HAWAII CHILDREN'S CANCER FOUNDATION

Financial Assistance Program Guidelines

(Revised February, 2018)

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.

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;
3. Tutoring/counseling and other education expenses during cancer treatment;
4. Child care for siblings during cancer treatment;
5. Transportation expenses incurred during cancer treatment;
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 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.

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, or transplant: $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-month period

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 and witnessed

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.

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 Child in Cancer Treatment	Child's Date of Birth
Diagnosis	Date of Diagnosis
Treatment Facility	
Signature of treating oncologist or medical professional verifying diagnosis	**Date**

Name of primary family contact	Mobile Phone No.	Relationship to Child
Mailing Address		E-Mail Address
Name of secondary family contact	Mobile Phone No.	Relationship to Child
Mailing Address (if different)		E-Mail Address

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 primary family contact	**Date**

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Financial Assistance Request Form Part I

All requests for financial assistance must be accompanied by both Part I and II of this form.

Code	Assistance Categories
	Expenses incurred as a result of having a child in cancer treatment
A1	Cancer-related medical expenses
A2	Travel expenses directly related to cancer treatment
A3	Tutoring/counseling and other education expenses for cancer child
A4	Child care for siblings during cancer treatment
A5	Transportation expenses incurred during cancer treatment
A6	Meals consumed in the hospital during cancer treatment
	Basic necessities affected by treatment-related income disruption
B1	Rent or mortgage payments to prevent eviction or foreclosure of primary residence
B2	Payment of essential utility bills to prevent shutoff during cancer treatment
B3	Other (please describe)

Code	**Description of expense** *(complete additional forms as necessary)*	**$ amount**
Total request for assistance		

Note: Corresponding receipts must be attached for all requested reimbursement items. A copy of utility bills may be provided if direct payment to provider is requested.

Please complete Part II information on the back of this form.

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Financial Assistance Request Form Part II

All requests for financial assistance must be accompanied by both Part I and II of this form.

Please describe how your family has benefitted from HCCF's programs

_____

_____

_____

_____

_____

_____

☐ Please check this box if you ***Do Not*** give HCCF permission to publicly share your name and above comments for fundraising and/or promotional purposes.

I hereby certify that the information provided in this request is true and accurate, and that no expenses listed have been or will be submitted for reimbursement by any other source including insurance, public or private agencies or flexible spending plans.

I understand that HCCF will make best efforts to process requests in a timely manner but cannot be responsible for meeting specific deadlines for bill payment or reimbursement.

_____ _____

Signature Date

_____

Print name

_____

Print name of Child

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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 # _____