Application for Financial Assistance

Eligibility

The applicant is eligible if age of onset of condition is before his or her 21st birthday. Priority will be given to applicants under 21.

Requests for assistance should be received or postmarked by: Feb. 10, May 10, Aug. 10 or Nov. 10.

Expense must have occurred within the last 18 months.

Priority will be given to applicants residing within the following counties:

<table>
<thead>
<tr>
<th>Adams</th>
<th>Dunn</th>
<th>Logan</th>
<th>Renville</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnes</td>
<td>Eddy</td>
<td>McHenry</td>
<td>Rolette</td>
</tr>
<tr>
<td>Benson</td>
<td>Emmons</td>
<td>McIntosh</td>
<td>Sheridan</td>
</tr>
<tr>
<td>Billings</td>
<td>Foster</td>
<td>McKenzie</td>
<td>Sioux</td>
</tr>
<tr>
<td>Bottineau</td>
<td>Golden Valley</td>
<td>McLean</td>
<td>Slope</td>
</tr>
<tr>
<td>Bowman</td>
<td>Grant</td>
<td>Mercer</td>
<td>Stark</td>
</tr>
<tr>
<td>Burke</td>
<td>Griggs</td>
<td>Morton</td>
<td>Stutsman</td>
</tr>
<tr>
<td>Burleigh</td>
<td>Hettinger</td>
<td>Mountrail</td>
<td>Ward</td>
</tr>
<tr>
<td>Dickey</td>
<td>Kidder</td>
<td>Oliver</td>
<td>Wells</td>
</tr>
<tr>
<td>Divide</td>
<td>LaMoure</td>
<td>Pierce</td>
<td>Williams</td>
</tr>
</tbody>
</table>


Financial eligibility will be established based upon tax returns and other financial records of the patient or his/her financial guarantor if necessary. Evidence of Medicaid enrollment as primary payer will satisfy financial eligibility without additional inquiry. For all others, at a minimum, the applicant will be required to provide a copy of the most recent year’s federal tax return and complete a certification that the applicant does not have sufficient assets to pay for the requested funds without undue burden.

The requested tax return will be the individual tax return for the patient or financial guarantor, the joint return for married couples filing jointly or both individual returns for married couples filing separately. In cases where the financial guarantors of the patient are parents who are not married (whether divorced or otherwise), the tax return of each financial guarantor will be reviewed as possible given social circumstances. For any applicant, the Committee reserves the right to request additional financial information in its discretion.

The patient or financial guarantor can meet financial eligibility criteria in two ways:

1. If taxable income is equal to or less than 500 percent of the Federal Poverty Guidelines as amended from time (See table below for 2017 Guidelines), or
2. If taxable income is greater than 500 percent of the Federal Poverty Guidelines but the annual medical expenses associated with the patient’s condition are 7.5 percent or greater than the taxable income. Only expenses in excess of the 7.5 percent threshold will be eligible for reimbursement.

In addition to the other limitations described above, the Committee may grant partial reimbursement based upon the family’s income and perceived economic hardship as determined by the Committee in its discretion. In addition, the Committee may deviate from the Federal Poverty Guidelines for good cause.

Applicants for reimbursement must use the GABR Application for Reimbursement.

<table>
<thead>
<tr>
<th>Family size</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>500%</td>
<td>59,400</td>
<td>80,010</td>
<td>100,800</td>
<td>121,500</td>
<td>142,200</td>
<td>162,900</td>
<td>183,650</td>
<td>204,450</td>
</tr>
</tbody>
</table>

From the U.S. Department of Health & Human Services
Please send the following with your completed application:

- Applicant Information
- Parent/Guardian Information
- Medical Information
- Type of Request
- Authorization of Disclosure of Medical Information
- Marketing Release Form
- Color picture of the child (optional)

*By sharing a photo of your GABR funds in action you help make a difference.*

**If you fail to submit all of the required documentations, your application may be denied.**

In order to advance financial assistance in conjunction with the medical treatment of ____________________________ (applicant), the undersigned do hereby affirm the following:

1. The undersigned is the parent or legal guardian of the applicant or the applicant (if over 18).

2. The undersigned will receive a letter outlining the committee’s decision approximately one month after the application due date.

3. The undersigned further agrees to return any unused funds immediately to GABR so that those funds can be utilized by the organization to benefit other families.

4. The undersigned has read the guidelines for financial assistance and the eligibility checklist and declares that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

Date ___________________

___________________________________________  ________________________________
Signature of person filling out application  Please Print Name

Relationship to the patient: (circle one)  Self  Mother  Father  Grandparent  Other________________________

RETURN THIS APPLICATION FORM TO:
GABR
701 E. Rosser Ave.
P.O. Box 5525
Bismarck, ND 58506-5525

For more information, please feel free to contact us:
Phone: 701-323-8450
Email: foundation@sanfordhealth.org
Fax: 701-323-8453
### Patient Information

Patient’s Name (first, middle, last) _______________________________________
- Male
- Female

Date of Birth____________________ Birthplace (state/country) ____________________________________________

Patient’s Address__________________________________________________________

City/State/Zip__________________________________________ County____________________

Home Phone # (____)______________ Cell # (____)______________ Work# (____)_________________

Email Address ______________________________________________________________

### Parent/Guardian Information (if applicable)

Parent/Guardian Name____________________________________________________

Home Phone # (____)______________ Cell # (____)______________ Work# (____)_________________

Email Address _____________________________________________________________

Best way to reach you:  
- Home Phone
- Cell Phone
- Work Phone
- Email

Is address same as patient’s?   
- Yes
- No

If no, address ____________________________________________________________

City/State/Zip____________________________________________________________

### Medical Information

Patient’s Diagnosis _______________________________________________________

Primary Physician ________________________ Clinic/Hospital ________________________

Rehabilitation Physician (if applicable) ________________________ Clinic/Hospital: ______________________

Therapist(s) ____________________________________________________________

Therapist(s) ____________________________________________________________

### Photo

You’re welcome to send a photograph of the individual or family receiving GABR funds with the application or by email to foundation@sanfordhealth.org. The photo may be used in marketing materials to help encourage people to fundraise for the Great American Bike Race and help other children like yours.
Required Documentation

Annually in August or First Time GABR Applicants

- Previous year’s tax statement
- Copy of insurance card(s)

Please mark which items you need and submit the respective items with this application.

- **Travel** — Mileage will be reimbursed at $0.19 per mile from destination to destination. Hotel per diem will be capped at $100 per night. Meals will be reimbursed at a maximum of $50 per day. *(alcohol is not reimbursable)*
  - Proof of appointment
  - Meal/hotel receipts
  - Spreadsheet (attached)

- **Equipment requests/assistive technology** — GABR has pricing agreements (MSRP – 20%) with the following vendors: Sanford Health Care Accessories, Great Plains Rehabilitation Services and NuMotion. If you choose to use an alternative durable medical equipment vendor it is the responsibility of the applicant to ensure the selected vendor honors this pricing requirement in the quote provided to GABR. If this requirement is not met GABR will reimburse for equipment requests up to 80% of MSRP.
  - Letter of support from a therapist or prescription from a physician
  - Invoice
  - EOB, Insurance Denial Letter or non-covered item list from insurance policy

Please make check payable to: ____________________________________________

*If self, proof of payment must be submitted.

- **Rehabilitation Therapies (PT/OT/ST)/Additional or Alternative Therapies/Independent Exercise Programs/Prescriptions/Other Medical Supplies**
  - Letter of support from physician/therapist within each area of practice (PT/OT/ST)
  - One therapist note per year for individuals participating in self-pay independent services explaining need for the independent services (i.e.. hydrotherapy, massage therapy, etc.)
  - EOB or Insurance Denial Letter

Please make check payable to: ____________________________________________

*If self, proof of payment must be submitted.

- **Home Renovation** — Rental properties and facility owned properties are not eligible; $10,000 maximum per five-year period
  - Provide two estimates on business letterhead
  - Letter of support from physician/therapist

Please make check payable to: ____________________________________________

*If self, proof of payment must be submitted.

- **Vehicle Modification/Purchase** — Consideration will be given for vehicles modified for accessibility (ex. lifts, ramps, loading devices, tie downs, etc.); $10,000 maximum per five-year period
  - Provide two estimates on business letterhead
  - Letter of support from physician/therapist

Please make check payable to: ____________________________________________

*If self, proof of payment must be submitted.
<table>
<thead>
<tr>
<th>Date</th>
<th>City of Origin</th>
<th>City of Destination</th>
<th>Mileage ($0.19/mile)</th>
<th>Meals ($50 max. per day)</th>
<th>Hotel ($100 max. per night)</th>
<th>Total (include receipts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 5-6, 2017</td>
<td>Bismarck</td>
<td>Rochester</td>
<td>$194.56</td>
<td>$50.00</td>
<td>$100.00</td>
<td>$150.00</td>
</tr>
<tr>
<td>Jan 6-7, 2017</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Authorization for Disclosure of Medical Information
(please write the applicant name at the top and sign your name at the bottom)

Applicant name: 

Address: N/A Birthdate: N/A SSN: N/A

I authorize Sanford Health to release to: Great American Bike Race Disbursement Committee

Sanford Health

Information to be disclosed:
- Medical information including location of services, diagnosis
- Eligibility information including county of residence, financial eligibility, age of applicant

Purpose of request:
- To assist with GABR application, including services for travel, equipment/technology, therapy, home renovation, vehicle modification

Dates of Service:

___Clinical Resume ___Final Autopsy Report
__History & Physical ___Lab Report
__Consultation Report ___X-Ray Report
__Operative Report ___EKG Report
Pathology Report ___Emergency Dept.

X. Other: Verbal discussion pertinent to GABR application

**All records pertaining to psychotherapy/mental health, chemical dependency, HIV/AIDS related illness and testing will not be released unless specifically authorized below in writing.

I specifically authorize the disclosure of the following records:

N/A Psychotherapy/ Mental Health (signature) _________________ Date __________________

N/A Chemical dependency (signature) __________________________ Date __________________

N/A HIV/AIDS related illness/testing (signature) _____________________ Date __________________

This information is required for the following purpose:

___ Diagnosis and treatment ___ Legal ___ Personal ___ Insurance / Billing

___ Military ___ Other: Consideration for GABR funds

Your rights with respect to this authorization:

1. This authorization will remain effective until the following date, event or condition: If there is no date, event or condition, it will remain effective for 1 year and will automatically expire without my express revocation. I understand that I can revoke this authorization at any time upon written request. Any information released prior to my written revocation of this authorization will not be a breach of confidentiality.

2. I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed under this authorization.

3. I understand that if I sign this authorization, I have a right to receive a copy of it.

4. I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature. Medical treatment to the patient is not conditioned on the signing or failure to sign this form.

5. I understand that if the individual or organization that receives this information is not a healthcare provider or health plan covered by the federal privacy regulations, the information released to the above may be redisclosed and is no longer protected by these federal regulations.

Signature of Applicant: ___________________________ Date: ___________________________

Witness: ___________________________ Date: ___________________________

If signed by person other than patient, specify reason patient is unable to sign: ___________________________

Legal authority: ___ Legal guardian ___ Parent of minor ___ Next of kin ___ Power of attorney for health care
Permission to Use Your Information or Image for Promotional Purposes

Information about you and your health is personal. Sanford is committed to protecting the privacy of your information. When Sanford wants to share your information for the public to see or hear, we must ask for your written permission (authorization). If you let us share your private information, you can ask how it will be used. You can also ask to stop an interview, recording, film or photo session at any time. People will likely recognize you in a promotion or interview, so please read this form carefully and ask any questions you have before signing.

I give permission for Sanford Health, Sanford Marketing and Media Relations, and the Sanford Health Foundation or their representatives to use and share my health information for:

☒ Sanford promotional purposes through written, video, internet or any other means of publication
☒ Local and national media interviews or stories
☒ Learning/Educational purposes

Information about me to be used or shared includes:

☒ My appearance in photographs, videos, audios or any other image

Information about me gathered by Sanford staff or news reporters through interviews with me, my physicians or any others involved in my care. This information may include my name and my health condition(s) related to the Sanford promotion or media interview.

The information described above becomes Sanford’s property or the property of the news media. Once your information is shared, it is no longer protected under federal and state privacy laws and may be re-disclosed or re-published by others in the future. Information published on the internet is available to anyone in the world and may be accessed, reproduced or downloaded at any time. Sanford will not receive payment of any kind for the use of your information. This permission does not include any promise to pay you.

Signing or refusing to sign this authorization will not affect your care at Sanford in any way. After you sign, you may change your mind at any time unless the information has already been used or shared. Please contact Sanford Marketing at 605-312-4300 if you change your mind and do not want your information to be used for new or future stories and promotions. This authorization will expire on ____________, or five years from the date of signature if no date is entered.

Are you a current or former patient of Sanford Health? ☒ Yes ☐ No

Patient Name (Please Print) __________________________

☒ Signature of Patient or Personal Representative

Date of Birth __________________________

Date __________________________ Time __________________________

Name of Personal Representative (if applicable) __________________________

Relationship to Patient __________________________

Witness/Organization Representative __________________________

Comments: __________________________

Distribution: Page 1 - Marketing; Page 2 - Patient