LJ'S HEALING HEARTS

Hospital to Home Application Packet

The application must include the following documents and be submitted as a single packet or be subject to denial.

- Doctor's letter addressed to LJ's Healing Hearts verifying Congenital Heart Defect diagnosis - the letter must be on doctor's official letterhead (cannot be discharge notes)
- Family and Medical Information
- Assistance and Detailed Hardship
- Patient Authorization (included)
- Proof of Residence – copy of driver's license or utility bill
- Copies of bills - must have payment stub or subject to denial

Please note the following:

- All payments will be made directly to vendors
- If an approved bill is no longer required that assistance is forfeited.
- Application turn-around time is 4 to 6 weeks
- Please do not contact us regarding the status of your application.
- Applying for assistance does not guarantee approval

Packets can be emailed to:
application.ljs@gmail.com

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Family and Medical Information

Person Filling out application:_____ Date: _____
Child's Full Name:_____ DOB: _____
Mom's Name:_____
Dad's Name:_____
Address:_____
City: _____ State: _____ Zip: _____
Parents live at same address: YES NO
Mom Phone:_____ Dad Phone:_____
Mom Email:_____ Dad Email:_____

Employment - Please fill in place of employment. N/A is not acceptable.
Mom:_____ Dad: _____
If not employed, include brief explanation.

_____

_____

No. of Dependents: _____ Ages: / / / / / Total in Household: _____
Medical Insurance:_____ _____
Deductible:_____ Max Out of Pocket: _____
Guarantor Name:_____ Guarantor DOB:_____
Current Hospital:_____ _____
Hospital Social Worker:_____ Email Address:_____

Congenital Heart Defect Diagnosis: Please check all that apply

O Aortic coarctation
O Aortic stenosis
O Atrial septal defect
O Cor triatriatum
O D-Transposition of the great arteries
O Double outlet right ventricle
O Ebstein's anomaly
O Heterotaxy syndrome
O Hypoplastic left heart syndrome
O Interrupted aortic arch
O Pulmonary atresia
O Pulmonary atresia w/ intact ventricular septum
O Single ventricle
O Stenosis of pulmonary artery
O Tetralogy of Fallot
O Total/partial anomalous pulmonary venous connection
O Transposition of the great arteries
O Tricuspid atresia
O Truncus arteriosus
O Ventricular septal defect
O Other:_____

*a diagosis of other may require additional documentation submitted by a medical professional, including medical intervention

Last surgery date:_____ Last cardiology appointment:_____
Is patient in active treatme YES NO
What type of treatment is the child undergoing?_____

_____

_____

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Assistance Request

CHILD'S NAME D-O-B:

Assistance options: Grocery / Gas / Mortgage-Rent / Utilities / Car payment / Car Insurance Medical Bills / Medication

Grocery available is Jewel, Walmart, Target, Aldi and Meijer

Please Note: Any bill needs to have a payment stub for foundation to send in payment

List your top three assistance/bills ONLY in the order of which should be paid first

Assistance Type 1: _____

Vendor: _____ Amount: _____

Assistance Type 2: _____

Vendor: _____ Amount: _____

Assistance Type 3: _____

Vendor: _____ Amount: _____

For Rental Lease Payment

Who should the check be made out to: _____

Where should the check be mailed: _____

Who is the lease under: _____

Address of leased property: _____

If landlord accepts electronic payment via Zelle, please provide email/phone number

**please note this cannot be attached to a debit card for payment

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Family payment details if necessary

Zelle: _____

Venmo: _____

LJ'S HEALING HEARTS

Detailed Hardship

Tell us how your Heart Warrior is currently doing.

Tell us about your family and support system.

Describe how the CHD diagnosis created a financial hardship for your family.

This letter should be shared with the healthcare professional or organization providing care to your child. It will allow LJ's Healing Hearts to validate information included in your application for assistance.

Dear Healthcare Provider,

Authorized Designee for Release of Information

I, _____, as an applicant for assistance through LJ's Healing Hearts, an Illinois not-for-profit corporation with its principal offices at 1S750 Vista Avenue in Lombard, Illinois (60148), hereby authorize the following designated representatives of LJ's Healing Hearts, or any designated representative named by such corporation for the limited purpose of carrying out the responsibilities of determining whether I, my successors or assigns qualify for benefits, donations or other assistance provided by, on behalf of or in relation to my application for assistance through LJ's Healing Hearts, regardless of whether I am selected as a recipient of benefits, donations or other assistance, to act as my agents with respect to the matters specified in this Release:

Betsy Shannon- Executive Director
LJ's Healing Hearts
1S750 Vista Avenue
Lombard, Illinois 60148

Authorization for Release of Protected Information

I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services (referred to herein as a "covered entity"), to give, disclose, and release to my agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually-transmitted diseases, mental illness, and drug or alcohol abuse. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to any protected medical information, pertaining to myself or my child, to my agent.

The authority given to my agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my agent may be subject to redisclosure by my agent and may no longer be protected by HIPAA.

This Release and all of the provisions contained herein are effective immediately. I intend for my agent to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information, the same of my child and other related medical records. This Release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C.A. § 1320d, and 45 C.F.R. § 160.101 et seq.

This Release shall terminate on the first to occur of: (1) two years following my death, or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, electronic mail, or any other receipt evidencing actual receipt by the covered entity. This Release shall not be affected by my subsequent disability or incapacity. There are no exceptions to my right to revoke this Release.

Further, I hereby release each covered entity, as defined by HIPAA, that acts in reliance on this Release from any and all liability, which may result from my disclosing my individually identifiable health information, that of my child or spouse, and other medical records for the purpose of applying for assistance through LJ's Healing Hearts.

I authorize my agent or their designee to bring a legal action against a covered entity, which refuses to accept and recognize this Release. No covered entity may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b)(4) applies.

Further, in order to fulfill my intent as expressed herein, I authorize my agent or their designee to sign any documentation that my agent deems necessary or appropriate in order to secure the disclosure of my individually identifiable health information and other medical records.

Any information disclosed to my agent or their designee pursuant to this Release may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a covered entity or perform any act in the event information is subsequently disclosed by my agent.

As stated above, I hereby authorize and agree to the terms of this release of protected information, as set forth above, on this ___ day of _____, _____, in _____, _____.
(month) (year) (city) (state)

_____
Signature Date

_____
Name (Print) Relationship to Child

_____
Address City State Zip

Witnessed by:

_____
Signature Date

_____
Name (Print)

_____
Address City State Zip