Navigating the Road to Health: Healthcare Fund

Return to: **Phillip Burrell @ Project Everlast**
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Applications must be filled out by the person requesting funds. Exceptions may be made due to disability if stated on the application. Applications will be reviewed as received. Please allow up to 5 business days for review and processing of applications if they are filled out completely. If approved, applicant may receive up to $150 within a 12-month period. After approval, Project Everlast will either provide applicant with a voucher to pay for future services, a check for reimbursement of services or a confirmation that payment has been sent to the provider.

General Information

Have you applied for assistance through this fund in the past? ☐ No ☐ Yes

Amount requested $_____ Date application submitted: _____

****Please provide documentation of amount owed for services****

Type of provider (*optional*): ☐ Medical ☐ Dental ☐ DME (Durable Medical Equipment) ☐ Pharmacy ☐ Vision ☐ Behavioral Health

_____ _____ _____
First Name Last Name MI

_____ _____ _____ _____
Date of Birth Age Gender Phone Number

_____ _____ _____ _____
Address City State Zip code

Background Information

What is your annual income? (*Optional)*
(include all forms of income, ie. child support, SSI/SSD, ADC, alimony, SNAP, etc.)
$_____ per hour _____hours per week _____ (other)

Were you formerly a state ward or in foster care? ☐ Yes ☐ No ☐ Verified _____
(office use only)

If known, please list a professional reference who can verify that you were a state ward (DHHS/NFC caseworker, Independent Living worker).

_____ _____ _____
Name Phone Email

Are you currently enrolled in Medicaid? ☐ Yes ☐ No ☐ Unknown

If not, have you applied? ☐ Yes ☐ No ☐ I want help applying

If yes, do you have a share of cost? ☐ Yes ☐ No

*Share of cost advises the provider that the client is eligible for Medicaid, but before payment of medical services is approved, the client must pay or obligate his/her share of cost on medical services or supplies.

Do you have private health insurance through family, work or school? ☐ Yes ☐ No

If yes, do you need assistance paying your copays and/or deductible? ☐ Yes ☐ No

If not, have you completed a Health Insurance Marketplace application? ☐ Yes ☐ No

Do you want information on how to pay for your prescriptions? ☐ Yes ☐ No

Referral Information – Who referred you to the healthcare fund?

_____ _____

Name Organization

_____ *Do we have your permission to contact this person?* ☐ Yes ☐ No

Phone Number

Applicant Statement

I certify all information on this application is true, complete, and accurate. I understand any information given falsely or withheld may make me ineligible for consideration or award. I understand that funds must be used for the purpose stated on this application and that I am required to submit documentation. I give my permission for Nebraska Families Collaborative and Project Everlast to the state governmental department to verify previous ward or guardianship status for the purpose of requesting financial assistance. I give my permission for Nebraska Families Collaborative and Project Everlast to contact _____ (*healthcare provider or non-applicable*) to verify the outstanding balance amount requested in this application. I understand that neither Nebraska Families Collaborative and Project Everlast nor _____ (*healthcare provider or non-applicable*) will share any confidential information outside of the billing process. I understand that this application is not a guarantee of payment to the provider or a reimbursement to the applicant.

_____ _____

Applicant Signature **Date**

Are you a member of Project Everlast Council? ☐ Yes ☐ No

If not, would like more information or to be contacted by the local Youth Advisor? ☐ Yes ☐ No

Office Use Only:

☐ Approved ☐ Denied Reason: _____

☐ Provider remittance ☐ Applicant reimbursement ☐ Voucher

Name of Provider: _____ Approved amount: _____

Date approved: _____ Date voucher provided: _____

Date voucher submitted by provider for payment: _____

Date payment sent to provider or to applicant: _____