



Capernaum  
Foundation

## Application for Financial Assistance

You will need the following information to complete the application:

- Name, contact and identification information for the person requesting financial assistance (e.g., home address & telephone number, birth certificate copy, passport, Social Security Number.) Copies of some documents must also be submitted.
- Insurance information and ID (e.g., insurance card(s), physician office or hospital claim forms, insurance company Explanation of Benefits)
- Applicant financial information (e.g., tax return for the most recently filed tax year, pay stub(s)).
- Name and contacts for the applicant's physician(s).
- Medical information about the patient/applicant, including his or her current condition, treatment plan and prognosis, and the expected cost of treatment.

When completing the form, Applicant refers to the individual(s) who would enter into a grant award agreement with the Capernaum Foundation. Generally, this will be the patient whose medical situation is the basis for the grant request. However, this may be a parent or guardian in the case of a minor child or dependent adult.

The Capernaum Foundation closely evaluates each application for financial assistance. Please complete each section completely and carefully. Common factors that cause delay or rejection of applications include missing or incorrect information, items that cannot be verified, or contact information that is no longer active.

If you need assistance in completing the form or have questions about what documents to use and/or submit, please call us at 720-324-5050.

Continue to Application 



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## Application for Financial Assistance

### PART I: PATIENT/APPLICANT INFORMATION

Family/Last Name                      Given/ First Name                      Middle Name/Initial

Date of Birth (mm/dd/yyyy)              Gender                      Marital Status

Social Security Number              Height                      Weight

Home Address

Street

Apt. Number

City

State/Province

ZIP/Postal Code

Country

Primary Telephone No.

Alternate Telephone No.

Email Address



**PART III: CURRENT MEDICAL CONDITION**

Primary Medical Diagnosis

Date First Diagnosed

Primary Symptoms

Current Treatment(s)

Treating Physician(s)

Name	Address	Phone

Other Medical Conditions

Current Medications

Name	Dosage	Frequency	Prescribing Physician	Out of Pocket Cost

**PART IV: MEDICAL HISTORY**

Medical Conditions from which You Suffered in the Past

Past Surgeries (List procedure, reason for the procedure and the month/year it was performed)

**PART V: FINANCIAL INFORMATION**

For the most recent tax year, what was your household

Gross Income?

Adjusted Gross Income?

How many people live in your household?

Is the person for whom assistance is requested claimed as a dependent on a tax return?

Yes

No

If Yes, By whom?

Employment (List all members of the household)

Person's Name	Current employer	Position	Monthly Salary/Wage	Employer Address & Phone

Income Verification: You will need to send the Capernaum Foundation a copy of your current Federal Income Tax Return, or a copy of your Social Security awards letter, pension statements, or W-2 forms if you do not file a tax return or if this information does not appear on your tax return.

**PART VI: MEDICAL TREATMENT(S) FOR WHICH ASSISTANCE IS REQUESTED**

**Surgery(ies)/Treatment**

Procedure	Physician & Hospital	Estimated Billed Charge(s)	Estimated Insurance Pmt.	Your Out-of-Pocket Cost

How much did you spend on medical care for the Applicant during:  
The most recent 12 month period?                      The upcoming 12 month period

**PART VII: INSURANCE INFORMATION**

**Section A. Insurance Coverage**

List all insurance companies that provide coverage for the applicant's medical expenses. Submit a copy of the front and back sides of any insurance cards to the Capernaum Foundation along with this application.

**Primary Insurance Company Information**

Insurance Company Name

Member Services Telephone Number

Subscriber Name

Relationship to Applicant

Subscriber ID No.

Subscriber Date of Birth

Subscriber Address (If different from Applicant)

Street

Apt. Number

City

State/Province

ZIP/Postal Code

Country

Primary Telephone No.

Alternate Telephone No.

**Secondary Insurance Company Information**

Insurance Company Name

Member Services Telephone Number

Subscriber Name

Relationship to Applicant

Subscriber ID No.

Subscriber Date of Birth

Subscriber Address (If different from Applicant)

Street

Apt. Number

City

State/Province

ZIP/Postal Code

Country

Primary Telephone No.

Alternate Telephone No.

**Section B. Other Benefit Programs**

List any public, private, charitable, or government benefit program that provides support for the Applicant's medical expenses. Include a description of the benefits or funds available, any restrictions on their use, and a contact person with whom Capernaum Foundation representatives can speak to review the benefits.

Program Name	Benefits	Restrictions	Contact name & telephone number

**PART VIII: AUTHORIZATION TO RELEASE MEDICAL RECORDS**

[Click to open the Authorization to Release Medical Records form.](#) It will open in a new window. Complete, sign, and return the form to the Capernaum Foundation.

**PART IX: AUTHORIZATION TO COMMUNICATE WITH OTHERS**

Name Relationship to Applicant  
Primary Telephone No. Alternate Telephone No.

**PART X: DESTINATION HEALTHCARE**

Destination healthcare is the practice of traveling, often across state, national and international borders for medical care. Hospitals selected for destination healthcare are considered centers of medical excellence in a particular specialty(ies). This often creates opportunities for available financial resources to extend to cover more frequent and/or more effective treatment.

If the medical procedure for which you are requesting assistance is a candidate for international destination healthcare, are you willing to travel outside the United States for medical services?

Yes No

## PART XI: AGREEMENTS

I affirm that the information provided in this application is complete and accurate. I understand and agree that reported financial information may be verified as deemed necessary by the Capernaum Foundation. I understand that I am required and agree to notify the Capernaum Foundation if my financial situation, insurance status, or medical condition changes from that which is reported in this application (including changes in the products I am using or the dosage or frequency of therapy).

Accepted and Agreed

I affirm that I have not received any other financial assistance for the payment for which I have applied to the Capernaum Foundation (including, but not limited to, Medicaid, state and/or pharmaceutical company drug assistance programs, or copayment assistance programs) nor will I receive such assistance from a medical reimbursement plan, including flexible spending accounts, health savings accounts, or health reimbursement accounts.

Accepted and Agreed

I understand and agree that the Capernaum Foundation is providing grant assistance for the treatment described in this application as prescribed by my healthcare provider(s). I agree that the Capernaum Foundation is in no way responsible for the success or failure of this therapy or for any harm to my health that it may cause.

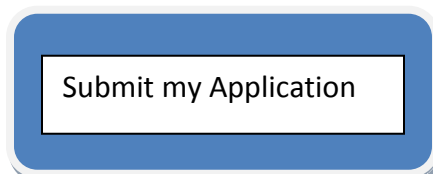
Accepted and Agreed

I understand and agree that the Capernaum Foundation may, at any time and without notice, modify or discontinue any or all of the programs with respect to any application or in their entirety, to modify the related eligibility criteria, or to terminate assistance at any time.

Accepted and Agreed

By clicking below, I affirm that the information provided in this application is complete and accurate. I further authorize the Capernaum Foundation to verify my financial information as deemed necessary by the Foundation. I agree to notify the Capernaum Foundation if my financial situation, insurance status, or medical condition changes from that which is reported in this application (including changes in the products I am using or the dosage or frequency of therapy). I affirm that I have not received any other financial aid for the medical need for which I have applied, including, but not limited to, Medicaid, state drug assistance programs, or copayment assistance programs nor will I receive such assistance from a medical expense reimbursement plan, including, but not limited to, a flexible spending account, health savings account or health reimbursement account.

Accepted and Agreed





Thank you for submitting your application for grant assistance to the Capernaum Foundation.

Please remember that you are not quite finished yet. You will need to submit the following information to complete the application:

- Proof of identity: Submit either a copy of the applicant’s passport or one each from Column A and from Column B.

Column A	Column B
Driver’s license with photo	Explanation of Benefits form from an insurance company
Military ID	Social Security card
Military dependent ID	Government-issued Permanent Resident Card
Birth certificate copy	Government-issued Alien Registration Card
Student ID with photo and a grade report from the most recent school term	Employer pay stub

- Insurance information: Submit a copy of both sides of all insurance cards covering the applicant.
- Financial information: Tax return from the most recently completed tax year
- Authorization to Release Medical Information

The information above may be or emailed to [info@capernaumfoundation.org](mailto:info@capernaumfoundation.org) or faxed to 720-324-5067.

Include on the fax cover sheet or in the email subject line, the Applicant’s full name and postal code.