Hawaii Children's Cancer Foundation

Financial Assistance Program Guidelines

(Revised February 2020)

Section A

Hawaii Children's Cancer Foundation (HCCF) is a 501(c)(3) non-profit organization that serves to assist, support, and advocate for the needs of Hawaii children diagnosed with cancer.

HCCF understands that having a child in cancer treatment can be extremely stressful in many ways. The Financial Assistance Program is designed to relieve some of the financial stress associated with having a child in cancer treatment. This program is funded through private donations within the community and is managed by HCCF's Financial Assistance Committee (FAC) under the supervision of HCCF's Board of Directors.

These guidelines describe the specific process through which eligible families may apply for financial assistance from HCCF, and the types of expenses that will be considered by the FAC for reimbursement.

The gathering of this information also assists HCCF in writing grant proposals that fund the mission.

Program Eligibility

Persons eligible to apply for assistance must be:

1. A Child receiving cancer treatment in Hawaii, regardless of domicile; or
2. A Child domiciled in Hawaii receiving cancer-related treatment out-of-state; or
3. Parents or legal guardians of a Child described in 1 or 2 above.

For eligibility purposes, a Child is defined as a person who is diagnosed with any form of cancer through the 21st year of age or a person up to 25 years of age diagnosed with a pediatric cancer as determined by a treating oncologist.

**All applications will be considered without regard of race, color, sex, sexual orientation, or national origin.

Eligibility Period and Assistance Limits

1. The Eligibility Period begins on the date of initial cancer diagnosis and ends at 24 months post Active Treatment, or death of the Child if sooner. Funeral expenses incurred and submitted within 90 days of death are deemed to have been incurred during the Eligibility Period.

2. Category I: Active Treatment
   - **a.** Active Treatment includes oncology treatment and/or end-of-life care confirmed by the health care provider
   - **b.** First 12 months after initial cancer diagnosis, relapse, ortransplant: $4,000 limit
   - **c.** Subsequent years of treatment: $2,000 limit per year
   - **d.** Total assistance is limited to $4,000 per 12-month period

3. Category II: Off Therapy
   - **a.** Up to 24 months post Active Treatment: $1,000 per 12-monthperiod

4. Funeral Expenses
   - **a.** Payable to mortuary or funeral home for up to $2000

How to Apply for Assistance

1. Complete and submit the following to enroll in the Financial Assistance Program:
   - **a.** Financial Assistance Application Form – signed by treating medical professional and primary family contact.
   - **b.** Authorization to Release Information Form – signed andwitnessed

2. Complete and submit Financial Assistance Request Form(s) along with corresponding receipts to HCCF no later than 90 days after the end of the Eligibility Period, for expenses incurred during the Eligibility Period.

3. Please be patient while assistance requests are being reviewed, approved, and processed. HCCF will not be responsible for meeting deadlines for bill payment or reimbursements.

What Expenses Are Considered for Assistance?

The intended purpose of this program is to relieve some of the financial stress associated with having a child in cancer treatment. HCCF strives to help families cover expenses that are incurred due to cancer treatment and/or to help pay for basic necessities that families struggle to meet due to income disruption related to having a child in cancer treatment.

The following are examples of expenses that are considered for reimbursement under HCCF financial assistance program guidelines:

A. Expenses incurred as a result of having a child in cancer treatment

1. Cancer-related medical expenses not covered by insurance;
2. Travel expenses directly related to cancer treatment (airfare, ground transportation & lodging);
3. Tutoring/counseling and other education expenses during cancer treatment;
4. Childcare for siblings during cancer treatment;
5. Transportation expenses incurred during cancer treatment (Uber, Lyft, taxis, rentals & gas, car payments & repairs);
6. Meals consumed in the hospital during cancer treatment, or
7. Funeral expenses (direct payment to mortuary only).

B. Basic necessities affected by treatment-related income disruption

1. Rent or mortgage payments to prevent eviction or foreclosure of primary residence during cancer treatment;
2. Essential utility bills such as water, electricity, gas, or cell phone – to prevent shutoff of services during cancer treatment.

Specific exclusions from financial assistance

- Recreational drugs, tobacco, electronic cigarettes, or alcoholic beverages;
- Clothing;
- Restaurant or grocery expenses;
- Legal fees of any kind;
- Rental security deposits; or
- Expenses that have been or intended to be submitted for reimbursement by any other source including public or private agencies or flexible spending plans.

Exceptions and Appeals

- HCCF resources are limited. Any and all financial assistance requests may be subject to budgetary restrictions.
- The FAC reserves the right to deny financial assistance requests that it considers to be unreasonable.
- The FAC may, in its discretion, consider exceptions to the above guidelines based upon review of a signed letter of request attesting to circumstances warranting special consideration.

Hawaii Children's Cancer Foundation

1814 Liliha Street Honolulu, Hawaii 96817
Direct Line: 528-5161 ● Fax: 521-4689
Toll-Free: 1-866-443-HCCF (4223)
www.hccf.org / info@hccf.org

Financial Assistance Application

HCCF provides assistance intended to relieve some of the financial stress associated with having a child in cancer treatment. The Financial Assistance Program is designed to help cover expenses that are incurred due to cancer treatment and/or to help pay for basic necessities that families struggle to meet due to income disruption related to having a child in cancer treatment.

Name of the Child in Cancer Treatment:_____DOB: _____

Parent/Guardian's Name _____

Relationship to child:_____

Ethnicity:_____ Gender: _____

Primary Address: _____

Temporary Address if Away for Treatment: _____

Mobile Phone No. _____

Personal Email: _____

Employer: _____

Branch of Military Service: _____

Parent/Guardian's Name: _____

Relationship to child:_____

Ethnicity:_____ Gender: _____

Primary Address: _____

Temporary Address if Away for Treatment: _____

Personal Email: _____

Mobile Phone No. _____

Employer: _____

Branch of Military Service: _____

Marital Status: _____

Child Resides with: _____

Names of Siblings (include Foster Children)

Sibling:_____DOB:_____ M( ) F( )

Ethnicity: _____

Sibling:_____DOB:_____ M( ) F( )

Ethnicity: _____

Sibling:_____DOB:_____ M( ) F( )

Ethnicity: _____

Sibling:_____DOB:_____ M( ) F( )

Ethnicity: _____

Sibling:_____DOB:_____ M( ) F( )

Ethnicity: _____

Sibling:_____DOB:_____ M( ) F( )

Ethnicity: _____

On behalf of the family, I acknowledge receipt of HCCF's Financial Assistance Guidelines and hereby submit this application for financial assistance and wish to be included on HCCF's mailing list.

Signature of Parent or Guardian:_____ Date: _____

For Medical Professionals Only:

Diagnosis:_____ Date of Diagnosis: _____

Treatment Facility: _____

Print name of treating oncologist or medical professional: _____

Signature of treating oncologist of medical professional: _____

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Authorization to Release Information

I hereby authorize HCCF and its representatives or agents to contact my child's physician, medical institution or facility, medical insurance company or the provider of services for the bill(s)/expenses for which I am seeking reimbursement or payment in order to verify the charges incurred and to verify whether the charges are related to my child's cancer diagnosis.

I also hereby authorize:

_____

_____

_____

[Name(s) of physician, institution, or provider] to release information and records to HCCF and its representatives or agents with regard to my child as HCCF may request of said physician, institution, or provider.

Signature	Date
Print Name	Relationship to Child
Signature of Witness	Date
Print Name of Witness	

For HCCF use only:

Date received:____ Date approved:_____ Application # _____