Family Assistance Program
Medical Travel Assistance Fund

About the Program:

The CHARGE Syndrome Foundation Family Assistance Program (FAP) was created in the Spring of 2020 in response to increased needs of families related to the COVID-19 pandemic. Since its inception, the Foundation has supported over 100 families across the United States. Since that time, the Foundation has continued to receive donations and the program is being expanded to include supporting families of individuals with CHARGE who need to receive medical care which requires travel out of state/long distance. This is a ***needs based program*** intended for families who would be unable to travel for medical care without this assistance.

Requirements:

- A family member must have a diagnosis of CHARGE syndrome
- Applicant must live and receive medical care in the United States
- Travel must be over 200 miles roundtrip

The money from this program may be used to cover the following:

- Transportation (for individual with CHARGE and one additional family member/care provider):
    - Gas for round trip transportation
    - Airfare
    - Train fare
- Meals during travel
- Lodging, as needed
- Parking (as applicable)

Approval Process:

- Prior to the scheduled medical appointment, the application must be submitted explaining the reason for the appointment and need for financial assistance.
- The applicant will be notified within one week as to whether the reimbursement will be approved and the total amount that will be covered.
- In certain circumstances, the Foundation may request the front page of your most recent tax return in order to determine approval.

If a family has an unplanned medical trip, they can request reimbursement within 30 days after returning home from a completed treatment. The Foundation's ability to fund the amount requested and future requests will be based on the number of requests we receive and the funding of the program. The Foundation may not be able to cover all expenses.

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Reimbursement Process:
After the scheduled appointment, the applicant will be required to provide the following documentation (as applicable):

- Proof of the medical visit occurring (receipt from medical provider, after care visit summary)
- Receipts for lodging and/or transportation for up to the amount approved.

The Foundation will mail a reimbursement check to the applicant within two weeks of receiving documentation. **Documentation should be sent to: info@chargesyndrome.org**

Submit application:
• Scan and e-mail to info@chargesyndrome.org
• Fax to 888-317-4735
• Mail to: CHARGE Syndrome Foundation
318 Half Day Road #305
Buffalo Grove, IL 60089

Questions? info@chargesyndrome.org or 800-442-7604.

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Applicant's Name: _____

Relationship to the Individual with CHARGE syndrome: _____

Name of Individual with CHARGE syndrome: _____

Age of Individual with CHARGE syndrome: _____

Home Address: _____

City, State, Zip Code _____

Home phone: _____

Cell phone: _____

E-mail address: _____

How many people live in the household: _____

Are you a member of the CHARGE Syndrome Foundation?

- ❑ Yes
- ❑ No
- ❑ Unsure

Annual household income from all sources (including disability or social security):

- ❑ Under $25k
- ❑ $25-$75k
- ❑ $75-$150
- ❑ Over $150k

Name of Medical Care Facility: _____

City, State of Medical Care Facility: _____

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Expected date of medical visit: _____

Briefly describe reason for the medical visit: _____

_____

_____

Briefly explain why this funding is needed: _____

_____

_____

Anticipated out of pocket travel expenses:

- Transportation $ _____
- Hotel $ _____
- Food $ _____
- Total $ _____

What portion of the above anticipated costs do you need help covering? _____

What type of insurance do you have?

- ❑ Medicaid
- ❑ Private Insurance,
- ❑ Both medicaid and private insurance
- ❑ Other (specify) _____

Is your insurance paying for any travel costs with getting medical care? _____

If yes, how much is being covered? _____

Have you searched for other funding sources to help cover your expenses? (please explain)

_____

_____

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I hereby affirm that the information I provided within this Application Form is true and accurate to the best of my knowledge. I understand that failure to disclose full details or falsifying information could invalidate my Application.

The CHARGE Syndrome Foundation's ("The Foundation") sole obligation is to fund the amount approved upon receipt of the required documentation. The Foundation reserves the right to deny any assistance if adequate documentation is not provided.

The Foundation had no role in determining the medical treatment, travel arrangements, lodging, parking, or meals. The Foundation assumes no responsibility or liability for any injuries or damages arising out of the treatment, travel, lodging, parking, or meals.

I WAIVE any right or cause of action, of any kind whatsoever, arising as a result of my participation, my child's or family's participation in this assistance program from which any liability may or could accrue to the Foundation, its directors, members, officers, employees, volunteers, and agents.

Applicant Signature: _____

Applicant Name (printed): _____

Date: _____