To whom it may concern:

Thank you for your interest in The Hailey Mayz Foundation Financial Assistance Program in partnership with aMAYZing Kids. While aMAYZing Kids is contractually obligated to collect insurance co-payments and co-insurance from its contracted insurance payers, those in financial need may be eligible for co-pay or other financial assistance in accessing pediatric therapy. There are a number of medical co-payment and financial assistance providers that can help with this - a partial list is available from aMAYZing Kids at the front desk.

The Hailey Mayz Foundation, a 501(c)(3) non-profit organization, has the unique opportunity to assist current patients of aMAYZing Kids who have a documented determination of financial need. This Hailey Mayz Foundation Financial Assistance Program was established primarily to assist patients who have current and valid commercial insurance but are in need of financial help with their co-payment and or co-insurance to meet contractual obligations with insurance carriers for pediatric therapy.

To apply for this program, please follow the steps listed below:

1. Complete the attached Enrollment Application in full – including signature section on page 3
2. Submit copies of current financial documents
3. Submit copies of your insurance card(s)
4. Submit a copy of your child's most recent evaluation. If you do not have a recent evaluation, we welcome you to reach out to aMAYZing Kids Clinic to set one up. We will not be able to process your application without a complete evaluation. They can be reached at (949) 600-5437
5. Mail or fax the completed and signed application with supporting documents to:
    a. The Hailey Mayz Foundation – 20902 Bake Parkway, Ste 100, Lake Forest, CA 92630
    b. Fax: 949-600-5439 – attn: The Hailey Mayz Foundation Financial Assistance Program

We will process and evaluate all completed enrollment applications. Approval is not guaranteed and is dependent on a number of factors, including Hailey Mayz Foundation funds available, correct and complete enrollment application information and financial need. Please ensure all information is correct and copies of all supporting documentation are provided. Once a completed enrollment application is received, eligibility and approval or denial status will be determined. Criteria for eligibility can be obtained by contacting the Hailey Mayz Foundation.

We look forward to receiving your application.

Sincerely,

The Hailey Mayz Foundation

Copay Assistance Enrollment Application

Completing this application does not guarantee acceptance in The Hailey Mayz Foundaion Copay Assistance Program.

Patient Information – Please Complete in Full

Patient Information – Complete in Full

Patient Legal Last Name:	Legal First Name:	Marital Status: ☐ Married ☐ Single	
Phone: ☐ Home ☐ Other	Phone: ☐ Home ☐ Other	The Assistance Fund may contact me via text message or E-mail regarding my assistance. ☐ Yes ☐ No	
Mailing Address or P.O Box:	E-mail Address:		
City:	State:	Zip Code:	
Social Security Number:	Sex: ☐M ☐F	Date of Birth (MM/DD/YYYY):	Are you a U.S. citizen or permanent resident? ☐ Yes ☐ No
Diagnosis:			
Alternate Contact First and Last Name:	Relationship to Patient:	Phone: ☐ Home ☐ Work ☐ Cell	

Insurance Information

Insurance Information

Do you have insurance from: (Check all that apply) ***(Include copies of insurance cards):***

☐ No Insurance (Move to Income/Financial section) ☐ Employer supplied ☐ VA benefits

☐ State Assistance or State Medical Aid ☐ Private Drug Coverage ☐ Military benefits

☐ Medicaid ☐ Other _____

☐ Medicare (Select all that apply)

☐ Medicare Part A ☐ Medicare Part B ☐ Enrolled in Medicare Part D ☐ Eligible for Medicare Part D

Do you currently receive Social Security Disability Benefits? ☐ Yes ☐ No

Date you started receiving Social Security Benefits:

Name of Insurance:		Cardholder First and Last Name:	Relationship:
Member ID #:	Group #:	Phone:	Secondary Phone:

Type of **Secondary** Insurance Coverage, check the box below that applies ***(Include copies of insurance cards):***

☐ Not Applicable ☐ Medicare ☐ Medicaid ☐ State Medical Aid ☐ Commercial Coverage ☐ Other _____

Name of Insurance:		Cardholder First and Last Name:	Relationship:
Member ID #:	Group #:	Phone:	Secondary Phone:

Income / Financial Information

Income / Financial Information

Household Size:
(Number of people who contribute to or are dependent on your current annual household income including yourself)

(Check appropriate box) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Other ____ (list number of people)

Current Annual Household Income based on Household Size from above (Specify Below): _____*

☐ Salary/Wages: $_____	☐ Alimony: $_____
☐ Social Security: $_____	☐ Interest/Dividends/Annuities: $_____
☐ Pension:$ _____	☐ Income Assistance (Other Government Entitlements): $_____
☐ Other:$_____	☐ Unemployment Compensation:$_____

Income / Financial Documentation

PROOF OF FINANCIAL - INCOME DOCUMENTS
REQUIRED WITH SUBMISSION OF APPLICATION
****** SEND COPIES ONLY ******

INCLUDE COPIES OF FINANCIAL - INCOME DOCUMENTS WITH ENROLLMENT APPLICATION

Did you file Federal Income Tax last year? ☐ Yes ☐ No

IF YES: Provide the following Preferred Documentation:

☐ Copy of last year's Federa l Tax Return
(Examples: 1040, 1040EZ, 1040A, 1040X, 1099, W2)

IF NO: Provide one of the following Alternative Financial Documents:

☐ Statement of Social Security Benefits

☐ Statement of Pension/Retirement Benefits

☐ Copies of last three (3) pay statements showing income and deductions for applicant and/or spouse or guardian.

Financial Assistance Program Enrollment Terms and Conditions

Compliance: If enrolled, I agree to attend all scheduled sessions in accordance to the plan determined by the aMAYZing Kids specialists. I understand that failure to attend these sessions will result in a termination of my involvement in this program. In the event I no longer need financial assistance because I have found other means of financial assistance to pay for my sessions, I may be removed from participation in the Financial Assistance Program.

Certification and Acknowledgement: I agree that all of the information I have provided is truthful and accurate to the best of my knowledge. I understand that my application for assistance does not guarantee funding will be available. I understand that financial assistance is provided for a set period of time - or sessions - as determined by the aMAYZing Kids specialists and The Hailey Mayz Foundation. I must reapply for assistance after each set period expires. There is no guarantee funding will be available in any subsequent period of time.

Provision of Assistance: I acknowledge that the Financial Assistance Program has been established to help patients in need of financial assistance with their pediatric therapy program who qualify for such assistance pursuant to the rules established by The Hailey Mayz Foundation. I further agree that if approved for financial assistance, my participation requires that I meet the program rules throughout the period of time that I receive assistance from the Financial Assistance Program.

Change in Insurance, Household Income / Household Size or Other Information Provided in the Application: I agree that at any time that I am receiving assistance from the Financial Assistance Program if my insurance benefit changes, if I am no longer in need of assistance, if I am in need of less assistance, or if my household income or household size changes, I will immediately notify The Hailey Mayz Foundation with such change. Changes may impact my participation in the Financial Assistance Program including a reduction in the amount of assistance provided or a termination of assistance entirely. All provisions of assistance are based upon the program rules established by The Hailey Mayz Foundation and not all applicants are eligible for participation.

Furthermore, if I begin receiving government medical / therapy benefits (ie. Medicare, Cal-Optima, CCS, RCOC, MSI), and any portion of the benefits are retroactively billable for and reimbursed to aMAYZING Kids, I will be responsible for reimbursing The Hailey Mayz Foundation for any amount of retroactive assistance that I received under this program allowed under expectation and limitations of California and US law.

Patient Authorization to use or release Protected Health Information

I authorize the use and disclosure of my individually identifiable health information ("Protected Health Information") by the Hailey Mayz Foundation, a non-profit organization, to process my application for the Financial Assistance Program, to enroll me in the Financial Assistance Program if I am eligible and there are funds available, and to administer the Financial Assistance Program if I am enrolled. I authorize my health care provider and insurance benefit provider (including my insurance benefit providers' administrator – if any) to disclose to The Hailey Mayz Foundation my health information (orally or in writing) for the purposes herein. I understand that once my Protected Health Information is released pursuant to this authorization that it may be subject to re-disclosure. I may withdraw this authorization at any time by mailing or faxing a letter of revocation of authorization. If I revoke this authorization I will no longer be eligible to receive assistance through The Hailey Mayz Foundation Financial Assistance Program. This authorization expires annually.

_____ _____

Signature of Patient or Patient's Representative (*if applicable)* Date

_____ _____

Print Name of Patient or Patient's Representative (*if applicable)* Relationship to Patient (*if applicable)*