CATASTROPHIC ILLNESS IN CHILDREN RELIEF FUND
COMMISSION INITIAL APPLICATION

Date: _____ E-mail Address: _____

Name of Parents: _____ Marital Status: _____

Name of Child: _____

Medical Diagnosis: _____

_____

DOB: _____ Sex: _____

Social Security #: _____

Mailing Address: _____

County: _____

Telephone: Home: _____

Other: _____

Primary Language Spoken at Home: _____

1. At the time your child had medical expenses was he/she 21 years of age or younger?
   Yes _____ No _____
2. How long have you lived in NJ? _____
3. What are your child's estimated uncovered medical expenses?

_____

- For what 12 Month Period of time?

_____

- What is your estimated income for that same period of time?

_____

If your answers indicate that you might be eligible for assistance, you will be mailed further documentation to complete.
Questions—call 1-800-335-3863 *www.njcatastrophicfund.org*

Signature of Parent/Guardian: _____

INTER-OFFICE USE ONLY
- Preliminary Determination: E ____ I ____
- Date packet sent: _____
- Assign to: _____
- ID#: _____

CATASTROPHIC ILLNESS IN CHILDREN RELIEF FUND PROGRAM
CASE MANAGER'S ACTIVITY SHEET

Application on Behalf of: **12-Month Period Coverage: From:** **To:**

Diagnosis:

Clinical/Social Summary

Is Child in Case Management?	If Not is Child Eligible?	Will Child be followed by SCHS?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Referrals to other Resources?

	Date Referred	Outcome
☐ Family Care	____/____/____	_____
☐ SSI	____/____/____	_____
☐ Medicaid	____/____/____	_____
☐ Medically Needy	____/____/____	_____
☐ Model Waiver	____/____/____	_____
☐ New Jersey Care Special Medicaid Project	____/____/____	_____
☐ Charity Care	____/____/____	_____
☐ Other _____	____/____/____	_____
☐ Community Services (Identify)	____/____/____	_____

Date Received from Family: ____/____/____

Date Mailed to State Office: ____/____/____

Signature of Case Manager

_____

Telephone Number

( ) _____ - _____

County

_____

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

TO: Any provider of health care, legal, financial or other services to the above-named patient which may include, but is not limited to: health care providers; community organizations; school nurses; collection agencies; law offices; financial institutions; local, county, state or federal agencies including the New Jersey Division of Medical Assistance and Health Services.

I authorize the above-named providers to disclose the above-named patient's health information, as described below, to the following recipient for the purpose of determining whether the above-named patient's family is entitled to assistance from the State of New Jersey, Catastrophic Illness in Children Relief Fund:

State Office, Catastrophic Illness in Children Relief Fund Commission
P.O. Box 728
Trenton, New Jersey 08625-0728

The type of information to be used or disclosed is as follows:

Any information required to determine the above-named patient's eligibility for financial assistance from the Catastrophic Illness in Children Relief Fund, which may include, but is not limited to: income verification; itemized billing records; collection notices; supporting insurance explanation of benefits and other correspondence; verification of payments; legal documents pertaining to settlements and corresponding financial documents; and clinical summaries prepared by licensed health care providers.

This authorization shall remain in full force and effect until it expires one year from the date set forth below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the State Office of the Catastrophic Illness in Children Relief Fund Commission. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon.

I understand that I can refuse to sign this authorization. I understand that my refusal to sign this authorization may affect the recipient's ability to make a determination as to my eligibility for assistance from the Fund. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

_____ _____

Signature of Parent/Guardian **Date:**

This Authorization was drafted in accordance with the Health Information Portability and Accountability Act (HIPAA), 42 U.S.C.A. A§1320d et seq., and its underlying regulation 45 C.F.R. 164.508.

VI. MEDICAL/HEALTH-RELATED EXPENSES DURING 12-MONTH PERIOD OF APPLICATION

Attach all itemized bills, verification of payments and insurance explanation of benefits.
Refer to Instruction Packet for specific information required.

[For State Use Only]

Medical Expenses	Total Amount of Bill	Amount Covered by Ins. or Other Source	Amount Paid by Family	Current Balance Due	Date(s) of Service	Account Status
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

IF ADDITIONAL SPACE IS NEEDED, EITHER COPY THIS FORM OR INCLUDE EXTRA PAGE.

Catastrophic Illness in Children Relief Fund Program
PO Box 728
Trenton, NJ 08625-0728

SUPPORTING DOCUMENTATION

Name of Child: _____

Please print or type. All information pertains to the 12-month time period for which you are applying. Return completed application to Special Child Health Case Management Unit for your county (list attached) (see instructions)

I. MEDICAL HISTORY

List all diagnoses included in your 12-month application:

Diagnoses	Date/Year
a.	
b.	
c.	
d.	
e.	

List all surgery(s)/treatment(s) that occurred in your 12-month application:

Surgery/Treatment	Date/Year
a.	
b.	
c.	
d.	
e.	

Is a lawsuit pending, other than collection activity, related to the expenses submitted in this application?

☐ Yes ☐ No

Have you ever received a settlement related to your child's medical condition?

☐ Yes ☐ No

Name and Address of Attorney: _____ Phone Number: _____

Docket Number: _____

II. FAMILY FINANCIAL INFORMATION

Attach proof of income for the 12-month time period of application.

Sources of Income	Annual Amount
Gross Wages	_____
TANF	_____
Social Security	_____
Pension	_____
SSI	_____
Unemployment/Disability/Worker's Compensation	_____
Strike Benefits	_____
Veteran's Benefits	_____
Training Stipends/School Scholarships	_____
Alimony/Child Support	_____
Military Allotment	_____
Regular Support from Absent Family Member	_____
Income from Insurance/Annuity	_____
Income from Estates/Trusts	_____
Income from Dividends/Interest/Rents/Royalties	_____
Other (Specify) _____	_____
Total Income for 12-month period of application	_____

Individual legally responsible
For child's medical bills: _____ (Name) _____ (Relationship to Child) _____ (Social Security Number)

If you have any local fundraising on behalf of your child, provide the following:

Administrator of account: _____ Phone: _____

Address: _____ Amount raised to date: _____

III. EMPLOYMENT HISTORY FOR 12-MONTH PERIOD OF APPLICATION

How many people live in your household? _____

Full name of Parent/Guardian _____ Full Name of Parent/Guardian _____

Name & Address of Employer _____ Name & Address of Employer _____

_____

Occupation: _____ Occupation: _____

☐ Self employed	☐ Migrant Worker	☐ Self employed	☐ Migrant Worker
☐ Part time	☐ Unemployed	☐ Part time	☐ Unemployed
☐ Full time		☐ Full time	

IV. HEALTH INSURANCE

For 12-months of application unless otherwise specified

- **Health Insurance for child is available through:**

Employer sponsored plan	☐ yes	☐ no
Small group	☐ yes	☐ no
Self-pay	☐ yes	☐ no
Self-employed business	☐ yes	☐ no
Non custodial parent	☐ yes	☐ no
NJ Medicaid	☐ yes	☐ no
Uninsured	☐ yes	☐ no
COBRA	☐ yes	☐ no
NJ FamilyCare	☐ yes	☐ no

- **Health Insurance that covers your child:**

Managed Care (HMO, PPO, POS, etc.)	☐
Indemnity	☐
Union	☐
Self Funded	☐
NJ Medicaid (NJ FamilyCare, Medicaid Waivers)	☐
Other: _____	☐

- **Cost of Health/Dental/Vision Insurance:**

Payroll deduction $_____
Circle: weekly or biweekly

Premium Payment $_____
Circle: monthly or quarterly

- **Expenses are a result of the following: (check all that apply)**

☐ Pre-existing condition
☐ Non-participating provider/out-of-network
☐ Non-covered services
☐ Lapse in coverage
☐ Exceeded insurer's level of reimbursement for year/lifetime
☐ No pre-authorization/pre-certification
☐ Inability to purchase insurance
☐ No dependent coverage
☐ Late claim submission
☐ Other: _____

Did you file an appeal with your insurance company: yes ☐ no ☐
If yes, is it pending ☐ approved ☐ denied ☐

If you have received financial assistance from another state agency, provide the following:

Name of Agency: _____ Financial Assistance Received: $ _____

Contact: _____ Telephone Number: _____

If you have a loan for any of these expenses, complete the following:

Name and Address of Lending Institution: _____ Loan Number: _____

Telephone Number: _____

V. REFERRAL TO PROGRAM

How did you hear about the Catastrophic Illness in Children Relief Fund Program? (check all that apply)

- ☐ Newspaper
- ☐ Provider (Name):_____
- ☐ SCHS Case Manager
- ☐ Elected official:_____
- ☐ Bus Advertising
- ☐ Internet/Web site
- ☐ Collection Agency/Law Firm_____
- ☐ Employer/Co-worker
- ☐ TV
- ☐ Radio
- ☐ Friend
- ☐ School Nurse
- ☐ Other: _____

State of New Jersey Department of the Treasury
Division of Taxation

WAIVER AND AUTHORIZATION TO RELEASE CONFIDENTIAL NEW JERSEY TAX INFORMATION

☐ For the sole and limited purpose of income verification to determine eligibility for Catastrophic Illness in Children Relief Fund Commission (CICRFC), I hereby agree to a limited waiver of the confidentiality of my NJ income tax records for the periods at issue, and hereby authorize the Division of Taxation to release information from such tax records to the CICRF and its contractors. By signing this form, I release the New Jersey Division of Taxation from its legal obligations of confidentiality under N.J.S.A. 54:50-8 and waive any right to make any claim against the Division for the release of the above information by the Division.

_____ *Address:* _____
(Print Name of Applicant) _____

_____ _____
(Signature of Applicant) (Date)

Social Security Number or Individual Taxpayer Identification Number

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

_____ *Address:* _____
(Print Name of Second Applicant, *If applicable*) _____

_____ _____
(Signature of Second Applicant) (Date)

Social Security Number or Employer ID Number

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

For Official Use by CICRFCC representative:

Received by: _____
(Signature)

_____
(Official CICRFC Title)

_____
(Date)

Catastrophic Illness in Children Relief Fund Program
PO Box 728
Trenton, NJ 08625-0728
1-800-335-3863/609-292-0600
www.njcatastrophicfund.org

SUPPORTING DOCUMENTATION INSTRUCTIONS

Please read ALL of the instructions first. Print or type all your information. If additional assistance is needed you may contact the Special Child Health Case Management Unit for your county. Return the completed application to the Special Child Health Services Case Management Unit in your county.(see list attached).

Application(s) can be submitted for incurred expenses dating back to January 1, 1988.

I. MEDICAL HISTORY:

1. List child's primary diagnosis first, followed by other diagnoses. If primary diagnosis is unknown, explain child's medical condition to the best of your knowledge. If diagnosis or condition was present at birth, enter child's birth date.

2. List all surgeries and treatments (in 12 month period of application) relating to child's diagnoses (i.e. surgery, home health care, rehabilitative care). Include the date of each hospitalization, or other type of medical or health-related care.

3. Settlement of a lawsuit following assistance from this program would obligate you to reimburse the Fund. Check if a lawsuit is pending or if you have received a settlement. Please also include the name and phone number of your attorney.

II. FINANCIAL INFORMATION:

1. Income for Period of Application: The State Office requires information on family income for the same 12 month period in which a child's expenses were incurred. Supplemental statements of income may be requested by the State Office.

   Income is the combined income of the child, parent(s) and/or guardian(s) who is/are legally responsible for the child's medical bills. If the parents are divorced and are residing apart, the individual who is legally responsible for the child's medical care is required to report his/her income. If the child receives income from any other source, it must be reported. Income includes alimony; child support payments and any other form of financial assistance (refer to application).

   Include a signed copy of your Federal Income Tax Return (Form 1040, in most cases) and other supporting wage information to reflect income earned during the entire 12 month period of application. If the parent(s)/guardian(s) file separately, include copies of each tax return.

If you did not file a tax return with the IRS for the year of application, another form of income verification is needed; copies of all W2's or a statement of income prepared by your employer(s). A Profit & Loss statement prepared by an accountant may be necessary for self-employed families.

2. Eligibility for assistance is based primarily on income and expenses. Caps may be applied to expenses submitted and may be specifically applied to the following services: speech, language and hearing services, modified vehicles, and home modifications.
3. Expenses paid by fundraising cannot be included for consideration. The State Office is required to verify all payments made through any fundraising activity. Include a contact and phone number to provide information on fundraising and amount raised to offset expenses.

III. EMPLOYMENT HISTORY FOR 12-MONTH PERIOD OF APPLICATION:

1. Indicate number of people in your household:
2. Enter name(s) of parent(s)/guardian(s).
3. Enter employer(s) name and address during time period of application.
4. Enter parent(s)/guardian(s) occupation. Indicate if parent(s)/guardian(s) were self-employed, worked full-time or part-time.

IV. HEALTH INSURANCE:

Provide health insurance information for the 12 month period of application.

1. Check all that apply.
2. If you contribute towards the cost of insurance through a payroll deduction indicate the amount.
3. If you purchase insurance directly indicate the premium payment.
4. Expenses are a result of, check all that applies.
5. Indicate if an appeal was filed with your insurance.
6. If you have received financial assistance from another state or another agency, please identify the agency and provide our office with the name of your case manager and phone number.
7. If you acquired financing for the expenses you submitted in your application, the State Office will require a contact at your lending institution to verify necessary information to review your application and documentation of the loan. Also, include a copy of your monthly payment coupon. For a personal loan, please submit a promissory note indicating the amount and terms of re-payment.

V. REFERRAL TO PROGRAM:

1. We are interested in knowing how you found out about the Catastrophic Illness in Children Relief Fund Program. Check all the appropriate box(es).

VI. MEDICAL HEALTH RELATED EXPENSES DURING 12 MONTH PERIOD OF APPLICATION:

1. Include itemized copies of child's uncovered medical bills and proof of payment for each expense you list in the application. Ineligible expenses include, but are not limited to, special education expenses. The payee is any provider that has rendered a service to the child (i.e. physician, health care professional, hospital, home health agency). For each payee, provide the following information:

   Total Amount of Bill = the total amount due from the payee.

   Amount Covered by Insurance or other Source = the dollar amount your insurance company paid either you or the payee, or the dollar amount covered by any other source (i.e., Charity Care, Victims of Violent Crimes Compensation Board, fundraising, financial assistance received from another state agency or school system).

   Amount Paid by Family = the dollar amount the family paid from their own resources on the bill. Do <u>not</u> include any dollar amount the family received from an insurance company.

   Current Balance Due = the dollar amount the family currently owes on the bill <u>after</u> insurance payments, provider write-offs, fundraising, stipends received from another state agency, and/or other payments.

   Health expenses paid or reimbursed by fundraising are not considered by the Fund.

   NOTE: Include itemized copies of all bills, collection notices, cash receipts and/or copies of canceled checks & credit card statements to verify payments and any insurance statements or explanation of benefits for expenses listed on page 5 of the application. Include any transportation receipts for tolls, parking, transit or taxi fare.

VII. CERTIFICATION:

1. Parent(s)/guardian(s) should read this section carefully, then sign and date the application.

2. **REMINDER: Please return completed application to the Special Child Health Services Case Management Unit in your county (see attached list).**

NEW JERSEY STATE DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL CHILD HEALTH SERVICES PROGRAM
COUNTY CASE MANAGEMENT UNITS

1. Atlantic County-SCHS-CMU
6101 Black Horse Pike
Building C
Egg Harbor Twp., NJ 08234
(609) 909-9269

2. Bergen County-SCHS-CMU
Bergen Co. Dept. of Health Services
1 Bergen County Plaza
Hackensack, NJ 07601-4895
(201) 634-2621

3. Burlington County-SCHS-CMU
Virtua Community Nursing Services
15 Pioneer Boulevard
Westampton, NJ 08060-0287
(609) 914-8550, Ext. 48560

4. Camden County-SCHS-CMU
Camden County Div. of Health
DiPiero Center – 512 Lakeland Rd.
Suite 401
Blackwood, NJ 08012-0009
(856) 374-6021 or (800) 999-9045

5. Cape May County-SCHS-CMU
Cape May County Dept. of Health
6 Moore Rd., DN 601 Crest Haven Complex
Cape May Court House, NJ 08210-3067
(609) 465-6841

6. Cumberland County-SCHS-CMU
Cumberland County Dept. of Health
309 Buck Street
Millville, NJ 08332
(856) 327-7602, Ext. 7133

7. Essex County-SCHS-CMU
Special Child Health Services
50 S. Clinton Street, Suite 4301
East Orange, NJ 07018
(973)395-8836 or (973)395-8476

8. Gloucester County-SCHS-CMU
Gloucester Co, Health & Human Serv. Dept.
204 East Holly Avenue
Sewell, NJ 08080
(856) 218-4111

9. Hudson County-SCHS-CMU
Jersey City Medical Center
1825 John F. Kennedy Blvd.
Jersey City, NJ 07305
(201) 201-0004, Ext. 1085

10. Hunterdon County-SCHS-CMU
Hunterdon Med. Ctr.- Child Develop.
190 Route 31, Suite 500
Flemington, NJ 08822-9238
(908) 788-6399

11. Mercer County-SCHS-CMU
Special Child Health Services
1068 Old Trenton Road
Hamilton, NJ 08690
(609) 588-8460

12. Middlesex County-SCHS-CMU
Office of Health Services
35 Kennedy Blvd.
East Brunswick, NJ 08816
(732) 745-3100

13. Monmouth County-SCHS-CMU
SCHS/Early Intervention
Monmouth County
23 Main St., Suite D1
Holmdel, NJ 07733
(732) 224-6950

14. Morris County-SCHS-CMU
Morristown Medical Center
100 Madison Avenue, Box 99
Morristown, NJ 07962-1956
(973) 971-4155

15. Ocean County-SCHS-CMU
Ocean County Health Department
P.O. Box 2191
175 Sunset Avenue
Toms River, NJ 08754-2191
(732) 806-3931

16. Passaic County-SCHS-CMU
Catholic Family & Community Svcs.
775 Valley Road
Clifton, NJ 07013
(973) 523-6778

17. Salem County-SCHS-CMU
Salem County Dept. of Health
110 5th Street, Suite 400
Salem, NJ 08079
(856) 935-7510, Ext. 8305

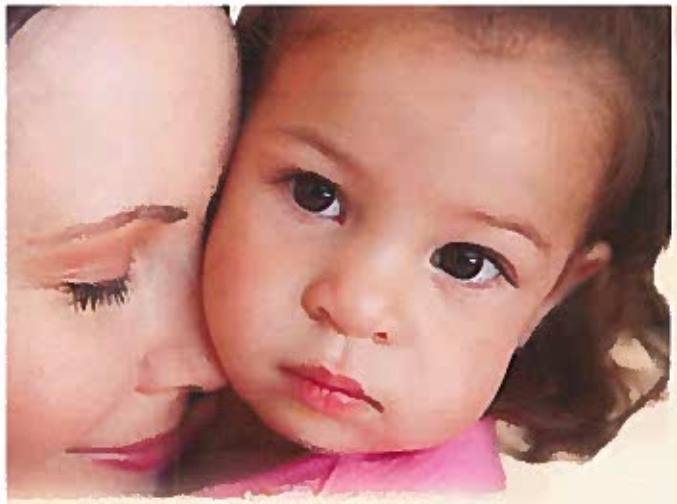
18. Somerset County-SCHS-CMU
Somerset Children's Center
377 Union Avenue
Bridgewater, NJ 08807-0824
(908) 725-2366

19. Sussex County-SCHS-CMU
Special Child Health Services
201 Wheatsworth Road.
Hamburg, NJ 07419
(973) 948-5239

20. Union County-SCHS-CMU
313 South Avenue, Suite 200
Fanwood, NJ 07023
(908) 889-0950, Ext. 2544

21. Warren County-SCHS-CMU
Warren County Health Dept.
Special Child Health Services
700 Oxford Road
Oxford, NJ 07863
(908) 475-7960, Ext. 7035

7/2019-JVF



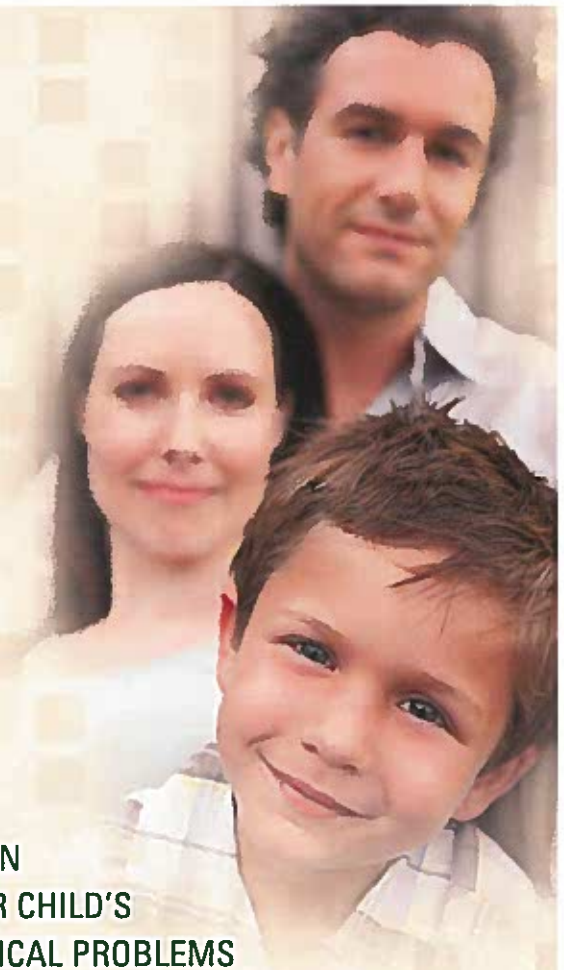
CATASTROPHIC
ILLNESS IN CHILDREN
RELIEF FUND

HOW CAN YOU REACH THE FUND?

EXECUTIVE DIRECTOR
CATASTROPHIC ILLNESS IN CHILDREN RELIEF FUND
PO BOX 728
TRENTON, NJ 08625-0700
(609) 292-0600

FAMILY INFORMATION LINE:
1-800-335-FUND (3863)

WWW.NJCATASTROPHICFUND.ORG



HELP WITH MEDICAL BILLS.
HOPE FOR NJ FAMILIES.

WHEN
YOUR CHILD'S
MEDICAL PROBLEMS
BECOME
FINANCIAL PROBLEMS.

The Catastrophic Illness in Children Relief Fund provides a financial safety net for New Jersey families overwhelmed by medical expenses that are not fully covered by insurance, state or federal programs, or any other resource.

The Catastrophic Illness in Children Relief Fund is a dedicated, revolving, non-lapsing trust fund. The program was established through legislation in 1985 (P.L. 1985 C.370) to be a financial resource for NJ families struggling with their child's medical bills. The Catastrophic Illness in Children Relief Fund Commission administers the Fund.

CATASTROPHIC
ILLNESS IN CHILDREN
RELIEF FUND

ARE YOU ELIGIBLE FOR
FINANCIAL RELIEF?

The Catastrophic Illness in Children Relief Fund was established as a financial resource to help New Jersey families cope with uncovered medical expenses for their children. Any New Jersey family, regardless of income – whether insured or uninsured – may be eligible for assistance.

The Catastrophic Illness in Children Relief Fund Commission reviews income and expenses for a prior consecutive 12-month period in which the expenses were incurred. Eligibility requirements:

- Child was 21 years of age or younger when expenses were incurred.
- Uncovered medical expenses incurred exceeded 10 percent of the first $100,000 of a family's annual income, plus 15 percent of income over $100,000.
- Child's parents or legal guardian have been residents of New Jersey for at least three months prior to submitting an application. Temporary residents are not eligible.

WHAT EXPENSES
ARE ELIGIBLE?

The Catastrophic Illness in Children Relief Fund considers a wide range of health and medical expenses, including services that traditional health insurance may not cover. There are no specific exclusions by diagnosis.

The following list provides examples of the types of incurred expenses that will be considered and may be eligible for payment/reimbursement. The categories include, but are not limited to:

- Specialized pediatric ambulatory care
- Treatment for addictions/mental health services
- Care in acute or specialized hospitals (in and outpatient)
- Physician care in all settings
- Durable medical equipment or disposable medical supplies
- Pharmaceuticals
- Home modifications and medical transportation
- Home health care

HOW DO YOU
APPLY?

- Call the toll-free Family Information Line at 800-335-FUND (3863) for information and to request an application.
- Go to WWW.NJ.CATASTROPHICFUND.ORG and begin the application process on line.
- The completed application is forwarded to the Catastrophic Illness in Children Relief Fund Commission for screening and review All applications to the Fund are confidential.
- The Commission will review the application and determine eligibility and the amount of assistance.
- The Fund disburses approved grant awards directly to the providers to offset outstanding balances.
- The Fund may reimburse families for their out-of-pocket expenses.