Catastrophic Illness in Children Relief Fund (CICRF) Application, April 2023

The Catastrophic Illness in Children Relief Fund

*When other resources end, we begin.*

**Catastrophic Illness in Children Relief Fund (CICRF) Application**

## What is a catastrophic illness?

Any acute or chronic illness or condition may be considered "catastrophic." For CICRF, “catastrophic illness” is based on the amount of uncovered and eligible medically related expenses for the care of a child/youth that are greater than a certain percent of the family’s

annual income. CICRF is the payor of last resort, meaning expenses covered by insurance, other state or federal programs, the education system or fundraising are not considered.

## Who is eligible?

CICRF provides reimbursement for eligible medically related expenses for families of children and young adults with significant medical needs who meet the following:

* Families with eligible expenses greater than 10% of the first $100,000 of annual family income from all sources plus 15% of any family income over $100,000
* Child/youth under age 22 at time of the expense
* Massachusetts residents

## Is my family eligible?

CICRF cannot tell if your family is eligible for financial assistance until we know more about your child’s medical issues and care, your household income from all sources (including public benefits and earned income), and the medical expenses you have incurred.

You will be asked to provide documentation of your income and proof of payment of medical expenses for your child. CICRF will use this information to compare your income from all sources to money spent on medically related expenses during the last 24 months, up to the date of your application. CICRF will contact you with questions and any additional documentation that may be required.

## Please review the application for all paperwork required, gather the required income and expense information, complete all sections, and fax or mail application with all paperwork.

**SUBMIT YOUR APPLICATION**

**FAX:**

(857) 323-8322

**MAIL:**

Catastrophic Illness in Children Relief Fund MA Department of Public Health

250 Washington Street, 5th Floor Boston, MA 02108-4619

Visit <https://www.mass.gov/cicrf> for more information.

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# APPLICANT CHILD/YOUTH (under age 22 at time of expense)

|  |  |  |
| --- | --- | --- |
| Legal Name (First) | Names (All Last) | Street Address |
| City/State/Zip Code |
| Date of Birth: / / (mm/dd/yy) | What is your relationship to the child listed above?* Mother
* Father
* Legal guardian
* Other, please

specify  | What is your child’s gender identity (check all)?* Male
* Female
* Nonbinary, Genderqueer, not exclusively male or female
* Transgender
* My child is questioning/not sure of their gender identity
* I don’t understand what this question is asking
* Decline to answer
 |

**FAMILY INFORMATION**

|  |  |
| --- | --- |
| **Parent/Guardian #1** | **Parent/Guardian #2** |
| Legal Name (First) | Names (All Last) | Legal Name (First) | Names (All Last) |
| Relationship to Child | Relationship to Child |
| Home Address* Same as child’s
 | Home Address* Same as child’s
 |
| Mailing Address (if different from Home Address) | Mailing Address (if different from Home Address) |
| Home Telephone: | Home Telephone: |
| Cell Phone: | Cell Phone: |
| E-mail: | E-mail: |
| Please select contact preference:Home telephone  Cell phone  Text  | Please select contact preference:Home telephone  Cell phone  Text  |
| In what language do you prefer to communicate? | In what language do you prefer to communicate? |
| In what language do you prefer to receive written materials? | In what language do you prefer to receive written materials? |

**How did you learn about CICRF? Please check all that apply.**

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

  |

# CHILD/YOUTH HEALTHCARE INFORMATION

**What kind of health insurance does your child have?**

|  |
| --- |
| **HMO/Insurance Company** |
| **Primary Insurance Company:*** Private Health Insurance
* Medicaid or MassHealth (specify plan)
	+ CommonHealth
	+ Family Assistance
	+ Kaileigh Mulligan
	+ Limited
	+ Standard
* Children Medical Security Plan
* TRICARE or other military healthcare
* Other health insurance, specify:
* No insurance
* Don’t know
* Declined to answer
 | **Secondary Insurance Company:*** Private Health Insurance
* Medicaid or MassHealth (specify plan)
	+ CommonHealth
	+ Family Assistance
	+ Kaileigh Mulligan
	+ Limited
	+ Standard
* Children Medical Security Plan
* TRICARE or other military healthcare
* Other health insurance, specify:
* No insurance
* Don’t know
* Declined to answer
 |
| **Policy Holder Name** |
|  |  |

**Please list any hospitals your child has used for inpatient and outpatient care in the past 24 months:**

|  |
| --- |
|  |
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|  |

**Does your child have a pediatrician or primary care doctor?**

* Yes
* No
* Don’t know
* Declined to answer

## Please list any case managers, social workers, care coordinators or others helping your family:

|  |  |  |
| --- | --- | --- |
| **Name** | **Facility/Address** | **Phone/Email:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Your signature on the “Permission to Share Information” on the last page allows CICRF staff to contact anyone listed here.

# QUALIFYING FOR FINANCIAL ASSISTANCE

CICRF counts income from all sources, such as earned gross income, public benefits and child support. Your application cannot be processed without proof of income. Since eligibility for the Fund is based on a comparison of expenses and income, the 12-month period of expenses must match the 12-month period of income. All information will be kept private.

|  |
| --- |
| What is your total annual household income before taxes? Include your income, your partner’s income, and any other income you may have received (e.g., SSI, TAFDC, SNAP, child support). All information will be kept private. |
| * < $25,000
* $25,000 - $34,999
* $35,000 - $49,999
* $50,000 - $74,999
 | * $75,000 - $99,999
* $100,000 - $149,999
* $150,000 - $199,999
* $200,000 and above
 | * Don’t know
* Declined to answer
 |
| How many people does your household income support? Adults age 18 or older: Children age 17 or younger: * Declined to answer
 |

## During the past 24 months, what were the sources of income for your household?

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Income** | **Family Member Receiving Income** | **Annual Received ($)** | **Required Documentation (please attach)** |
| Employer: |  |  | Federal tax return with all W-2s |
| Employer: |  |  | Federal tax return with all W-2s |
| Adoption Subsidy |  |  | CICRF can request on your behalf |
| Child Support/Alimony |  |  | Court order, DOR payment history or letter(s) from non-custodial parent |
| Money from family member not in home |  |  | Letter from family member or parent/guardian explaining the agreement |
| Pension / Retirement |  |  | Federal tax return and 1099 for each year |
| Social Security / SSDI |  |  | Annual award letter for all family members receiving benefits |
| State Supplemental Income(SSI) |  |  | Annual award letter for all family membersreceiving SSI |
| Dept of Transitional Assistance SNAP/TAFDC / EAEDC |  |  | CICRF will mail you a release allowing us to get this information for you |
| Unemployment |  |  | Federal tax return |
| Veterans’ Benefits |  |  | Federal tax return and 1099 for each year |
| Paid Family Medical Leave (PFML) |  |  | 1099 for each year, PFML benefit letter or PFML payment history report for each parent |
| If no income is reported, please describe your living situation: |

During the past 24 months, has your household received money from fundraising/donations? ☐ Yes ☐ No

|  |  |
| --- | --- |
| **Name of Fundraiser** | **Total $ fundraised or donated to your family** |
|  |  |
|  |  |
|  |  |

**ELIGIBLE EXPENSES**

CICRF considers certain medically-related expenses for your child towards eligibility and potential reimbursement; please visit [www.mass.gov/cicrf](http://www.mass.gov/cicrf) to download *CICRF Eligible Expenses* and *CICRF Ineligible Expenses*. Fund policy limits the amounts counted toward eligibility, and reimbursement is calculated on a sliding scale for expenses such as vehicle purchases, home modifications and whole- house generators.

Please provide proof of payment, invoices and other information for each expense below. The date of the expense and payments must occur within 24 months before the date the application is received and before the child/youth’s 22nd birthday.

|  |  |  |
| --- | --- | --- |
| **Type of Expense** | **Amount** | **Dates of Service** |
| **Family Support,** daily rate depending on distance traveled to assist with expenses of child’s hospital admissions and outpatient visits* Estimated number of inpatient days for the past 24 months
* Estimated number of outpatient days for the past 24 months
 |  |  |
| **Lodging Expenses**, if you live 50 miles or more from the provider |  |  |
| **Home Modifications** Complete the *Home Modification Statement\****(**needed for accessibility or safety) |  |  |
| **Vehicle Purchase** Complete the *Accessible Vehicle Statement\** (if child uses a wheelchair that does not fold, travels sitting in the wheelchair, or travels with durable medical equipment) |  |  |
| **Vehicle Modification** Complete the *Accessible Vehicle Statement\**(needed for accessibility) |  |  |
| **Medical Expenses,** such as hospital, physician, laboratory, ambulance, home nursing, etc. |  |  |
| **Medical Equipment & Supplies,** mobility equipment, generators, etc. |  |  |
| **Medication** |  |  |
| **Mental Health Services** |  |  |
| **Funeral Expenses\*\*** MA/instate services, burial plot & headstone |  |  |
| **Therapy Services** |  |  |
| **CommonHealth, MassHealth, and CMSP premiums** |  |  |

\* Download the *Home Modification Statement* and *Accessible Vehicle Statement* at [www.mass.gov/cicrf](http://www.mass.gov/cicrf)

\*\* Maximum reimbursement of $10,000 for families with annual income < 400% Federal Income Poverty Guideline

# HOUSEHOLD AND INCOME INFORMATION

List all people who live in the child’s home including parents/guardians. Attach another page if necessary.

|  |  |  |
| --- | --- | --- |
| **Name**(Legal First and All Last Names) | **Date of Birth**(mm/dd/yy) | **Relationship to Child** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Which household type best describes your household? (Select one)* Single-parent/guardian
* Two-parent/guardian
 |
| During the past 30 days, where did your child usually sleep at night? (Choose ONE. If more than one place, choose the one where they slept most often.)* In their parent’s or guardian’s home ☐ In a foster home or residential placement
* With a friend, family or other people because ☐ In a hospital or skilled nursing facility we lost our home and cannot afford housing ☐ In a group home
* In a shelter or emergency housing ☐ They moved from place to place
* In a hotel/motel, car, park, campground, or other public space
* Somewhere else, please specify:
 |

**CHILD/YOUTH’S HEALTH INFORMATION**

What are your child's primary diagnoses? Please select all that apply and write in any other diagnoses.

* Autism spectrum disorder
* Cancer (please specify below)
* Cerebral palsy
* Chromosomal or genetic disorder (please specify below)
* Chronic feeding issues (please specify below).
* Chronic lung disease (please specify below)
* Congenital brain abnormalities or neurological disorders (please specify below)
* Cytomegalovirus (CMV)
* Developmental delay (please specify below)
* Hearing loss (please specify below)
* Hypotonia
* Intellectual disability (please specify below)
* Leukodystrophy (please specify below)
* Metabolic disorder (please specify below)
* Orthopedic diagnosis, please specify below:
* Prematurity
* Seizure disorder (including epilepsy)
* Spinal cord injury
* Spinal muscular atrophy (SMA)
* Vision impairment (please specify below)
* Other birth defects (please specify below)
* Unspecified neurological or sensory disorder
* Unspecified disorder affecting multiple systems
* Unspecified disorder of the digestive system
* Unspecified disorder of the musculoskeletal system
* Unspecified congenital disorder
* **Other, please specify:**
* Don't know
* Decline to answer

|  |
| --- |
| **Clinical Medical Complexity** |
| Does your child have a physical, mental, or developmental condition that is expected to last at least one year?* Yes ☐ No ☐ Don’t know ☐ Decline to answer

**If yes**, does your child’s condition cause weakness, severe pain, nausea, reduce their strength and abilities, and/or limit major life activities?* Yes ☐ No ☐ Don’t know ☐ Decline to answer

**If yes**, does your child’s condition involve 2 or more body systems? Body systems are groups of organs and tissues that work together to perform important jobs for the body such as the heart, lungs, muscles, digestive system, nervous system or immune system.* Yes ☐ No ☐ Don’t know ☐ Decline to answer

Does your child have a condition that does not have a current cure and is expected to shorten their life?* Yes ☐ No ☐ Don’t know ☐ Decline to answer

Does your child have, or do you expect your child to have an ongoing need for technology for at least 6 months (for example, a feeding tube, oxygen, or ventilator)?* Yes ☐ No ☐ Don’t know ☐ Decline to answer

Does your child currently have cancer or had cancer within the last 5 years?* Yes ☐ No ☐ Don’t know ☐ Decline to answer
 |
| **Functional Limitations** |
| Is your child limited or prevented in any way in their ability to do the things most children of the same age can do?* Yes, mildly limits their daily activities
* Yes, moderately limits their daily activities
* Yes, severely limits their daily activities
* No
* Don’t know
* Decline to answer
 |

|  |
| --- |
| **Impact of Child’s Health on Family** |
| Are the health needs of your child posing a significant impact on your family with regards to the following? Check all thatapply.* Time devoted to their direct care
* Frequent provider/doctors’ visits
* Care coordination (the need to coordinate your child’s care)
* Financial stress (due to medical care not covered by health insurance)
* None of the above
 |

|  |
| --- |
| **Healthcare Utilization** |
| Within the **last 2 years**, has your child had any of the following?* Frequent or lengthy ER visits and/or hospitalizations compared to the average child
* 2 or more surgeries
* Ongoing involvement of 3 or more subspecialty providers
* None of the above
 |

**Please share any additional information about your child’s diagnosis or health condition:**

|  |
| --- |
| **Caregiver Health Status** |
| In general, how would you rate your physical health?* Excellent
* Very Good
* Good
* Fair
* Poor
 | In general, how would you rate your mental health?* Excellent
* Very Good
* Good
* Fair
* Poor
 |
| Do you have any health or other concerns about any other children in your household?* No concerns
* Some concerns
* A great deal of concerns Please specify concerns:
 |

# DEMOGRAPHIC INFORMATION

|  |
| --- |
| **Race/Ethnicity** |
| Is your child Hispanic/Latinx? Latinx is a gender-neutral term to refer to a Latino/Latina person. |
| * Yes ☐ No ☐ Do not know ☐ Prefer not to answer
 |
| What is your child’s ethnicity? (You can specify one or more). Ethnicity represents your ethnic origin or descent, heritage, nationality, or the place of birth of your child or your child’s ancestors. |
| * African (specify: )
* African American
* Albanian
* American
* Armenian
* Brazilian
* Cambodian/Khmer
* Canadian
* Cape Verdean
* Caribbean Islander

(specify: )* Chinese
* Columbian
* Cuban
* Dominican
* English
* Filipino
* French
* German
* Greek
* Guatemalan
* Haitian
* Honduran
 | * Honduran
* Indian/Asian Indian (from/family from India)
* Irish
* Italian
* Japanese
* Korean
* Laotian
* Mexican, Mexican American, Chicano
* Middle Eastern (specify: )
* Native American
* Polish
* Portuguese
* Puerto Rican
* Russian
* Salvadoran
* Scottish
* Swedish
* Ukranian
* Vietnamese
* Other not named above (specify: )
* Do not know
* Prefer not to answer
 |
| What is your child’s race? (You can specify one or more). |
| * American Indian/Alaska Native

(specify tribal nation: )* Asian
* Black
* Native Hawaiian or other Pacific Islander (specify: )
 | * White
* Other (specify: )
* Do not know
* Prefer not to answer
 |

**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**