Request for Financial Assistance Application

OUR MISSION

For the Children, Inc. is a non-profit organization whose mission is to provide financial assistance to families with children in need of medical treatment outside the Flathead Valley. We do not provide funding for medical treatment; rather we provide financial assistance for travel expenses to the treatment facilities.

All funding comes from private donations raised at our annual fundraiser, the Whitefish Winter Classic. We strive to make sure our donations are utilized effectively and appropriately. We appreciate your understanding as you fill out the application.

WHO CAN APPLY

To be eligible for funding, you and your child must meet the following requirements:

- Child is 18 years old or younger.
- Family resides in Northwest Montana (Flathead, Lincoln, and Lake County)
- Child custody is parent(s) or the legal guardian(s).
- Treatment outside the area must be prescribed by a licensed physician. (Verification from your doctor may be requested.)
- No other financial resources are available for family. (Proof of family income may be requested.)
- Total household income not to exceed income guidelines using Healthy Montana Kids Income Chart. Please refer to table below:

Household Size (Children and Adults)	Annual Gross Household Income
Family of 2	$38,775
Family of 3	$48,825
Family of 4	$58,875
Family of 5	$68,925
Family of 6	$78,975
Family of 7	$89,025
Family of 8	$99,075

APPLICATION DIRECTIONS

Please fill out the application and consent form. Once completed, you can mail the form to: For the Children, Inc. P.O. Box 21, Whitefish, MT 59937. Please note that all areas must be filled out in order to be reviewed.

Your application will be reviewed by a committee. The committee meets on a monthly basis. You should receive a response by mail within 30 days of applying.

We provide financial assistance on a reimbursement basis based on receipts from your travel to your child's medical treatment facility. **If you are approved, you must provide us receipts for your travel expenses in order to be compensated. The dates on these receipts must match the days your child was in treatment.** We compensate up to 3 visits and/or $2,000 per child within his/her lifetime (to include all expenses).

PLEASE NOTE:

- We DO NOT pay for medical expenses. Travel expenses only which is limited to transportation, lodging, and meals.
- If your child is on Medicaid, we will only compensate for those expenses beyond what Medicaid will reimburse. Please do not request reimbursement for expenses covered under Medicaid. Failure to comply with this will result in a loss of current financial assistance and denial of future applications.
- For the Children, Inc. has the right to refuse financial assistance at anytime.

PROCESS

After your application is approved, you will be responsible for providing necessary documentation to obtain reimbursement for travel expenses for your child's travel to a treatment facility. You will need to submit the following after your travel:

1) A copy of all receipts and the total expenses for one adult and one child you are requesting for reimbursement. Bank and/or credit card statements will not be accepted.
2) Financial assistance is based on standards guidelines that coincide with national per diem rates. In providing estimates for travel, please note the following:
   a. Transportation is based on car mileage to treatment city regardless of form of travel. For example, we will provide reimbursement for car mileage to Seattle even though travel was done by train. You will be responsible for the difference.
   b. Lodging is based on average rates for the treatment city. However, we are aware of many hotels that provide deep discounts for those seeking medical treatment. We will request that you stay at one of these locations. If you decide not to stay at a discounted location, we will only pay the rate of discounted location. You will be responsible for the difference.
   c. Meals are based on a per diem rate. We provide financial assistance only for one adult and the child who is in need of medical care. Any child age 12 and under will receive half the adult per diem rate.
3) Please note that the following items will not be reimbursed:
   a. Alcohol or Tobacco products.
   b. Junk Food – potato chips (including Doritos, Cheetos, etc.), candy, chocolate, liters of soda, high energy drinks, etc. A soft drink from a restaurant is acceptable.
   c. Toiletries, diapers, and other incidentals.
4) Request for Reimbursement Form – complete this form and attach all receipts to the back of the form. You will be expected to deduct any costs that are not approved for reimbursement. Failure to turn in receipts will result in loss of current financial assistance as well as any future requests.
5) Sign the form to verify that travel has occurred for medical treatment reasons and that you have not received other funding for these expenses. Completed forms are to be mailed to For the Children, Inc. P.O. Box 21, Whitefish, MT 59937. You should receive reimbursement within 30 days of mailing.

For more information or help with the application process, please contact us at (406) 862-8146.

FOR THE CHILDREN, INC.
FINANCIAL ASSISTANCE APPLICATION

Name of Child Needing Treatment:__________________________ DOB:___/___/____ Age_____

Name of Parent(s):__________________________________ Are you the legal guardian?____

Address:____ City:__________________________

State:_______ Zip Code:_____________________ Phone:______________________________

Please identify the medical condition and a brief description of medical treatment needed:

____

____

Is this treatment prescribed by a physician?_______

Name of physician:_________________________________ Phone:________________________

Please provide the name of the treatment facility, location, and attending physician of where your child will receive medical care: (Ex. Deaconess Hospital, Spokane WA, Dr. Smith)

____

Dates of medical treatment:____________ Number of trips needed to treatment facility:_______

Please check the types of travel expenses you will be requesting for reimbursement:
(Check all that apply)
□ Transportation If yes, please indicate type: □ Car □ Train □ Airline
□ Lodging □ Meals

Please estimate the total amount of reimbursement requested: $______________
*This must be filled in to complete your application.

Is your child covered under private insurance/Healthy MT Kids/ Medicaid?______
Name of Insurance:____________________
(Medicaid will reimburse for some transportation costs. For more info, call Medicaid Transportation 1-800-292-7114)

Have you received or applied for other financial assistance your child's treatment costs?_____

Has child or any other family member received funding from For the Children, Inc. before?_____
If so, please list the amount and date received:____

Please list how many people living in your household and ages of each person:

____

Annual Household Income:$____________________
(You may be requested to provide verification of employment and income for application approval.)

Place of Employment Per Person:____

Please list other sources of income such as Child Support, SSI, and Disability:

____

Do you have other resources to assist your child during this difficult time, such as church, extended family members, etc.?____

PLEASE FILL OUT THE CONSENTS BELOW TO COMPLETE YOUR APPLICATION

Verification of Information

I, __________________________, hereby state that the above information is correct and that there are no other sources of funding for the expenses for which I am requesting reimbursement. In addition, I agree to abide by all guidelines as required by For the Children, Inc. to receive financial assistance. I understand that failure to do so may result in my forfeit to obtain funding.

______________________________ ____________________
Signature of Applicant **Date**

Release of Medical and Insurance Record

I authorize the release of medical and insurance record to For the Children, Inc. for the purpose of certification of need. This release expires within one year of authorization.

______________________________ ____________________
Signature of Parent/Legal Guardian **Date**

Consent for Testimonial

Whitefish Winter Classic is the annual fundraiser for our organization. Many times, there is a need to have testimonials from our recipients to help market our mission. If you are willing to participate in helping us by providing a testimonial, please check the box below.

□ **Yes, please contact me to provide a testimonial for the Whitefish Winter Classic.**

Please send application and consent form to:
For the Children, Inc.
PO Box 21
Whitefish, MT 59937

COMMITTEE USE ONLY

□ APPROVED ($______________) □ SPECIAL CONSIDERATION ____

□ DECLINED
Reason____