THE PETER ROONEY FUND

FISCAL YEAR JANUARY 1-DECEMBER 31
LAST CONSIDERATION FOR APPLICATION IS NOVEMBER 1 OF EACH YEAR

AUTHORIZATION: Physicians signature required on ALL request for financial assistance.

CONFIDENTIALITY: Insofar as is possible, the record keeping systems shall be maintained to keep the names of clients confidential.

DISCRETION OF THE PETER ROONEY BOARD MEMBERS: The Board Members are granted discretion in meeting requests for assistance.

FINANCIAL ASSISTANCE LIMITATION: There is no exclusion provided documentation substantiates a relationship to a medical situation. ALL REQUESTS FOR FINANCIAL ASSISTANCE ARE DEPENDENT ON AVAILABILITY OF FUNDS.

APPLICATION FOR ASSISTANCE: Requests should be made to THE PETER ROONEY FUND prior to or at the time of need for the service. Retroactive expenses incurred before application for assistance, can only be considered during the current fiscal year and upon receipt of appropriate receipts.

THE PETER ROONEY FUND

CLIENT SERVICE POLICY

THE PETER ROONEY FUND provides a family with financial assistance and/or reimbursement for medical expenses and expenses related to medical treatment, including travel, lodging, meals, sibling childcare and other related expenses.

Please return the attached completed data form to **The Peter Rooney Fund, P.O. Box 1063, Wrangell, Alaska 99929** your application for assistance will be reviewed by board member of **THE PETER ROONEY FUND. (Last *application consideration date is November 1, of each year)***

Please be sure your name, address and contact phone number is indicated on the application and the type of assistance requested. Your physician's signature must appear in Part 111 of the application.

Please attach copies of bills and /or receipts for which you are seeking reimbursement and /or payment. You may also send a letter of explanation of you circumstances if you wish.

THE PETER ROONEY FUND
P.O. BOX 1063
WRANGELL, AK 99929
(907) 874-2074
www.peterrooneyfund.org

TO WHOM IT MAY CONCERN:

Enclosed please find a packet from **THE PETER ROONEY FUND. THE PETER ROONEY FUND** was created to assist families with children between birth and 18 years of age who are dealing with life threatening illnesses and who may be in need of financial assistance.

The Fund allows families to apply for funds to cover anything that is related to their child's illness. All requests for financial assistance are dependent on availability of funds. The families are eligible to apply one time per year.

This letter serves as your authorization to make copies of the required application as needed. Once the application is completed and the required documentation is included, please send the application to **THE PETER ROONEY FUND, P.O. BOX 1063, WRANGELL, AK 99929.** Distributions are made quarterly during the fiscal year, which is January 1 to December 31. Should you have any questions, please call Janell Privett, **THE PETER ROONEY FUND**, at (907) 874-2074.

Sincerely,

_____
Board Member

Enclosures

THE PETER ROONEY FUND
P.O. BOX 1063
WRANGELL, AK 99929
(907) 874-2074
www.peterrooneyfund.org

PART I

Patient Information (To be filled out by parent/guardian)

Name of Patient _____ Date of Birth _____

Address (City, State, Zip) _____ Telephone No. & Area Code _____

Social Security Number (Child) _____ Birthplace _____ Total Years Alaska Resident _____

Diagnosis _____

Primary Physician's Name _____ Telephone No. & Area Code _____

Primary Physician's Address _____ City _____ State _____ Zip _____

Parent/s and/or Guardian Information

Name of Mother and/or Guardian _____ Name of Father and/or Guardian _____

Address _____ City _____ State _____ Zip _____ No. of Years in Alaska _____

PART II (To be filled out by parent/guardian)

A. Family Financial Information (Please attach copy of last tax return filed)

1. Monthly Gross Income (all sources, including public assistance, Federal or State Benefits) $_____

2. Insurance Information (Please circle all that apply and fill in identifying information)

TYPE	CARRIER	GROUP NO.	ID#
Medicaid			
Private Medical Ins.			
Other Insurance			

B. Assistance Requested

1. Funding is requested for the following:_____

_____

_____

_____

(If more room is needed, please use additional paper and attach them to this form.)

PART III (To be filled out by the physician)

A.

1. Diagnosis:_____
2. Date of Diagnosis:_____
3. Name of facility:_____
4. Prognosis:_____

_____

PART III (To be filled out by physician, con't.)

B. 1. Certification of Physician:

This patient has a confirmed diagnosis of:_____

_____

_____

_____ _____

Primary Physician's Signature Telephone Number & Area Code

_____

Primary Physician's Name (Please Print)

*Please attach letter from the physician confirm the details shown above.

PART IV

A. Support Network (To be filled out by physician and/or hospital social worker)

SOCIAL SERVICE AGENCIES	CONTACT NAME	TELEPHONE NO.

HOSPITAL/MEDICAL CENTER	CONTACT NAME	TELEPHONE NO.

ELIGIBILITY: **(To be completed by the primary physician and/or hospital social worker.)**

I hereby certify that this patient is eligible for the assistance requested under the terms of the Service Policy of the PETER ROONEY FUND.

Date

Primary Physician and/or Hospital Social Worker

PLEASE NOTE: PROOF OF FINANCIAL NEED AND COPIES OF BILLS, AIRLINE TICKETS, ETC., MUST BE RECEIVED ALONG WITH APPLICATION BEFORE REIMBURSEMENT CAN BE MADE.

APPROVED:_____

DATE:_____

THE PETER ROONEY FUND

CHECK LIST

1. Patient information (to be filled out by parent/guardian)_____
2. Parent's and/or guardian information_____
3. Family financial information_____
4. Proof of financial need through legal documents (example: last individual tax return information or other source)_____
5. If your insurance is not covering needs due to the medical situation you are facing, you may attach a letter of explanation (example: does not cover travel for both parents, medicine, medical supplies etc,.)_____
6. Assistance requested (funding is requested for the following)_____
7. Section to be filled out by physician_____
8. Signature of physician_____
9. Support Network (to be filled out by physician and/or hospital social worker)_____
10. Attatched copies of bill and/or receipts for which you are seeking reimbursement and or payment._____
11. Letter of explanation (optional)_____

The application must be complete and all above information provided for the application to be considered.