Helping Challenged Children, Inc.
Guidelines for Financial Assistance

The following are guidelines to be considered when submitting an application to Helping Challenged Children, Inc. ("HCCI"). Availability of funds, cooperation and adherence to these guidelines will increase the likelihood that HCCI will be able to assist.

Nominations must be prepared and submitted by a third party health care professional (i.e. doctor, nurse, physical therapist, social worker) who has verified the diagnosis and recommended need.

1. Recipients **must** be 18 years of age or younger.
2. The gift is to be individual in nature and for the benefit of the child for whom the request is made. For example, requests for a new TV or air conditioner for the benefit of the family or carpeting of a building or clinic will be rejected.
3. The gift **must** enhance the quality of life for the child. Some examples of gifts previously provided, in whole or in part, include the following:

Wheel Chairs	Leg Braces	Nebulizer
Communication Devices	Hearing Aids	Orthopedic Shoes
Insulin Pumps	Digital Blood Pressure Cuff	Learning Devices
Adaptive Tricycles	Therapy Equipment	Walkers

4. There should be **no** insurance or other outside assistance available for the requested item(s). If there are state funds or insurance available, please use this financial support so our focus can remain on children whose family resources are stretched. (Another Example: If the request falls within the guidelines of "Make a Wish", please contact that organization). If additional funds are needed to supplement funding from insurance, state, etc, HCCI will consider the request for the uncovered portion.
5. Most gifts are in the range of $50.00 to $750.00. HCCI is more inclined to provide smaller gifts that are complete in nature rather than contribute toward a higher cost item. This should **not** discourage requests greater than $750.00; however in some cases, HCCI has encouraged the applicant to look for supplemental funding whereby HCCI and another organization can both contribute to the gift. HCCI is looking to benefit as many children as possible.
6. All requests **must** be made using the HCCI Application form attached. All sections of the application **must** be completed thoroughly and accurately in order for the organization to review the request. ***Failure to provide complete and truthful information is a basis for denial.***
7. HCCI reserves the right to examine the financial condition of any family to verify need.
8. Funds or payments will **only** be submitted directly to the supplier of the requested item(s), **not** the recipient.
9. If this application is approved, do you give permission for HCCI to use photographs, audio tape recording, letters, or video tape of the applicant to use in publications, voice recordings, slides, videotapes or on the internet?

   ☐ Yes ☐ No

   I understand they will be used to only inform families, volunteers, the media and general public about HCCI programs, services or events.

After you complete the application, e-mail it to: info@helpingchallengedchildren.org

Or Mail to: Helping Challenged Children, Inc., P.O. Box 4264, Carmel, IN 46082

www.helpingchallengedchildren.org

Helping Challenged Children, Inc.
Application: *Page One*

Patient Information (*Please PRINT and complete all sections accurately.)*

Patient's Name (first, middle, last): _____

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

Patient's Address: _____

City/State/Zip: _____

Parent's/Guardian's Name(s): _____

Permanent Phone # : _____ Mobile Phone # : _____

Email : _____

Is address same as Patient's? ☐ Yes ☐ No If No, Address: _____

City/State/Zip: _____

How did you hear about Helping Challenged Children, Inc.? ☐ Health Care Professional ☐ Friend

☐ Other (Please Specify) _____

Medical Information (*This section must be completed by a Health Care Professional (nurse, doctor, therapist, etc.))*

Date Application Submitted (mm/dd/yyyy): _____

Health Care Professional (First & Last Name): _____

Occupation: _____

Mailing Address: _____ Dept: _____

City/State/Zip: _____

Phone #: _____ Mobile Phone #: _____

Email: _____

Diagnosis: _____

_____

_____

_____

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

Application: ***Page Two***

Request for Assistance with Medical Expenses (*For device/equipment denied by insurance or other outside assistance.)*

An applicant may be eligible for assistance when requests for medical expenses have been denied by insurance or other outside assistance. **HCCI does not assist with expenses already incurred, co-pays or deductibles.**

Please provide detail for the item(s) requested.

Item Description (Include Item Specific Model # & Color): _____

_____

Recommended* Supplier: _____

Supplier Address: _____

Contact #: _____

Ship To Address: _____

Price: _____

**H.C.C.I. may select a preferred supplier*

Item Description (Include Item Specific Model # & Color): _____

_____

Recommended* Supplier: _____

Supplier Address: _____

Contact #: _____

Ship To Address: _____

Price: _____

**H.C.C.I. may select a preferred supplier*

Total Cost _____

How will the item(s) listed assist or provide support to the child? _____

_____

_____

_____

_____

Application: *Page Three*

Insurance Information

Is the patient covered by private insurance? ☐ Yes ☐ No

Is the patient covered by a state funded insurance plan (i.e. Medicaid)? ☐ Yes ☐ No

What is the name of the plan? _____

What is the percentage of coverage?_____

Has the family completed an application for Medicaid? ☐ Yes ☐ No

Describe the family's financial situation. **Also, please provide all documentation verifying that a request, for the requested item(s), has been previously denied by the family's insurance provider**.

(*This section must be completed by a Health Care Professional (nurse, doctor, therapist, etc.))*

_____

_____

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HCCI Office Use Only

Date Application Received: _____

Application Approved? Yes ☐ No ☐

If No, basis for denial: _____

_____

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_____

Date Invoice Received: _____

Date Invoice Paid: _____

Check #: _____