Childhood Diabetes Expense Relief Fund
Application for Financial Assistance

"This is my commandment, that you love one another as I have loved you…" **John 15:12**

If you are in need of financial assistance, please fill out the form below.

What does CDERF supply financial assistance for?

- Insulin
- Diabetes Testing Supplies
- CGM and Insulin pumps
- Doctor Visit Expenses
- Hospitalization Expenses
- Other – As approved by board of directors

The person requesting assistance on behalf of an eligible child must be a parent or legal guardian of the child.

Eligibility Checklist:

- ❑ **Child must be diagnosed with Type 1 Diabetes. Assistance for Type 2 diabetics is not available at this time.**
- ❑ **Child must be age 18 or under.**
- ❑ **Child must have a valid insurance policy**
- ❑ **Child must be a citizen of the United States or reside in the United States with an I-551(Green Card).**
- ❑ **Documented proof that patient's household income is at or below 200% of the current federal poverty guidelines (see page 5). This can include documents such as:**
  - **a. W-2 withholding statements**
  - **b. Pay check stubs**
  - **c. Income tax return**
  - **d. Forms from employers or welfare agencies.**
- ❑ **You(parent/legal guardian) must be able to prove there is a valid need for financial assistance.** ***Examples include: Past due invoices/statements, bank statements, catastrophic situations, and any other documents that show that the family would be unable to pay this medical need and still provide for necessary expenses.***
- ❑ **Copy of monthly rent/mortgage statement**
- ❑ **Copy monthly utility bills (Ex: gas, water, electricity etc.)**

******* CDERF does not provide financial assistance in the form of cash or check directly to the recipient. We will make payments directly to the pharmacist, hospital, doctor or diabetic supply company of the qualified applicant. We do not pay deductibles. *******

Anti-Discrimination Policy:

You and your child will not be discriminated against or denied assistance because of your race, religion, color, national origin, gender or political affiliation. All financial applications will be reviewed on a case-by-case basis and final determination will be made based upon your eligibility, CDERF guidelines and the availability of funds.

Please PRINT in black or dark blue ink and complete ALL sections accurately

Child/Patient Info – Must be completed

Patient Name (first, middle, last): _____ ❑ Male ❑ Female

Street Address: _____ City: _____ State: _____

Zip Code: _____ Email(if applicable): _____

Child's Date of Birth(mm/dd/yyyy): _____/_____/_____

Parent/Guardian Information – Must be completed

Parent/Guardian Name(s): _____

Home Phone #: (_____)_____-_____ Cell Phone #: (_____)_____-_____

Best way to contact parent/guardian (check only one) ❑ Home Phone ❑ Cell Phone

Email: _____

Can CDERF email updates to you regarding upcoming events and happenings?

Is address same as patient's? ❑ Yes ❑ No If no, Address: _____

City/State/Zip: _____

Marital status Parent/Guardian: ❑ Single ❑ Married ❑ Divorced ❑ Cohabitants ❑ Widowed ❑ Separated ❑ Other_____

If divorced, who is the custodial parent/guardian of the patient/child? _____

Does parent/guardian speak English? ❑ Yes ❑ No If no, primary language? _____

Medical Information – Must be completed

A letter from the child's doctor, endocrinologist, nurse or social worker explaining the child's diagnosis, T1D treatment plan and any other information that you feel is important is required along with this section.

Referring Doctor/Endocrinologist/Hospital: _____

Social worker(if applicable): _____ SW Phone #: (_____)_____-_____

Date of Diagnosis (mm/dd/yyyy): _____/_____/_____

Pharmacy Used: _____ Pharmacist Name(if known):_____

Pharmacy Phone: _____

Upon completion, please fax this application to (337) 443-4766 or e-mail to assistance@cderf.org.
Questions? Call 337-329-1372

Patient Name _____

Household Income

Total Annual Family Income $_____

Family Income Sources (please check all that apply):
❑ **Salary** ❑ **SSI** ❑ **Child Support** ❑ **TANF** ❑ **Other**

If Other, explain: _____

Parent/Guardian's Employer_____
Is Parent/Guardian on unpaid leave? ❑ **Yes** ❑ **No**

Parent/Guardian's Employer_____
Is Parent/Guardian on unpaid leave? ❑ **Yes** ❑ **No**

Banking

❑ **Check here if family does not have a bank account**

Please list your checking/savings and other easily accessible accounts in the space provided. Include any fund-raising accounts that have been established on behalf of your child. *Copies of your most recent statements for all accounts below must be included.*

Bank Name	**Account Type**	**Account Number (Last 4 digits)**
Ex.: Bank of America	*Checking*	*4321*

Insurance and Assistance Information

Does patient have health insurance? ❑ **Yes** ❑ **No**
If yes, please indicate what type of insurance (check all that apply):
❑ **Private** ❑ **Medicaid** ❑ **Medicare** ❑ **Other**

If Other, explain: _____

What type of assistance is needed (check all that apply)?
❑ Insulin
❑ Diabetes Testing Supplies
❑ CGM and Insulin pumps
❑ Doctor Visit Expenses
❑ Hospitalization Expenses
❑ Other, Specify: _____

Please provide details of the need such as RX number and pharmacy, copy of bill/invoice from doctor/hospital, CGM or pump company bill/invoice, total monetary amount being requested etc. Please attach copies of any of the above. Patient name must be included:

_____
_____
_____
_____
_____

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Patient Name _____

Does insurance provide coverage for assistance being requested? ❑ Yes ❑ No
If Yes, how much coverage is provided? Also, list deductible amounts and deductibles paid year to date:

_____
_____
_____
_____

Funding Procedures

1. **A case manager will contact you by phone once the application has been received and processed by CDERF to determine how we can best assist you.**
2. **Funding will be provided directly to the pharmacy, doctor, hospital or diabetic supply company. No funds will be given direct to patients or their guardian(s).**

Consent to Release Information and Affirmation

I do hereby authorize all hospitals, financial institutions, pharmacies and insurance groups to release to the CDERF, or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance. I further authorize the CDERF and its representatives to provide such information to those institutions as may be reasonably required to assist our family and our child. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

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

1. **The undersigned are the parents or guardians of the child.**
2. **Financial assistance will be provided with the use of said funds to be specified by CDERF.**
3. **The undersigned acknowledges and agree(s) to maintain records that will be made available to the CDERF upon reasonable request, detailing the expenditures made from the funds provided by the organization.**

The CDERF will pursue restitution for grants if it is determined that the information submitted on this application is false. I have read the guidelines for financial assistance and the eligibility checklist and I declare that the information furnished on this application form, included attached sheets, is true and correct to the best of my knowledge.

Furthermore, the undersigned does hereby give continuing consent to CDERF to use images of any and all kinds of my child, myself and our names, so long as they are only used on behalf of CDERF. I may void consent by scratching out this provision and initialing it.

Dated this _____day of_____, in the year_____

_____
Parent/Guardian Signature

_____
Please Print Name
Relationship to the patient/child:
❑ **Mother** ❑ **Father** ❑ **Self** ❑ **Grandparent**
❑ **Other**_____

_____
Parent/Guardian Signature

_____
Please Print Name
Relationship to the patient/child:
❑ **Mother** ❑ **Father** ❑ **Self** ❑ **Grandparent**
❑ **Other**_____

Witness: _____ *Necessary if the above signed are not parents/guardians
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Below is the Federal Poverty Guidelines chart.

Applicant's household income may not exceed the 200% threshold.

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$11,770	$15,654	$17,655	$23,540	$29,425	$35,310	$47,080
2	15,930	21,187	23,895	31,860	39,825	47,790	63,720
3	20,090	26,720	30,135	40,180	50,225	60,270	80,360
4	24,250	32,253	36,375	48,500	60,625	72,750	97,000
5	28,410	37,785	42,615	56,820	71,025	85,230	113,640
6	32,570	43,318	48,855	65,140	81,425	97,710	130,280
7	36,730	48,851	55,095	73,460	91,825	110,190	146,920
8	40,890	54,384	61,335	81,780	102,225	122,670	163,560