

# APPLICATION FOR ASSISTANCE



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## APPLICATION REQUIREMENTS:

You must meet the following requirements before submitting an application. For more information about funding and the application process please visit [cernercharitablefoundation.org/funding](http://cernercharitablefoundation.org/funding).

- Fall within the income guidelines found at [cernercharitablefoundation.org/funding](http://cernercharitablefoundation.org/funding)
- Child is age 18 or younger (special consideration for children ages 19–21)
- Request qualifies as a valid health care need

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## SUBMITTAL CHECKLIST:

Use this checklist to help expedite your request

### Every application must have the following documentation to be processed:

Cerner Charitable Foundation must receive all required documentation before processing your application.

- Complete application with signature on Page 4
- Letter from doctor (on letterhead) that includes the child's diagnosis, history of illness, specific request for funding and other relevant information
- First page of your most recent federal income tax return or W-2  
*\*If you have not filed taxes, please submit three months of bank statements and/or a letter from your employer*
- Child's photograph (this is not a requirement)  
*\*Please see the media release on Page 4*
- Letter from parent detailing any other awards granted/fundraising completed

### If applying for treatment/services, equipment/supplies or vehicle modifications, the following documentation must be submitted:

- Evaluation from specialist (therapist, audiologist, etc. for the requested item)
- Letter from the provider on letterhead showing the original cost and price after discount (discount must be given in order to receive assistance)
- Letter of denial from the insurance company or policy showing exclusion

### If applying for travel or lodging, the following documentation must be submitted:

- Letter of medical necessity from a social worker on letterhead stating the frequency and duration of travel for the next 12 months

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## APPLICATION SUBMITTAL AND CONTACT INFORMATION:

*Application Submittal:*

**Upload:** [www.cernercharitablefoundation.org/upload](http://www.cernercharitablefoundation.org/upload)  
**Fax:** (816) 571-1569  
**Mail:** 2800 Rock Creek Parkway  
North Kansas City, MO 64117

*Contact:*

**Phone:** (816) 201-1569  
**Email:** [casegrants@cerner.com](mailto:casegrants@cerner.com)  
**Website:** [www.cernercharitablefoundation.org/funding](http://www.cernercharitablefoundation.org/funding)

Cerner Charitable Foundation reviews applications on the first Wednesday of each month. To be considered during a given month, you must submit all documentation by the last Wednesday of the previous month.

\*\*\*PLEASE COMPLETE THIS PAGE IN ITS ENTIRETY\*\*\*



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## CHILD INFORMATION

Last name \_\_\_\_\_ First name \_\_\_\_\_ Birth date (MM) \_\_\_\_ (DD) \_\_\_\_ (YYYY) \_\_\_\_

Male      Female      Country of citizenship \_\_\_\_\_

Race:  American Indian/Alaska Native    Asian    Black/African American  
 Native Hawaiian/Other Pacific Islander    Caucasian    Other

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## GUARDIAN INFORMATION

Last name \_\_\_\_\_ First name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Primary phone \_\_\_\_\_ E-mail address \_\_\_\_\_ Occupation \_\_\_\_\_

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Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Primary phone \_\_\_\_\_ E-mail address \_\_\_\_\_ Occupation \_\_\_\_\_

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## HOUSEHOLD INFORMATION

Child lives with \_\_\_\_\_ Number of guardians in household \_\_\_\_ Number of dependent children in household \_\_\_\_

Does the household speak English? Yes      No      If no, what is the primary language \_\_\_\_\_

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## FUNDING INFORMATION

Does the child have health insurance? Yes      No

Health insurance name (Private) \_\_\_\_\_ (Medicaid) \_\_\_\_\_ Annual family income (prior year) \$ \_\_\_\_\_

Last year's out-of-pocket medical expenses for the child \$ \_\_\_\_\_ Amount requested from Cerner Charitable Foundation \$ \_\_\_\_\_

Has funding been requested from additional sources? Yes      No      If yes, please list \_\_\_\_\_

If funding has been received, from whom? \_\_\_\_\_ Amount \$ \_\_\_\_\_

How did you hear about Cerner Charitable Foundation?

Family      Friend      Social worker      Health care professional      Internet      Other

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## MEDICAL INFORMATION

*(Health care professionals associated with current care)*

Physician's last name \_\_\_\_\_ First name \_\_\_\_\_ Title (DO, MD, etc.) \_\_\_\_\_

Social worker's last name \_\_\_\_\_ First name \_\_\_\_\_ Organization \_\_\_\_\_

Social worker's email address \_\_\_\_\_ Phone number \_\_\_\_\_

Child's clinical diagnosis \_\_\_\_\_ Age illness started or was diagnosed \_\_\_\_\_

Description of request \_\_\_\_\_

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**\*\*\*COMPLETE ONLY THE SECTION(S) BEING REQUESTED\*\*\***

*Minimum of one section must be completed in its entirety*

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**1. REQUEST FOR TREATMENT/SERVICES/MEDICATION**

*(Surgeries, clinic visits, procedures, therapy, medication, etc.)*

Type of treatment \_\_\_\_\_

Number of treatments/visits \_\_\_\_\_ Cost per treatment/visit \$ \_\_\_\_\_ Price after discount \$ \_\_\_\_\_

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**2. REQUEST FOR EQUIPMENT/SUPPLIES**

*(Attach additional pages listing equipment or supplies if more than one is needed)*

Type of equipment/supplies \_\_\_\_\_

Cost of equipment \$ \_\_\_\_\_ Price after discount \$ \_\_\_\_\_

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**3. REQUEST FOR LODGING**

*(Include a quote from hotel/charitable housing)*

Is charitable housing an option? Yes      No

Number of individuals \_\_\_\_\_ Number of nights \_\_\_\_\_ Type of lodging \_\_\_\_\_ Discounted cost per night \$ \_\_\_\_\_

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**4. REQUEST FOR TRAVEL**

*(Please check with Angel Flight or major airlines for assistance)*

Purpose of travel \_\_\_\_\_

Starting and ending cities/locations \_\_\_\_\_ Number of individuals \_\_\_\_ Number of round trips \_\_\_\_

Method of transportation: Car    Plane    Train    Public transportation

*(A detailed breakdown of travel needs should be included in a social worker letter. If traveling by air, a quote/itinerary must be provided.)*

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**PAYMENT INFORMATION**

**If you completed Boxes 1, 2 or 3 above, fill out the following payment information:**

Check payable to (company/provider) \_\_\_\_\_ Person at company receiving the check \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

**If you completed Box 4 above, fill out the following payment information (Cerner Charitable Foundation will mail the check to the social worker):**

Check payable to (parent/guardian) \_\_\_\_\_

Organization name \_\_\_\_\_ Attention social worker name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

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## REQUIRED—CONSENT TO RELEASE INFORMATION AND AFFIRMATION

I do hereby authorize all hospitals, financial institutions and insurance groups to release to Cerner Charitable Foundation, or its duly authorized representatives, any information deemed necessary to complete its investigation of my application for financial assistance. In addition, I do hereby authorize all hospitals, financial institutions and insurance groups to release to Cerner Charitable Foundation, or its duly authorized representatives, any information or itemized statements that pertain to the diagnosis and treatment of the child and related expenses. I further authorize Cerner Charitable Foundation 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 FOR CERNER CHARITABLE FOUNDATION, A NOT-FOR-PROFIT ORGANIZATION, TO ADVANCE SUPPLEMENTAL FAMILY SUPPORT EXPENSES IN CONJUNCTION WITH THE MEDICAL TREATMENT OF \_\_\_\_\_ (CHILD), THE UNDERSIGNED DO HEREBY AFFIRM AS FOLLOWS:**

1. The undersigned are the parents or guardians of the child.
2. The term “non-medical expenses” is understood to mean lodging, gas, parking and transportation for children who require treatment incurred by the family or guardian of the above-named child in conjunction with that child receiving medical treatment. Financial assistance will be provided with the use of said funds to be specified by Cerner Charitable Foundation.
3. The undersigned further agree(s) to return any unused funds immediately to Cerner Charitable Foundation so that those funds can be utilized by the organization to benefit other families.
4. The undersigned acknowledge(s) and agree(s) to maintain records that will be made available to Cerner Charitable Foundation upon reasonable request, detailing the expenditures made from the funds provided by the organization.

Cerner Charitable Foundation reserves the right to distribute funds at its sole discretion. Cerner Charitable Foundation may pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge. (Please refer to the checklist at the top of page one of the application and attach all required documentation prior to submitting the application.)

When awarding a grant, Cerner Charitable Foundation is not advocating for the specific health care providers or medical equipment suppliers, but only providing the funds to enable you to access the services and equipment. You acknowledge and agree that accepting a grant from Cerner Charitable Foundation is strictly voluntary. Furthermore, you agree that you will be responsible for any choices you make regarding the medical care, equipment or supplies, or for the failure, malfunction, repairs or ongoing maintenance of any equipment obtained as a result of the grant of funds.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_

Mother/guardian signature \_\_\_\_\_ Please print name \_\_\_\_\_

Father/guardian signature \_\_\_\_\_ Please print name \_\_\_\_\_

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## MEDIA RELEASE CONSENT

*\*\*\*Signing the media release form is not a requirement in order to receive assistance from Cerner Charitable Foundation\*\*\**

I hereby give my permission for Cerner Charitable Foundation and/or its representatives to use photographs, letters, email messages, audio recordings, information and/or video footage of me and/or my child in publications, presentations, websites and/or other promotional materials. I understand that this data will be used to inform families, donors, media and the general public about Cerner Charitable Foundation and its programs, services or events. I gladly give this authorization to support the efforts of Cerner Charitable Foundation. I understand this authorization shall continue until terminated in writing.

Child's name (please print) \_\_\_\_\_ DOB \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

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