Safety Net Grant Program

Description:

The National Pediatric Cancer Foundation's Safety Net Grant Program (SNP) assists cancer patients (children under the age of 18**) with advanced cancer treatment related costs.
This is a grant program for "reimbursable event related support" – meaning, the grant supports expenses validated with a current / original invoice &/or receipt for said expense. Receipts are required to be submitted with the grant application.
Support is restricted for the following purposes:

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 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 not an endorsement of any pharmaceutical product.

•Applicants must demonstrate financial need on the patient application. Financial needs will be assessed based on numerous factors including household income, as compared to UW ALICE report. This report refers to populations in our community that are Asset Limited, Income Constrained, Employed.

•Financial assistance related to postmortem expenses will not be considered for reimbursement.

•Applicants may apply at six-month intervals – limited to two per calendar year. The maximum grant amount per year is $2,500.00. (maximum amount of $1,250.00 per six-month period)

Process**:**

1. To apply for support, mail the below “application to: NPCF, Attn: CEO @ 5550 West Executive Blvd., suite 200, 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/requirements.

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. ** NPCF reserves the right to interpret “age requirement beyond the age of 18” for the purpose of supporting scientific research.

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

9. 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:____