The Catastrophic Illness in Children Relief Fund

When other resources end, we begin.

APPLICATION FOR ASSISTANCE

(Revised October 2016)

The information on this application is needed to determine if you are eligible for reimbursement from the Catastrophic Illness in Children Relief Fund (CICRF). It may also help us learn if you are eligible for any other programs of assistance.

Please be as complete as possible in all your answers. Give as much information as you can.

You may send us your application now and send the needed documents as you gather them, or you may send it all to us at the same time.

The more information you provide with your application, the faster we will be able to determine if you are eligible for help with your expenses.

When CICRF staff review your application, they will contact you if there is anything else that is needed.

Please contact CICRF staff if you have any questions or would like help completing this application. If you are calling from within Massachusetts, CICRF staff may be reached by calling 1-800-882-1435. To reach us from out-of-state, call 1-617-624-6060.

SEND COMPLETED APPLICATION TO:

Catastrophic Illness in Children Relief Fund
MA Department of Public Health
250 Washington Street, 5th Floor
Boston, MA 02108-4619

You should receive a letter confirming that we have received your application. If you do not receive a letter, please call us at 1-800-882-1435 or 617-624-6060.

The Catastrophic Illness in Children Relief Fund (CICRF)
Application for Assistance
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HOW DID YOU LEARN ABOUT CICRF?

☐ Dept. of Public Health (DPH) web site	☐ DPH Care Coordinator	☐ Community Case Mgmt
☐ Health Care Provider *(doctor, nurse, etc)*	☐ DPH Community Support Line	☐ Autism Support Center
☐ Hospital Social Worker	☐ Family TIES of MA	☐ Pediatric Palliative Care Network
☐ Home Health Services / VNA	☐ MA Commission for the Blind	☐ Word of Mouth *(friend, neighbor, co-worker etc.)*
☐ Dept. of Developmental Services (formerly DMR) or Contracted Agency/Vendor	☐ MA Rehabilitation Commission	☐ Other *(specify)* _____
☐ Dept. of Mental Health	☐ Early Intervention	
	☐ Regional Consultation Program (RCP)	

APPLICANT CHILD

Name (First)	Name (Last)	Street Address	
City/State/Zip			Home Telephone
Date of Birth	Sex ☐ Male ☐ Female		Primary Language

Race

☐ American Indian or Alaska Native	☐ Hispanic/Latino/Black	☐ Native Hawaiian or Other Pacific Islander
☐ Asian	☐ Hispanic/Latino/White	☐ White
☐ Black	☐ Hispanic/Latino/other	☐ Other (specify: _____)

FAMILY INFORMATION

Parent/Guardian #1	**Parent/Guardian #2**
Name (First and Last)	Name (First and Last)
Relationship to Child	Relationship to Child
Home Address	Home Address
Mailing Address (if different from Home Address)	Mailing Address (if different from Home Address)
Contact Preference	Contact Preference
Home Telephone ☐	Home Telephone ☐
Cell Phone / Work Telephone ☐	Cell Phone / Work Telephone ☐
E-mail ☐	E-mail ☐
Preferred Language	Preferred Language

Household Type (select one):	☐ Single-parent/guardian ☐ Two-parent/guardian

List all people who live in the child's home. Include the child's parents/guardians listed on Page 1. Attach another page if you need more space.

Name (First and Last name)	**Date of Birth** (Month / Day / year)	**Relationship to Child**

CHILD'S HEALTH INSURANCE INFORMATION

HMO/Insurance Company	**Policy Holder Name**	**If MassHealth, specify type:**
Primary Insurance Company:		☐ MassHealth Standard ☐ MassHealth Limited ☐ CommonHealth ☐ Kaileigh Mulligan
Secondary Insurance Company:		☐ MassHealth Standard ☐ MassHealth Limited ☐ CommonHealth ☐ Kaileigh Mulligan

CHILD'S MEDICAL INFORMATION

Diagnoses: _____

_____

Briefly describe child's condition, including whether the child is currently hospitalized or at home:

_____

_____

_____

_____

Does your child use a wheelchair? _____

☞ **If you have a letter from your child's doctor describing his/her condition, please send us a copy. Please list all hospitals used in the past 24 months.**

Provider	**Name**	**Facility/Address**	**Phone**
Primary Care Doctor			
Other Doctors			
Social Worker, Case Manager, or Care Coordinator			
Other Contact			

Your signature on Page 6 gives CICRF staff permission to contact anyone listed here.

EXPENSE INFORMATION

- **Family income under $100,000 per year:** In order to be eligible for CICRF you must have spent more than 10% of your yearly income for expenses related to your child's illness, accident, or disability in a 12-month period.

- **Family income over $100,000 per year:** In order to be eligible for CICRF you must have spent more than 10% of the first $100,000 of your yearly income, and 15% of the amount over $100,000, for expenses related to your child's illness, accident, or disability in a 12-month period.

- See the list of Eligible Expenses on our website **www.mass.gov/cicrf** or call 1-800-882-1435 to have a copy sent to you. If you are not sure if an expense will be eligible, please include it.

- CICRF will only consider expenses within two years of the date the application is received.

- Proof expenses have been paid is needed. In some cases, proof of insurance denial will also be needed.

Type of Expense	Amount of Expense	Dates of Service
Family Support: Expenses of visiting a child in the hospital, or taking a child to certain medical appointments at a hospital or hospital-satellite. This is a daily rate based on the distance traveled, so do not send gas, toll, or parking receipts. Documentation is by discharge summaries, cadence reports, clinic notes, or a letter from the hospital.		
Lodging Expenses, if you live 50 miles or more from the treating facility		
Home Modifications needed for accessibility ▪ *Complete the Home Modification Statement**		
Vehicle Purchase, if child uses a wheelchair that does not fold or travels sitting in the wheelchair, or if child must travel with a ventilator that will not fit into a regular size vehicle ▪ *Complete the Vehicle Purchase Statement**		
Vehicle Modification needed for accessibility		
Medical Expenses, such as hospital, physician, laboratory, ambulance, home nursing, etc.		
Medical Equipment & Supplies, mobility equipment, generators, etc.		
Medication or nutritional supplements		
Mental Health Services		
Funeral Expenses, includes services, burial plot, memorial		
Therapy Services		
CommonHealth, MassHealth, and CMSP premiums		
Other:		

*** The Vehicle Purchase Statement and Home Modification Statement are available on our website www.mass.gov/cicrf or by calling 1-800-882-1435. (From out-of-state call 1-617-624-6060.)**

FAMILY INCOME INFORMATION

- List all income, before taxes, that your family receives.
- Provide proof of income received during the same time period as the expenses.
- Please send a copy of your federal tax return with W-2s for the year of your expenses, or just your W-2s if you have not yet filed your taxes. For the current year include several recent pay stubs for each person working.
- If you receive any public benefits, please send a copy of your payment history or benefit award letter. Payment histories are available at your local Department of Transitional Assistance (DTA) or Social Security office.
- CICRF staff will contact you if we need further proof of your income.

Type of Income	Name of Family Member Receiving Income	Amount Received	How Often (Circle one)	CICRF Use Only Annual Income
Employer:			Weekly, Monthly, Yearly	
Employer:			Weekly, Monthly, Yearly	
Adoption Subsidy			Weekly, Monthly, Yearly	
Short-/long-term Disability			Weekly, Monthly, Yearly	
Child Support / Alimony			Weekly, Monthly, Yearly	
Food Stamps			Weekly, Monthly, Yearly	
Interest / Dividends			Weekly, Monthly, Yearly	
Money from family member not living in home			Weekly, Monthly, Yearly	
Pension / Retirement Income			Weekly, Monthly, Yearly	
Rental Income			Weekly, Monthly, Yearly	
Social Security / SSDI			Weekly, Monthly, Yearly	
SSI			Weekly, Monthly, Yearly	
TAFDC / EAEDC			Weekly, Monthly, Yearly	
Trust / Estates/ Annuities			Weekly, Monthly, Yearly	
Unemployment			Weekly, Monthly, Yearly	
Veterans' Benefits			Weekly, Monthly, Yearly	
Workers' Comp.			Weekly, Monthly, Yearly	
Other Income (specify)			Weekly, Monthly, Yearly	

Explain why assistance is being requested from the Catastrophic Illness in Children Relief Fund. If coverage has been denied by your insurance company, or if you have received money from any other sources, please explain below or on a separate sheet of paper.

_____
_____
_____
_____
_____

PERMISSION TO SHARE INFORMATION

I understand that the information I have given you will be used by the Catastrophic Illness in Children Relief Fund (CICRF) staff to determine if I am eligible for the Fund. I understand that the CICRF Commission has final approval of all Fund decisions. I understand that I should not make financial decisions assuming that I will receive payment from the Fund.

I give permission for CICRF staff and Commissioners to contact any other state agency or any provider or insurer listed on this application in order to:

- get or check any information needed to determine if I am eligible for the Fund
- assist in the review of my application
- find other services for which I might be eligible.

Unless I cancel this permission, it will cover 18 months from the date I sign this form. I understand that I can cancel this permission at any time by writing to CICRF staff.

I SWEAR, UNDER PAINS AND PENALTIES OF PERJURY, THAT THE INFORMATION I HAVE GIVEN ON THIS APPLICATION IS TRUE AND COMPLETE.

Parent/Guardian #1:	**Parent/Guardian #2:**
_____	_____
Signature	Signature
_____	_____
Print Full Name	Print Full Name
_____	_____
Date	Date

FOR APPLICANTS AGE 18 OR OLDER:*

I have read and understand the information above. I give permission to CICRF staff to receive and share information in the ways described above. I also give them permission to share information about me with my parents, and to receive information from my parents in order to determine eligibility and the amount of assistance.

_____	_____	_____
Signature of applicant age 18 or older	Print Full Name	Date

*** A signature is required of all applicants age 18 or older unless they have a court-appointed guardian. If you are the court-appointed guardian for the applicant, please provide documentation of guardianship**