Safety Net Program

Dear Friends,

On behalf of the National Pediatric Cancer Foundation, it is our pleasure to introduce our Safety Net grant program!

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

With hope,

David Frazer
Chief Executive Officer

Carleigh DeLuca
Community Engagement Coordinator

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Safety Net Program

NATIONAL PEDIATRIC CANCER FOUNDATION
RISE UP FOR A FASTER CURE

Program Overview

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 Qualifications:

Support is limited 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 Requirements:

- 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 $250.00
- Number of annual grants – current program awards one $250 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

Application

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

Patient Name:_____
Patient's Birth Date:_____
Patient's parent &/or legal guardian: _____
Patient's parent &/or legal guardian agreement with program eligibility: Yes / No (circle)
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 &/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 (Please circle one): 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.

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