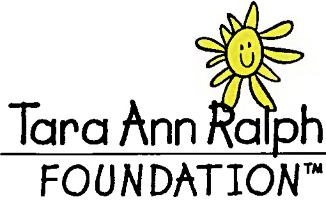
Application Number: ____________
(For Internal Use Only)



Confidential Application

P.O. Box 39
Rochelle Park, NJ 07662
Phone: 201.820.3167
www.taraannfoundation.com

Prior to submitting an application for a grant of financial assistance to the Foundation, please review the eligibility provisions which are located on the last page of this application. These eligibility provisions, and additional information concerning the Foundation and its operations, may also be viewed at www.taraannfoundation.com address.

The Tara Ann Ralph Foundation ("Foundation") is a not-for-profit organization which provides financial assistance to the families of certain qualifying children who require continuing medical care due to a life-threatening medical condition. Through its direct payment of certain financial expenses of such a child and/or his/her family, the Foundation seeks to help alleviate the financial stress which may be incurred by a family due to their child's continuing medical care. Expenses which are eligible for payment by the Foundation are not limited to medical expenses; however, the nature of the expenses and the financial resources of the family will be considered as part of the review of each grant application. All grant applications are considered on a case-by-case basis; however, not every grant request will be approved.

Please print clearly and complete the entire three page application and the attached two page Authorization for Release of Protected Health Information form.

SECTION I

Date ____________ Requested Total Amount ____________

Child ____________ Child's Date of Birth ____________

☐ Parent or ☐ Legal Guardian Name: ____________

Contact *(if different from parent or legal guardian)* ____________

How did you hear about the foundation? ____________

SECTION II

Please send all information or notifications regarding this application to:

Name ____________

Address ____________

Telephone ____________ Fax ____________ Email Address ____________

SECTION III

Medical Information – Must attach medical diagnosis and treatment plan on physician's letterhead, signed by physician

Physician's Name ____________

Address ____________

Telephone ____________ Fax ____________

Include supporting information/documentation ____________

____

____

Application Number: ____________________
(For Internal Use Only)

SECTION IV

Medical Expense Resources
(Please list all payment plans; i.e. health insurance, medical savings plans, etc., Attach additional documents if necessary)

Insurance Company ____________________

Telephone Number ____________________

Insurance Identification Number ____________________

Secondary Insurance Company ____________________

Telephone Number ____________________

Insurance Identification Number ____________________

Have you requested financial assistance from any other source? ☐ Yes ☐ No

Source ____________________ Amount Requested $ ____________________

Have you received financial assistance from any other? ☐ Yes ☐ No ☐ Pending

Source ____________________ Amount Requested $ ____________________

Have other avenues of relief been exhausted *(personal funds, relatives, government or other agencies)?* ☐ Yes ☐ No

SECTION V

Outstanding Providers or Suppliers – Must attach a copy of each current invoice(s) *(Funds are paid directly to the provider/supplier)*

Name/Provider 1 or Supplier 1 ____________________

Address ____________________

Telephone ____________________ Fax ____________________

Account Number ____________________ Amount $ ____________________

Purpose of Requested Payment Amount ____________________

____

Name/Provider 2 or Supplier 2 ____________________

Address ____________________

Telephone ____________________ Fax ____________________

Account Number ____________________ Amount $ ____________________

Purpose of Requested Payment Amount ____________________

____

Application Number: ______________
(For Internal Use Only)

Name/Provider 3 or Supplier 3 ______________________________

Address ______________________________

Telephone ______________ Fax ______________

Account Number ______________ Amount $ ______________

Purpose of Requested Payment Amount ______________________________

____

Name/Provider 4 or Supplier 4 ______________________________

Address ______________________________

Telephone ______________ Fax ______________

Account Number ______________ Amount $ ______________

Purpose of Requested Payment Amount ______________________________

____

The Tara Ann Ralph Foundation reserves the right to request additional information and or documentation to process your application. PLEASE NOTE: Incomplete applications will not be reviewed or considered.

Return the completed and signed Tara Ann Ralph Foundation Application and all supporting documents to:

Tara Ann Ralph Foundation
P.O. Box 39
Rochelle Park, NJ 07662

I certify that the information contained in this application (and any materials submitted in support of same) for financial assistance is true and correct. I acknowledge by my signature below that if any such information is knowingly false I am subject to penalty.

Signature ______________________

Name(Print) ______________________

Date ______________________

The Tara Ann Ralph Foundation is a private foundation within the meaning of Section 509(a) of the Internal Revenue code and is exempt from Federal Income taxation under Section 501(c)(3) of the Code.

All information submitted to the Foundation in support of a grant application will be held in confidence by the Foundation, and will be disclosed only as required under applicable law.

Application Number: ________________
(For Internal Use Only)

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Authorization for Release of Protected Health Information (PHI)

In support of your application to the Tara Ann Ralph Foundation (the "Foundation") for a grant of financial assistance, you must provide sufficient documentation to evidence a life-threatening medical condition of a qualifying child. In furtherance thereof, the Foundation requests that you provide it with this release form, which will permit the Foundation to obtain medical information directly from your child's physician or medical treatment facility.

Please complete this release form and return it to the Foundation, together with your completed application and supporting documents. You should notify the office of your child's physician that the Foundation will be contacting it for information in support of your request for a grant of financial assistance. If your child's physician has a HIPAA release form which he/she prefers to use, please complete the form and send a copy to the Foundation, together with the completed application. Please note that applications which do not contain the appropriate completed release form will not be processed.

I hereby authorize____ to disclose PHI concerning the individual identified below to the Tara Ann Ralph Foundation.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

Please Print All Responses

PATIENT INFORMATION

____

Last Name | First Name | Middle Initial

____

Social Security Number | Birth Date *(MM/DD/YYYY)* | Daytime Telephone Number *(include area code)*

____

Street Address | City, State and Zip Code

____

I authorize the Tara Ann Ralph Foundation to receive PHI for the individual identified above, which should be sent to the following:

Tara Ann Ralph Foundation
Attn: HIPPA Privacy Officer
P.O. Box 39
Rochelle Park, NJ 07662

PURPOSE(S) FOR THIS AUTHORIZATION

This authorization will apply to any and all requests for PHI made by the Tara Ann Ralph Foundation. It is not necessary to complete this section, unless you want to give a partial authorization.

If you prefer to authorize disclosure of only selected categories of information, please indicate below which types of information may be disclosed

- ☐ Health
- ☐ Behavioral Health

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below.

________________________________ through________________________________
mm/dd/yyyy mm/dd/yyyy

Application Number: ______________
(For Internal Use Only)

IMPORTANT: Your signature below means that you understand and agree to the following:

- The PHI disclosed pursuant to this authorization may include diagnosis and treatment information. These records will be included in the information made available to the Tara Ann Ralph Foundation.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations.
- You may receive a copy of this signed form if you ask for it by writing to the address listed at the bottom of this page.
- This authorization will expire one year from the date you sign this authorization. If you sign this form, you may revoke the authorization at any time by notifying the Tara Ann Ralph Foundation in writing at the address below. Revoking this authorization will not have any effect on PHI that was disclosed to the Tara Ann Ralph Foundation prior to the revocation date.

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

Minors* must sign this form below if (check applicable box):	All others must sign this for below as (check applicable box):
1. ☐ the minor is married or emancipated or; 2. ☐ the information being authorized for release pertains to drug or alcohol treatment or; 3. ☐ the information being authorized for release pertains to mental health treatment and applicable state law allows minors to receive such treatment without parental consent.	4. ☐ the member or member's legal representative or; 5. ☐ the parent of unemancipated minor, unless minor has signed at left and box 3 at left has been checked or; 6. ☐ the parent of unemancipated minor if the information authorized for release pertains to drug or alcohol treatment and applicable state law does NOT allow minors to receive such treatment without parental consent (Note: in this case, signature of both parent and minor are required.)
Signature Date	Signature Date
Print Name	Print Name

The Tara Ann Ralph Foundation reserves the right to request additional information and or documentation to process your application. PLEASE NOTE: Incomplete applications will not be reviewed or considered.

Return the completed and signed Authorization For Release of Release of Protected Health Information to:

Tara Ann Ralph Foundation
P.O. Box 39
Rochelle Park, NJ 07662

The Tara Ann Ralph Foundation is a private foundation within the meaning of Section 509(a) of the Internal Revenue code and is exempt from Federal Income taxation under Section 501(c)(3) of the Code.

All information submitted to the Foundation in support of a grant application including all PHI, will be held in confidence by the Foundation, and will be disclosed only as permitted under applicable law.

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Questions & Answers

WHO IS ELIGIBLE TO RECEIVE A GRANT OF FINANCIAL ASSISTANCE?

A grant of financial assistance may be made by the Foundation for the benefit of a child, or for the benefit of the family of a child, who requires continuing medical care due to a life-threatening medical condition. Subject to the satisfaction of all of eligibility requirements for receipt of a grant of financial assistance, a qualifying child is one who is between the ages of birth and 18 years of age.

WHAT IS "CONTINUING MEDICAL CARE DUE TO A LIFE-THREATENING MEDICAL CONDITION"?

A grant of financial assistance will only be made for the benefit of a child, or the family of a child, who is receiving "continuing medical care due to a life-threatening medical condition". Whether these circumstances exist will depend upon the facts and circumstances of each child's particular situation. However, continuing medical care generally means that the child is currently under a physician's active care for the treatment of a life-threatening medical condition. Although many children who are the beneficiaries of a grant of financial assistance from the Foundation require on-going medical treatments, the occurrence of a single, significant medical procedure may also be eligible for receipt of such a financial assistance grant. A "life-threatening medical condition" is generally any medically determinable physical or mental impairment which can be expected to result in the child's imminent death, which is reasonably expected to significantly reduce the child's life expectancy, or which can be expected to last for a continuous period of not less than twelve (12) months.

WHAT TYPES OF EXPENSES ARE PAYABLE BY THE FOUNDATION?

In general terms, the purpose of the Foundation is to provide grants of financial assistance to alleviate the financial stress which may be incurred by a family due to their child's continuing medical care due to a life-threatening medical condition. Accordingly, the Foundation does not provide a list of expenses for which such financial assistance grants either will or will not be made. Rather, a determination as to the propriety of an expense for which a financial assistance grant may be made is determined by the Foundation based upon a review of the totality of the facts and circumstances surrounding the request. However, grants of financial assistance will typically be made by the Foundation for expenses which are reasonably necessary for, and related to, the care of the afflicted child.

WILL THE FOUNDATION ISSUE A GRANT OF FINANCIAL ASSISTANCE DIRECTLY TO ME?

Except in unusual circumstances, the Foundation makes its grants of financial assistance directly to the third party debtor or service provider for whom such a grant request is made.

WHY IS A HIPAA RELEASE FORM REQUIRED TO BE SUBMITTED WITH MY APPLICATION?

All applications for a grant of financial assistance will be subject to an independent medical review concerning the life-threatening medical condition of the applicant child. Because federal law generally protects all information concerning such health conditions and the care associated with same, you must authorize in writing the disclosure of such protected health information (PHI) to the Foundation.

I RECEIVED A GRANT OF FINANCIAL ASSISTANCE FROM THE FOUNDATION TO PAY A PARTICULAR EXPENSE. NOW I HAVE ANOTHER EXPENSE FOR WHICH MY FAMILY SEEKS FINANCIAL ASSISTANCE. DO I NEED TO FILE ANOTHER APPLICATION?

Yes. Applications submitted to the Foundation for grants of financial assistance will be deemed to be "closed" following either the approval or denial of a particular request. In the circumstances wherein the Foundation approves a grant request, the payment of the grant amount will finalize the processing of the grant request. Thereafter, if the applicant seeks to request the payment of additional expenses, a separate grant application must be submitted. All applications submitted to the Foundation are considered on their individual merits, and an applicant who previously received a grant of financial assistance will be considered in the same manner as all other applicants, with no preferential or detrimental considerations.

ARE GRANTS OF FINANCIAL ASSISTANCE DEPENDANT UPON FINANCIAL NEED?

Although the Foundation may consider, as part of its application process, the financial circumstances of a requesting family, the Foundation does not base its application decisions solely upon financial need. In keeping with its stated purpose, the Foundation considers the totality of the circumstances surrounding the financial aspects of a requesting family, and seeks to make grants of financial assistance to families which are incurring financial stress due to the continuing medical care of their child.