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www.P4FOUNDATION.org

APPLICATION FOR ASSISTANCE APPROVAL

Welcome to the P4 Foundation Family Assistance Program

The P4Foundation Family Assistance Program helps you pay toward

- Transportation to & from clinic visits, treatment(s), Doctor(s) or Hospital(s) visits.
- Parent/Caregiver meals while patient is in hospital or undergoing treatment.
- Hospital parking and tolls.
- Assist with Co-pays for medications.
- Assist with private insurance Co-pays.
- A Family household bill during treatment
    - Electric Bill
    - Water Bill
    - Gas Bill
    - Rent/a Mortgage payment
    - Insurance premium
    - ETC….

Available Funding

Support for this program is based on the availability of funds. P4Foundation Family Assistance Program funds are available to any child age 1year-19 years of age affected with cancer.

Support amounts range from $50.00-$2,500.00

Eligibility Requirements

To be eligible for P4Foundation Family Assistance Program, you must

- Have a TOTAL household income that is at or below $45,000.00 per year.
- Be a United States citizen or permanent resident of the U.S. and be medically and financially qualified
- Have private medical insurance coverage
- Have cancer diagnosis confirmed by a doctor (see covered diagnoses listed above)

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How to Apply

Patients and or caregivers can easily submit a P4Foundation Family Assistance Program application by mail or by fax.

- **Patients and Caregivers:** Complete application included in your folder or the application may be downloaded online, or contact our office.

Patients and caregivers may check the status of submitted applications and claims Monday-Thursday 11:00a.m-3:00p.m. eastern time.

By Phone: You may get more information about the P4Foundation Family Assistance Program by calling **(844) 772-9367** to speak with a P4Foundation Assistance Specialist who will provide personalized service throughout your application process.

By Email: You may email your request for a P4Foundation Assistance Specialist to contact you about the program at **info@p4foundation.org.**

Required Information
The P4Foundation Family Assistance Program application requires information to be completed and signed by both you and your doctor. You must also submit documentation verifying household income. All documentation will be kept confidential and is used solely for approval into the program. If you mail or fax your application, send the forms and supporting documents to:

P4Foundation, Inc.
Family Assistance Program
P.O. Box 842
Buford, GA 30515

Your P4Foundation Family Assistance Program application will be reviewed, and you'll be notified of your approval status. You'll receive instructions for payment requests once your application is approved.

Information for Approved Applicants

For patients with approved applications who need assistance completing the claim form Please contact a P4Foundation Assistance Specialist

P4Foundation Family Assistance Benefits and Taxable Income

Expense reimbursements received by patients from the P4Foundation Assistance Program are generally not taxable. However, we recommend patients consult with a tax professional for a final determination.

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P4 Foundation Family Assistance Program Application.

Applications can be submitted by mail or fax ONLY.

You'll need the following information and documents:

- Patients date of birth
- the name of Patients diagnosis
- Name of your insurance company and proof of current coverage.
- the name of your pharmacy and its phone
- the name of your physician and his or her phone and fax numbers

Before you begin the application process, please read the following information.

Entering and Submitting the Application
Please note that only one application may be completed per patient. After you complete the application, you must identify yourself as either the patient or someone submitting the application on behalf of the patient. A comments section is available to include any additional information or special circumstances relevant to the application.

Application Review
Submitting the application doesn't guarantee acceptance in the program. All applications must be completed in their entirety before they can be reviewed and must include:

- signed patient application
- household financial information
- physician form
- a copy of the patient's insurance card

The P4 Foundation Family Assistance group will review all your documents and inform you via mail of your approval status.

*Support for this program is based on the availability of funds.

For More Information
For information or questions regarding the P4 Foundation Family Assistance application contact:
1-844-772-9367
P4 Foundation
Family Assistance Program
P.O. Box 842
Buford, GA 30515
info@p4foundation.org

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Tell us about yourself.

We will need to contact an Adult/Parent/Caregiver

Childs Name:_____

Childs: Diagnosis:_____

Childs Date of Birth:_____ **Childs age**: _____

Mothers Name:_____

Are you a U.S. citizen or permanent resident :_____

Fathers Name:_____

Are you a U.S. citizen or permanent resident :_____

Siblings : Yes ☐ No ☐

Siblings Names and ages:_____

Home Address:_____

City:_____ **State**:_____ **Zip**:_____

Home Phone:_____

Mothers Cell Phone:_____ **Fathers Cell Phone**:_____

Mothers Work Phone:_____**Fathers Work Phone**:_____

Total Household Income per year: $____,_____.00 *(include everyone living in home)*

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Mileage from Home to Treatment Center:_____

Insurance Company Name: _____

Pharmacy Name:_____**Phone**:_____

Treatment Hospital Name: _____

Doctors Name:_____**Phone**:_____

Church Affiliation:_____

Religious Denomination:_____

Mothers Signature:_____**Date**:_____

Fathers Signature:_____**Date**:_____

The Application information provided above has been given to the P4Foundation, Inc. by the above signed individuals for the sole purpose of approval into the Family Assistance Program. All information provided above is voluntary by the applicant signed above.

FAMILY ASSISTANCE PROGRAM (FAP) program provides direct financial assistance to qualified patients through funds. In some instances, assistance with insurance premiums and/or ancillary services associated with the disease also may be available. In order to qualify for a given fund, an applicant must (1) have a diagnosis for the given disease, (2) have a treatment regimen in place, (3) have and maintain health insurance and (4) meet the financial criteria set forth by FAP for the fund.

FAMILY ASSISTANCE PROGRAM will not consider the identity of any physician, provider, supplier of items or services, donor, drug therapy, services or supplies being utilized or the referral source when assessing whether an applicant is qualified for financial assistance from a FAMILY ASSISTANCE PROGRAM FAP fund. Under no circumstances will FAMILY ASSISTANCE PROGRAM recommend or refer an applicant or enrollee to any fund donor, provider, supplier or product.

Qualifying applicants are enrolled in a specific fund for up to one year from the date of approval and must re-apply thereafter to continue receiving assistance from a given fund. Approval in and financial assistance from any fund is provided on a first come, first serve basis to the extent funding is and remains available.

Enrollees are required to inform FAMILY ASSISTANCE PROGRAM in the event their financial circumstances change and/or they lose their health insurance coverage during their enrollment period as such changes may affect enrollee eligibility for a given FAP fund.