**Savannah’s Hope**

3603 E. 41st Court

Des Moines, IA 50317

[savannahshope@yahoo.com](mailto:savannahshope@yahoo.com)

**Application For Medical Expense Assistance**

Savannah’s Hope Medical Expense Assistance Program is designed to financially assist children living with Rare Diseases who are unable to pay medical traveling expenses not covered by insurance. Please read the following thoroughly and complete the attached application. All information provided on this application is confidential and will only be used for purposes of record keeping. Applications are currently accepted on a rolling bases as funds are available and we reserve the right to request additional information from applicants before offering assistance. Please bear in mind that an incomplete application could affect your chances of being considered for medical expense assistance. Do not leave any part of this application unfinished. For questions, comments, or concerns regarding this application, contact the Savannah’s Hope at [savannahshope@yahoo.com](mailto:savannahshope@yahoo.com)

**I. Qualifications**

The applicant must satisfy the following requirements:

(a) Be lawfully present in the United States

(b) Be a child diagnosed with a Rare Disease

(c) Read and sign nondiscrimination policy prior to award of assistance.

(d) Be able to furnish information to corroborate (a) and (b) as well as proof of medical traveling/supply expenses that are relevant to the current medical expense assistance application if asked.

**II. Additional Information**

If contacted by the board, the medical expense assistance applicant must respond within two weeks (14 days) in order for the application to remain active.

**III. Interview**

1. The board may choose to schedule a phone interview with the applicant.

2. The interview will consist of questions that will remain the same for all applicants as well as additional information requested by the board.

3. Interview Questions that might be asked.

1. What is the reason for applying for Medical Expense Assistance?

2. Are you getting funding from another source for the same thing?

3. Are you willing to provide receipts?

**IV. Appeals**

You may not appeal a denial of assistance. Your application will remain active and the Board may request updated information upon a review of your application as additional funding is available.

**V. Assistance Allotted**

Savannah’s Hope reserves the discretion to choose method payment and amount approved.

**Parent/Guardian Contact**:

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Information:**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child’s treatment under the direction of a local physician? If so what is the treating physician’s name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expense Information:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cost (Approx.):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_