Application for funds

Abby's All Stars, a non-profit organization, was founded in 2007 with the goal to raise funds to help families offset the out of pocket un-insured medical expenses due to Juvenile Diabetes.

Funds are designed to help patients and families members who, after a thorough investigation of other resources, are unable to meet medical expenses that are causing a financial burden.

Priority is placed on applications from Fairfield County with excess available funds granted to applicants outside Fairfield County. Abby's All Stars is not able to fulfill every request. While Abby's All Stars attempts to meet as many needs as possible, some applications may be approved for a grant that is lower than the requested amount, while others may be denied. Much depends on the availability of funds.

You may be contacted by an Abby's All Stars board member for further discussion about your application.

Application processing normally takes 30 days. A response letter and check for any approved scholarship amount will be mailed to you approximately 45 days after we receive your application and all required documentation. Applications expire after 1 year – date stamped received in office.

Mail completed form and appropriate documents to:

Abby's All Stars
P.O. Box 110010
Trumbull, CT 06611

Applicant's name: ____

Please state relationship to Beneficiary: ____

Beneficiary's name: ____

Beneficiary's Date of Birth: ____

Address: _____________________________ City/ State/ Zip Code: ___________________

Home telephone number: ________________Work telephone number: ______________

E-Mail address: ____

Brief description for which reimbursement is requested: ___________________________
____
____
____

Date of medical Procedure for which reimbursement is requested: ___________________

Name of Doctor who treated applicant for above referenced condition: _______________
____

Specialization: ____

Address: _____________________________ City/ State/ Zip Code: ___________________

Telephone number: ____

Doctors comments: *Enclose photo copy of doctor's report* _________________________
____
____
____
____

Name of primary medical insurance company: ___________________________________

Address: ___________________________City/ State/ Zip Code:_____________________

Telephone number: ____

Contact person: ____

Name of secondary medical insurance company: _________________________________

Address: ____________________________City/ State/ Zip Code: ____________________

Telephone number: ____

Contact person: ____

Applicant agrees to provide Abby's All Stars with insurance and healthcare providers' authorization for release of info form.

1). Total cost of above referenced medical procedure(s) $______________

2). Total amount of payment by insurance company $_________________

3). Total amount of deductible paid by applicant $______________

4). Total amount of payments (not including deductible) made by applicant $__________

Itemize payment and date incurred

5). Total amount requested for reimbursement $___________

Describe reason given for denial or lack of insurance coverage/reimbursement. Enclose copy of notice of denial.____

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Describe any sources other than medical insurance company you have contacted and the results.____
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____

Describe any other assistance or support.____
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____
____

Due to limited funds, Abby's All Stars may only be able to pay one bill or a portion thereof. Please prioritize the bill(s) for which you are requesting funding to be considered.____
____
____

The gross annual income* for your household at time of medical procedure for which reimbursement is requested. $ ___________________

**To figure gross annual income, add gross annual income received from work, plus untaxed income, according to your current IRS Form 1040.*

The current annual income for your household, if different $ ____________________

Total number of dependents in your household claimed on your current 1040._____________

Were your medical expenses for the calendar year in question more than, or equal to 7.5% of your adjusted gross income, as reflected on your 1040? ____________

Is there any other information you feel Abby's All Stars should know in considering your application, including extenuating circumstances? ________________________________
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____
____
____
____
____

Is this patient enrolled in MEDICARE? _____ Yes _____ No ______ Pending
Is this patient enrolled in MEDICAID? ______ Yes ______ No ______ Pending
Medicaid Spend Down: __________________

Other resources researched: Agency: ___________________ Status: ________________
Agency: ____________________ Status: _______________

Have you previously requested funding? Yes / No / Don't know

If yes, in which year(s) did you apply? ____

Have you ever been granted funding by Abby's All Stars? Yes / No / Don't know

If yes, in which year(s) was funding granted and for what amount(s)

Each year Abby’s All Stars needs help to stage the various events that the Committee organizes. As an individual seeking assistance from Abby’s All Stars, can you offer us assistance with the people-power that we need to set-up, marshal, run and clear up at any of our events?
please give a contact name and telephone number:

Submission of this application and all of its requested information does not guarantee a grant of a benefit.

The representations contained herein are made under penalty of false statement.

Thank You

________________________________ ________________________
Signature Date