# Henry Aucoin Foundation Grant Application Checklist

***Leaving any portion of the grant application blank and/ or not providing receipts for reimbursement may result in the application being dismissed from consideration for a grant. Please make sure you have ALL of the following or your application being dismissed from consideration for a grant.***

________ Complete application with all fields filled out
________ Copies of sources of Income - Include proof of ALL source:
    ________WIC
    ________EBT
    ________Social Security Income
    ________Child Support
    ________Alimony
    ________Disability
    ________Welfare
________ Copies of proof of insurance
    ________Medicaid/ Medicare
    ________Insurance Card
________ Complete HIPPA form
________ Complete Photography Release
________ Letter from cardiologist and/ or surgeon
________Copies of receipts for reimbursement

# Henry Aucoin Foundation Grant Application for Individuals

***Leaving any portion of the grant application blank and/ or not providing receipts for reimbursement may result in the application being dismissed from consideration for a grant.***

Date:_______________

**Personal Information:**

Child's Name:______________________________________

Child's Age______________________Child's Sex: M F

Child's Address:___________________________________________________________________

Parents' Name: ____________________________________________________________________

Parents' Address: __________________________________________________________________

Siblings Names & Ages:_____________________________________________________________

Home Phone:________________ Cell Phone:________________ Other:______________________

Email address:_____________________________________________________________________

Referred to HAF by:________________________________________________________________

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## Medical Information:

Diagnosis or Medical Condition:______________________________________________

Surgery or Procedure Required:_______________________________________________

Medical Equipment Required:__________________________________________________

Additional Medical Needs:____________________________________________________

Pediatrician's Name:_________________________________________________________

Pediatrician's Address:______________________________________________________

Cardiologist's Name:_________________________________________________________

Cardiologist's Address:______________________________________________________

Surgeon's Name:______________________________________________________________

Surgeon's Address:___________________________________________________________

Hospital Name (Where Surgery or Procedure Will Take Place):__________________________

Hospital Address:____________________________________________________________

Estimated Length of Stay in Hospital:_________________________________________

Estimated Length of Stay in New Orleans:______________________________________

Do you have transportation in the New Orleans area?: _________ Type of transportation:_________

Will you be commuting on a daily basis to New Orleans for your child's medical needs?:____________

If so, where from?:_________ Estimated length of commute in miles (round trip):_______________


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## Financial Information:

Are you currently employed: Yes______ No______ ; Full-time______ Part-time______

Annual Gross Family Income:__________________________________________

***Please note that all applications MUST be submitted with 2 most recent paystubs or proof of deposits for all income or application will be considered null & void. If direct deposited and you do not receive a paper stub, you must submit your bank statements.***

Amount of Other Sources of Income:____________________

Sources of Income Include: _______WIC _______EBT _______Social Security Income

_______Child Support _______Alimony _______Disability _______Welfare

_______Medicaid/ Medicare

If any other, please list & explain:________________________________________

Have you received any grants for medical expenses (CHAPS, etc.) : Yes______ No______

Number of Individuals living with child:________

Do either or both parents have special needs: Yes______ No______

_______Blind _______Deaf _______Physical Disability _______Paralysis

If other, please explain:_____________________________________________

Does the ***child*** receive any of the following services (Check all that apply & provide copies of most recent documentation if applicable):

_____SSI, Monthly Amount $_____________

_____ Medicaid/ Medicare

_____Private Insurance; Insurance Provider__________________________________

_____Parish/ County Social Worker/ Coordinator

Name:_________________________

Phone Number:___________________Email Address:___________________

_____Other__________________________________________________


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***Leaving any portion of the grant application blank and/ or not providing receipts for reimbursement may result in the application being dismissed from consideration for a grant.***

**<u>Grant Funds Information:</u>**

Amount of Funds needed (please specify):$________________________________________

What is the intended use of the funds you are applying for:

Food _________ Lodging _________ Gas _________ Medicine _________

Medical Equipment _________ Medical Expenses _________ Compounding __________

Other (Please List) ___________________________________________________________

Please attach any vendor estimate(s) if applicable. Lack of estimates or receipts may affect your grant amount and the type of grant you receive.

What portion or percentage will any of the previously listed sources of income and support service pay towards the request for your child's need(s)?_______________________________________

What amount of money from your personal funds will you be able to contribute towards the request for your child's need(s)?_____________________________________________________

Please describe in detail the main reason the funds are needed and any information you feel would be helpful. Include disability related expenses (clothing, equipment, dietary needs, medicines, etc.) that significantly reduce your family's annual income.

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*Applications will only be deemed completed and ready for consideration after letters of support from your child's physician (s) and vendors estimates, if applicable, are received. Additional documentation may be required upon request in order to be approved for a grant.*

*We request that you keep all receipts for any expenses incurred for which you are asking financial assistance. Our board may request copies before grant approval is given. Lack of receipts may affect your grant amount and the type of grant you receive.*

*Leaving any portion of the grant application blank may result in the application being dismissed from consideration for a grant.*

*Grant approval is based on information given in the grant application by the applicant and any supporting documentation. Grant approval is not guaranteed. Grant amount is not a set standard amount. Each application is reviewed and approved on an individual basis. Grant can be distributed in various forms and cash grants are not a guarantee.*

*Grants are reviewed and approved or denied by the HAF Board of Directors on a quarterly basis. Deadlines for each quarter are March 31, June 30, September 30 and December 31. Each applicant will be notified via mail of their grant approval or denial within 15 days of the HAF Board vote.*

I hereby grant permission for Henry Aucoin Foundation to receive medical information re: the above listed patient freely and without reservation, as well as any information related to my requests for grant funding, i.e. lodging, medical expenses, etc, without reservation.

I hereby grant permission to Henry Aucoin Foundation to verify the information provided within this application and to determine applicant's need for an HAF grant by all means allowable under state and federal law, including, but not limited to, by conducting background checks, by interviewing friends, family members and neighbors, by conducting criminal history checks, by interviewing past and present employers/co-workers and by otherwise verifying information received by the applicant and/or any other source regarding applicant's need and fitness for such grant. I understand that my application for these grant funds is not confidential and that by applying for these funds such application may be made public for the purpose of verifying the information contained therein, with the exception of any and all medical records, the confidentiality of which will be controlled by the Medical Records Release Authorization.

I hereby certify that by signing below that the foregoing information is complete and accurate to the best of my knowledge. I acknowledge that any falsification of information in the above application, and illegal or misuse of grant funding will result in the returning of the funds in full to the Henry Aucoin Foundation and legal ramifications.

I hereby further agree to submit a written report to the Board of Directors of the Henry Aucoin Foundation to the address below within twelve months of receipt of any grant funds explaining the actual use of the funds received.

Applicant's Name:________________________Applicant's Signature:______________________

Submit application and all documentation to:
Henry Aucoin Foundation Grants
P. O. Box 642
Metairie, Louisiana 70004
or info@henryaucoinfoundation.org

# MEDICAL RECORDS RELEASE AUTHORIZATION

Note:

This authorization consists of four (4) pages, each of which is to be signed and dated. The PATIENT shall sign this Authorization, or, in the case of a PATIENT who is deceased or incapable of signing this Authorization, the Authorization shall be signed by PATIENT's AUTHORIZED LEGAL REPRESENTATIVE.

The undersigned (please check one) ☐ PATIENT

☐ AUTHORIZED LEGAL REPRESENTATIVE of PATIENT

hereinafter referred to as GRANTOR OF AUTHORITY, hereby authorizes, grants permission to and requests the HEALTH CARE PROVIDER identified below to furnish to REQUESTING PARTY copies of any and all MEDICAL RECORDS regarding the PATIENT.

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**PATIENT identifying information:** please print or type:

PATIENT: Name: ______________________________________________________________

Social Security Number: ___________________________Date of Birth: _________________________

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**GRANTOR OF AUTHORITY (either the PATIENT or the AUTHORIZED LEGAL REPRESENTATIVE of the PATIENT):** please print or type:

Name: ______________________________________________________________

Address: ______________________________________________________________

Telephone: ______________________________________________________________

Statement of Authority to Act on behalf of PATIENT (If this Authorization is executed by the PATIENT, simply write in "self."): **SELF**

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**HEALTH CARE PROVIDER to whom/which this Authorization is directed:** please print or type:

Name: ______________________________________________________________

Address: ______________________________________________________________

Telephone: ______________________________________________________________

**This is page 1 of 4 pages of this authorization. It is signed and dated on this page by GRANTOR OF AUTHORITY, i.e., the PATIENT or the AUTHORIZED LEGAL REPRESENTATIVE of the PATIENT:**

DATE:________________________ ________________________________________________

Signature of GRANTOR OF AUTHORITY

This Medical Records Release Authorization is made pursuant and subject to the following provisions and restrictions:

1. Terms in "CAPITAL LETTERS" are defined below.

2. This release does not authorize verbal communications by the HEALTH CARE PROVIDER to the REQUESTING PARTY.

3. The HEALTH CARE PROVIDER is authorized and requested to honor a photostatic copy of this authorization as if it were an original.

4. The REQUESTING PARTY is obligated by Article 1465.1(C) of the Louisiana Code of Civil Procedure to provide to the PATIENT (or to his/her attorney if PATIENT is represented) a copy of the request directed to the HEALTH CARE PROVIDER. The REQUESTING PARTY is obligated by Article 1465.1(D) of the Louisiana Code of Civil Procedure to provide to the PATIENT (or to his/her attorney if PATIENT is represented), within seven days of receipt, a copy of all documents obtained by the REQUESTING PARTY pursuant to this authorization.

HIPAA-required provisions:

5. Identification of the persons or class of persons authorized to make the disclosures hereby authorized: HEALTH CARE PROVIDERS.

6. Identification of the person (recipient) to whom the HEALTH CARE PROVIDER is authorized to make the disclosures hereby authorized: the REQUESTING PARTY.

7. Description of the health information to be disclosed: MEDICAL RECORDS (i.e., any and all information, records, documents or reports of or regarding the provision of any HEALTH CARE PRODUCTS AND/OR SERVICES to PATIENT at any time during the ten years prior to the date of this authorization, as more fully defined below).

8. Description of the purpose for the disclosure of MEDICAL RECORDS authorized hereby: for use in litigation.

9. Statement regarding content of the MEDICAL RECORDS: The MEDICAL RECORDS whose disclosure is hereby authorized may contain sensitive medical information about the PATIENT, including, but not limited to, information relating to: sexually transmitted diseases; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral or mental health services; and treatment for alcohol and/or drug abuse.

10. Statement regarding re-disclosure: the MEDICAL RECORDS disclosed pursuant to this Authorization may be re-disclosed by the REQUESTING PARTY to other attorneys in or em ployees of his lawfirm, to his client and its representatives, and/or to other counsel or parties in the pending litigation, and thus may no longer be protected by Federal privacy regulations.

11. Statement regarding revocation: This Authorization may be revoked at any time by GRANTOR OF AUTHORITY. To revoke this Authorization, GRANTOR OF AUTHORITY or his representative should send a notice of revocation, in writing, by certified mail, to REQUESTING PARTY at the address given herein. It is understood that such a revocation will not apply to information previously released pursuant to this Authorization, and that prior reliance upon this Authorization cannot be reversed.

**This is page 2 of 4 pages of this authorization. It is signed and dated on this page by GRANTOR OF AUTHORITY, i.e., the PATIENT or the AUTHORIZED LEGAL REPRESENTATIVE of the PATIENT:**

DATE:________________________ ____________________________________________

Signature of GRANTOR OF AUTHORITY


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12. This Authorization has been signed by GRANTOR OF AUTHORITY voluntarily. GRANTOR OF AUTHORITY may refuse to sign this Authorization. No HEALTH CARE PROVIDER may refuse services to PATIENT based upon a refusal to sign this Authorization.

13. Statement regarding expiration: This Authorization shall expire one year from its date or upon termination of the litigation for which it was provided.

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**DEFINITIONS:**

"AUTHORIZED LEGAL REPRESENTATIVE" means and includes: a 'Representative' as defined by LSA-R.S. 40:1299.39(A)(5) and/or LSA-R.S. 40:1299.41(A)(6); and/or the guardian, tutor, executor, attorney or other legally-appointed and/or legally-authorized representative of PATIENT.

"GRANTOR OF AUTHORITY" means the person who has signed this Authorization. This shall be either the PATIENT or the AUTHORIZED LEGAL REPRESENTATIVE of the PATIENT.

"HEALTH CARE PRODUCTS AND/OR SERVICES" means and includes any of the following:

(a) Medical, physical, rehabilitative, psychiatric, psychological, and/or therapeutic analysis, consultation, counseling, diagnosis, examination, observation, testing, and/or treatment.

(b) Laboratory testing and analysis; radiological or roentgenological services; CT, MRI, PET, and/or other diagnostic scanning services; emergency medical services; and/or any other medical, physical, rehabilitative, psychiatric, psychological and/or therapeutic services.

(c) Drugs; medication; prostheses; equipment used to assist in mobility, such as wheelchairs, walkers, braces; optical products and devices, including, but not limited to eyeglasses and contact lenses; aural products and devices, including, but not limited to, hearing aids; therapeutic products and devices; biological products (including, but not limited to, tissue, blood, serum, bone, and/or organs); biomechanical products and devices; implanted electronic devices such as pacemakers; implanted electro-mechanical devices; implanted or replacement orthopedic devices such as replacement hips, knees, bones, screws and plates; and/or any other medical, physical, rehabilitative, psychiatric, psychological and/or therapeutic products and/or devices, and/or the sale or provision of any of the foregoing.

"HEALTH CARE PROVIDER" means and Includes:

(a) Any 'Health Care Provider" as defined by LSA-R.S. 13:3734(A)(1), LSA-R.S. 40:1299.39(A) and/or LSA-R.S. 40:1299.41(A)(1); any 'Hospital' as defined by LSA-R.S. 40:2102; any 'Nursing Home' or 'Home' as defined by LSA-R.S. 40:2009.2; any 'Physician' as defined by LSA-R.S. 40:1299.39(A)(2) and/or LSA-R.S. 40:1299.41(A)(2); and/or as contemplated by Article 1465.1 of the Louisiana Code of Civil Procedure; and/or

(b) Any person, partnership, corporation, limited liability company, government agency, facility, institution or other entity which sells or provides any HEALTH CARE PRODUCTS AND/OR SERVICES, including, but not limited to, any of the following: am bulance service, blood bank, bone bank, chiropractor, clinic, dentist, diagnostic laboratory, **doctor,** drugstore, emergency medical service, emergency medical technician, **hospital,** licensed midwife, medical laboratory, medical supply outlet, medical technician, nurse anesthetist, nurse midwife, occupational therapist, optometrist, organ bank, out-patient clinic, pathologist, pharmacist,

**This is page 3 of 4 pages of this authorization. It is signed and dated on this page by GRANTOR OF AUTHORITY, i.e., the PATIENT or the AUTHORIZED LEGAL REPRESENTATIVE of the PATIENT:**

DATE:________________________ ______________________________________________

Signature of GRANTOR OF AUTHORITY

pharmaceutical company, **physical therapist, physician,** podiatrist, prosthetist, **psychiatrist, psychologist,** radiologist, radiological or roentgenological clinic, registered or licensed practical nurse, rehabilitationist, social worker, **surgeon,** surgical supply outlet or tissue bank.

"MEDICAL RECORDS" means any and all information, records, documents or reports of or regarding the provision of any HEALTH CARE PRODUCTS AND/OR SERVICES to PATIENT at any time during the ten years prior to the date of this authorization, including, but not limited to:

**(a)** **hospital medical records,** including but not limited to: charts; files; clinical notes; doctors' notes; nurses' notes; progress notes; operative reports; notes, records or logs of any and all treatment and/or therapy; medication notes or logs; notes, records or reports of diagnosis or prognosis; emergency room records; and/or operating room records;

**(b)** **doctors medical records,** including but not limited to: patient files; patient charts; reports; consultation reports; reports, records and/or logs of exam inations, tests, treatment, diagnosis and/or prognosis;

**(c)** **medical and/or diagnostic test results of any kind,** whether generated by doctor, nurse, clinic, laboratory, camera, machine, computer or otherwise, including, but not lim ited to: x-ray films, CT scan films, MRI films and/or any other test procedure result;

(d) records of therapeutic services of any kind, including, but not limited to: **physical therapy** and/or acupuncture;

**(e)** **pharmaceutical records** of any kind, including, but not limited to: drugstore or pharmacy records of prescription medicine;

(O **records or reports of psychiatric, psychological, and/or disability/impairment care, therapy, treatment, consultation or testing;**

(g) records or reports of or regarding prosthetic devices and/or implanted hardware or devices; and

(h) any and all records or reports which are in the possession or control of the HEALTH CARE PROVIDER to which this authorization is directed, even though such records or reports were produced by any HEALTH CARE PROVIDER <u>other than</u> the HEALTH CARE PROVIDER to which this authorization is directed

(i) any and all billing/payment records for services provided by any HEALTH CARE PROVIDER.

including, but not limited to, computerized, imaged, photocopied, recorded and/or databased versions of any of the foregoing.

"PATIENT" means the person to whom HEALTH CARE PRODUCTS AND/OR SERVICES were provided by the HEALTH CARE PROVIDER to whom this Authorization is directed and whose MEDICAL RECORDS are hereby requested. The PATIENT is identified on page one of this Authorization.

"REQUESTING PARTY" means Henry Aucoin Foundation, 224 Penfold Place, Harahan, Louisiana 70123.

**This is page 4 of 4 pages of this authorization. It is signed and dated on this page by GRANTOR OF AUTHORITY, i.e., the PATIENT or the AUTHORIZED LEGAL REPRESENTATIVE of the PATIENT:**

DATE:________________________ __________________________________________________

Signature of GRANTOR OF AUTHORITY

**Henry Aucoin Foundation**
**Board of Directors**
Susan Sciortino Aucoin, *President*
Dwayne Aucoin, Vice President
Kelly Theard, Secretary
Betsy Hirling Dobson
Dr. Scott Macicek
Brian Marcelle
Jamie Napolitano
Anne Orillion
Caroline Munson Robertson
Lana Stevens
Roy Taylor

# PHOTO RELEASE

Release Form for Use of Photographs &/ or Videotape Materials

I hereby grant permission to the Henry Aucoin Foundation the use of any photographs or videotape material taken by myself or Henry Aucoin Foundation or its affiliates.

I understand and agree that these materials will become the property of the Henry Aucoin Foundation and will not be returned.

I hereby authorize the Henry Aucoin Foundation to edit, alter, copy, exhibit, publish or distribute the photo for purposes of publicizing the programs of the Henry Aucoin Foundation or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein the below named child appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photographs or videotape materials.

I hereby hold harmless and release and forever discharge the Henry Aucoin Foundation from all claims, demands, and causes of action, which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 21 years of age and am competent in my own name. I have read this release before signing below and I fully understand the contents. meaning and impact of this release.

___________________________
Name of Grant Recipient

___________________________ ________________________________ _________________
Printed Name Signature Date

If the person signing is under age 21, there must be consent by a parent or guardian.

I hereby certify that I am the parent or guardian of ______________________________, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

___________________________ ________________________________ _________________
Printed Name Signature Date


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