SPRING LAKE HOPE FOUNDATION

A NEW JERSEY NONPROFIT AND 501C3 CORPORATION

Our united mission is devoted to aiding families, organizing essential resources, creating awareness, advocating, and providing economic support to meet their child's medical/and medical related expenses. We are performance-driven through the lens of humanity.

GENERAL GUIDELINES.

- Children under the age of 18
- Reside in the State of New Jersey, New York, Connecticut or Pennsylvania
- Diagnosed with a life-limiting condition or life-threatening illness (includes mental illness and special needs).
- Please submit at least one medical bill/ or specific medical-related request accompanying this application.
- Please have basic insurance and income/expense information available before beginning the application process.

COVERED EXPENSES INCLUDING, BUT NOT LIMITED TO

- Surgeries not covered by insurance
- In-network and out-of-network deductibles
- Most therapies including physical, occupational, stem cell and more
- Durable medical equipment
- Adaptive Equipment
- Home and/or hospice care
- Handicap Vans
- Home modifications and more!

ALL DISBURSEMENTS WILL BE MADE DIRECTLY TO THE VENDOR, NEVER TO THE PATIENT.

IMPORTANT: We reserve the right to post a photo of the child, along with his/her first name, age and town on social media platforms and/or our website. If you disagree with photo, name, age and/or town, please email us to let us know.

Please email questions to: **info@springlakehope.org**

Please email or mail this application with medical bills, insurance declination letter (if applicable) and photo of child to: **info@springlakehope.org** OR mail to: **Sping Lake Hope Foundation 852 Franklin Ave, #115, Franklin Lakes, NJ 07417**

852 Franklin Avenue, Suite 115, Franklin Lakes, NJ 07417
email: info@springlakehope.org
website: www.springlakehopefoundation.org

spring lake HOPE FOUNDATION | A lil' miracle goes a long way.

CONSENT FORM

Due to patient confidentiality, we are unable to discuss any aspect of a patient's medical file with anybody other than the patient, without express consent, with the exception of someone holding a Power of Attorney, or the parent of somebody aged 15 or younger.

If you would like to consent for someone else to be able to discuss your medical records/bills with hospitals, doctor offices, clinics, insurance companies, etc., please indicate this on the form below.

Patient Name: _____ DOB: _____

I hereby give permission for Spring Lake Hope Foundation to discuss my medical records with the following people **(Please check all that apply) .**

Hospital Clinic: ☐ Insurance Company: ☐ Doctor Office: ☐
Other: ☐

Please Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Spring Lake Hope Foundation has already acted based on your permission. If you would like to revoke your authorization, please send a written request to Spring Lake Hope Foundation. This authorization remains in effect indefinitely, unless otherwise revoked in writing.

Name: _____ Date: _____

Relationship to Patient: _____

852 Franklin Avenue, Suite 115, Franklin Lakes, NJ 07417
email: info@springlakehope.org **website:** www.springlakehopefoundation.org

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APPLICATION

PATIENT INFORMATION **TODAY'S DATE:**

Patient First and Last Name:

Is the patient a U.S. Citizen? Yes ☐ No ☐

Please check one: White: ☐ Hispanic/Latino: ☐ Black or African American: ☐ Asian: ☐

Native Islander or Alaskan Native: ☐ Prefer not to answer: ☐

Age: Date of Birth:

Name of Person completing this form:

Parent or Caregiver First and Last Name(s):

Home Phone Number: Cell Phone number:

Mailing Address: City: State: Zip code:

Email Address:

Diagnosis of Patient: Date of Diagnosis:

Number of Dependents:

Siblings names and ages:

List all adults living in the household and places of employment:

Does the patient have insurance? Yes ☐ No ☐

If yes, who is the provider?

Approximate Annual Income (please check one) ☐ Under $25,000 ☐ $25,000-$75,000 ☐ $75,000-$100,000 ☐ $100,000-$150,000 ☐ $150,000 and above

How did the Patient's Family learn of Spring Lake Hope Foundation?

If applicable, what other organization is the family applying for financial assistance?

HOSPITAL INFORMATION

Please list the hospital or doctor most involved with the child's care in relation to the expense you would like us to fund.

Hospital Name: City: State: Zip:

Doctor First and Last Name:

Diagnosed by:

HOME CARE INFORMATION

Home Care Agency Name (if applicable):

City, State, Zip:

AMOUNT OF REQUEST:

INSURANCE INFORMATION

Did you try to submit the claim(s) through insurance?

Member name:

Insurance name:

Insurance ID and Group number:

Patient advocates assist patients and their loved ones in navigating the health care system in various ways, including communicating with physicians, negotiating with insurance companies, and discussing claims and balances on behalf of the patient as your advocate contributes to numerous aspects of a patient's medical care to make it a little less complicated.

By signing below, I authorize Spring Lake Hope Foundation to disclose personal health and financial information to the affiliated companies to help with outstanding bills. You have the right to revoke your authorization at any time, in writing, except to the extent that Spring Lake Hope Foundation has already acted based on your permission. This authorization remains in effect indefinitely unless otherwise revoked in writing.

_____
Patient's name

_____ _____
Patient's Guardian name Date

_____
Patient / Guardian signature

ADDITIONAL INFORMATION

In the space below please provide any additional information related to the family situation that might be helpful with making the decision.

SIGNATURES

By signing this application, I agree to the following:

I am authorized to submit this application on behalf of the patient and family. All information on this form is true to the best of my knowledge.

Parent's Printed Name: Date:

Parent's Signature:

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