AHMAD FAMILY FOUNDATION - Indigent Surgery Program Funding Guidelines

PURPOSE: Indigent Surgery Program is part of Ahmad Family Foundation's national and international mission to provide safe medical care to the indigent. Its objective is to provide funds to pay for surgical procedures for those who cannot afford the necessary medical procedure. Funds will be paid out of either Ahmad Family Foundation's operating account or funds donated specifically for a named beneficiary. Funds will then be paid directly to surgical facilities.

FUNDS: Indigent Surgery Program funding will be acquired through two methods. The funding is intended to pay the total cost or supplement a beneficiary lacking full payment for surgery. These funds will be assigned for the program from Ahmad Family Foundation as needed by the Board of Directors. The second method of acquiring funds will be to accept monetary donations from donors seeking to make charitable tax-deductible donations. The donors may or may not have a named beneficiary for their donation. The donors will be required to verify that they do not have ownership in or a relationship to an owner, familial or otherwise, of the surgical center that will be the recipient of the funds they have donated.

REQUEST FOR SURGICAL FUNDS: Patients may request funds from Indigent Surgery Program by completing and submitting the following online request form. The Board of Directors will review requests for funds and notify applicants of their status. **NOTE:** Please make sure you receive an email confirmation from the Ahmad Family Foundation acknowledging receipt of your application in order for your request to be considered.

FUNDING PRIORITIES: The Board of Directors established that funding will be given to those patients in need of surgery that is medically necessary. The funds are not intended to pay for surgery that has already occurred, rather it is intended for future procedures.

PROGRAM REQUIREMENTS: In order for a patient to participate, documentation from the surgeon stating the procedure and its need and cost estimate from the facility where surgery will be performed. Upon completion of the procedure, the surgery facility must contact the Program manager and advise that the procedure was completed and provide statement of costs due.

NAME: _____ PHONE NUMBER: _____
ADDRESS: _____

DATE OF BIRTH: ___/___/_____ SEX: _____

ARE YOU RECEIVING ANY TYPE OF ASSISTANCE FROM LOCAL, COUNTY, STATE, OR FEDERAL GOVERNMENT AGENCIES? IF SO, DESCRIBE THIS ASSISTANCE:

_____
_____

IF NOT, DO YOU QUALIFY FOR ASSISTANCE FROM LOCAL, COUNTY, STATE, OR FEDERAL GOVERNMENT AGENCIES? IF SO, WHAT TYPE OF ASSISTANCE ARE YOU QUALIFIED TO RECEIVE?

_____
_____

DO YOU HAVE OTHER HEALTH INSURANCE THAT COVERS HEALTH RELATED PRODUCTS OR SERVICES? YES NO IF "YES", LIST THE COMPANIES AND POLICY NUMBERS: _____
_____

IS A GUARDIAN OR ANYONE ELSE LEGALLY RESPONSIBLE FOR YOUR MEDICAL BILLS?
YES NO IF "YES", GIVE THE NAME, ADDRESS AND PHONE NUMBER OF THIS PERSON:

_____
_____

ARE YOU EMPLOYED? YES NO

IF "YES", WHAT IS YOUR PAY PERIOD (E.G., WEEKLY, EVERY OTHER WEEK, 1ST & 15TH)? _____ HOW MUCH DO YOU GROSS PER PAY PERIOD? _____

HOW MUCH DO YOU NET PER PAY PERIOD? _____

DO YOU OWN YOUR OWN HOME? YES NO

IF "YES", IS IT PAID FOR OR ARE YOU STILL MAKING PAYMENTS ON IT? YES NO
HOW MUCH IS EACH MONTHLY PAYMENT? _____

HOW MUCH DO YOU HAVE IN SAVINGS TO WHICH YOU HAVE IMMEDIATE ACCESS? (DOES NOT INCLUDE QUALIFIED RETIREMENT)

WHAT IS YOUR MONTHLY NET INCOME FROM:

YOUR EMPLOYMENT: _____

SOCIAL SECURITY: _____

RETIREMENT: _____

INVESTMENTS: _____

OTHER: _____

WHAT ARE YOUR MONTHLY EXPENSES:

RENT OR HOUSE PAYMENT:_____ UTILITIES:_____

CAR PAYMENT: _____

OTHER TRANSPORTATION: _____ FOOD:_____

MEDICAL BILLS:_____ OTHER:_____

TOTAL MONTHLY EXPENSES: $_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND I REQUEST ASSISTANCE WITH SURGICAL FEES.

_____ BENEFICIARY SIGNATURE

_____ SIGNATURE IF BENEFICIARY UNABLE TO SIGN

_____/_____/_____ DATE
_____ RELATIONSHIP TO BENEFICIARY

_____ REASON BENEFICIARY UNABLE TO SIGN

FOR OFFICE USE ONLY DATE:_____/_____/_____ APPLICATION APPROVED

APPROVAL SIGNATURE:

_____

TITLE: _____ DATE:_____/_____/_____

HIPAA Release of information AUTHORIZATION FORM

I, _____hereby authorize Ahmad Family Foundation and its affiliates, its employees and agents my personal health information submitted by me (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to seek health benefit coverage. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below

I understand that I have a right to revoke this authorization by providing written notice to Ahmad Family Foundation. However, this authorization may not be revoked if Ahmad Family Foundation, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

Name of Member: _____
Signature of Member: _____
Date:_____

Medical information

Please attach relevant medical records, including

* Surgeon that will perform surgery
* Facility at which surgery will be performed (Contact information for point of contact at that facility)
* Diagnosis / Indication for surgery