables, depends on available funds in the SNP pool. NPCF reserves the right, exercisable in its sole and absolute discretion, to revise eligibility criteria, from time to time, and make such changes effective as of any date selected by NPCF. In addition, and without limiting the discretion of NPCF as set forth above, applicants are advised that false or deceptive representations in connection with

eligibility for participation in the program, fraudulent conduct, or gross misconduct shall result in the immediate disqualification of an application for a grant, eligibility for future grant, &/or the termination and cancelation of a grant which has been approved. NPCF also reserves the right to obtain any applicable refund for cancelled grants.

4. NPCF reserves the right to request additional backup documentation to validate application information.

5. NPCF reserves the right to require new annual applications for all enrollees to ensure system accuracy and applicant eligibility.

6. All applications must be signed by the patient, parent or legal guardian on whose behalf SNP assistance is requested, and validated (signed) by a licensed healthcare provider. If the patient is unable to sign the Consent Form, it is permissible for a legally authorized representative of the patient (e.g., a person who has a power-of-attorney) to sign on behalf of the patient). The signed Consent Form cannot be older than 60 days of the application submission date.

7. Please allow NPCF at least 2 weeks to process and mail premium payments. Most requests, if correctly submitted, are processed within 10-14 days.

8. You may contact NPCF at 1-813-269-0955

SAFETY NET PROGRAM - APPLICATION:

Patient Name:_____

Patient's Birth Date:_____

Patient's parent &/or legal guardian: _____

Patient's parent &/or legal guardian agreement with program eligibility: Yes ☐ / No ☐

Home address:_____

_____

Phone:_____

Parent / Guardian Email:_____

Date of application_____

VALIDATION / REQUEST FOR SUPPORT

I request the following assistance and thereby submit validation / description of paid expenses:

(check appropriate boxes and describe documents attached with this application)

Transportation:_____

_____

Medicalsupplies:_____

_____

Medication:_____

_____

Co- Payment and /or deductible
payments:_____

_____

HOUSEHOLD FINANCIAL INFORMATION:

Number of People in Household:_____

Number of People Employed in Household:_____

Total Annual Household Income: (include all sources of income): _____
(*attach last calendar year's tax return*)

RECOMMENDING HEALTHCARE PROVIDER INFORMATION:

Name/title/Provider:_____

Healthcare Provider Relationship to Patient: (Physician, Nurse, Social Worker)

Diagnosis Information and Date:_____

Treatment dates: (from / to):_____

Type of Treatment Received in the Past 12 Months: _____

Provider email & phone #_____

Recommending (healthcare provider's) signature:_____

Requested amount (validated with attached receipts):_____

Signature of Healthcare Provider_____ Date_____

PATIENT / GUARDIAN VERIFICATION

I understand that by signing this application, I agree the above information is truthful and accurate to the best of my ability. I qualify for assistance based on eligibility requirements noted above. NPCF may need to contact me to verify the above information. Funding for this program is subject to availability of funds and approval of this grant is at the sole discretion of NPCF. All information provided will be kept confidential. No information will be made available or sold to a third party and is the sole property of NPCF.

Signature of Applicant (Parent/legal guardian) ***Date***

NPCF Internal:_____