MEDICAL ASSISTANCE FUND REQUEST

Program Outline & Application Form

The Medical Assistance Fund (MAF) provides financial assistance to families in need - whether it's to cover a co-pay or deductible, or to help purchase medical supplies and other comforting aid.

The request must serve a beneficial medical purpose for the recipient and/or improve their quality of life.

This program is ONLY for persons with EB, who live in Canada and are members of DEBRA Canada.

WHO CAN APPLY?

- Any person with EB who demonstrates financial need or extenuating circumstances.
- All applicants must have been diagnosed with Epidermolysis Bullosa by a medical practitioner and must provide written proof of diagnoses (re: doctor's letter).
- The MAF is open only to DEBRA Canada members. Membership is free – email ehoyos@debracanada.org , Subject: Membership Request, and request to become a member.
- Membership to DEBRA is free and can be applied for at the time of a MAF application.
- Fund applications can be made by anyone (i.e. a parent/guardian, advocate, physician, social worker etc. can apply on behalf of an EB patient/applicant); but the person living with EB or their legal guardian must give their consent to the application.
- Any grant that is made to a DEBRA member must be declared in the annual accounts. This will be shown as the amount received in any one year, but no details of the grants will be disclosed unless with the consent of the recipient.

WHAT KIND OF THINGS DOES THE FUND COVER?

- Medically necessary procedure or equipment related to the treatment of EB that is not covered by insurance or another source of assistance.
- Items which will serve a beneficial medical purpose for the recipient and/or improve quality of life.
- Items related to the care of EB.

FUNDING DETAILS:

1. The MAF Committee considers each request on an individual, case-by-case basis.
2. Grants have a limit of $5000 per family each year. Grants beyond this amount will be considered under special circumstances.

3. Applications will be assessed and funds distributed on a monthly basis. Full or partial funding is at the discretion of the MAF Committee.

4. In all cases, the payee should be the vendor or supplier. In special cases, DEBRA Canada may agree to reimburse the applicant, as long as receipt(s) are provided.

5. DEBRA Canada will acknowledge receipt of all applications within one week.

6. Disbursements are dependent upon available funds at time of request.

7. Final decisions and disbursements may take 5 weeks. PLEASE MAKE REFERENCE TO ANY EMERGENCY/URGENT NATURE OF REQUESTS ON APPLICATION FORM.

8. Further documentation may be requested by MAF committee to access financial need of applicant.

9. Funding may be denied without providing a reason.

HOW TO APPLY:

Complete application form below and submit by email, fax or post.

ATTN: Medical Assistance Fund Liaison Officer

EMAIL: debra@debracanada.org

Subject: MEDICAL ASSISTANCE FUND REQUEST

Otherwise by mail or fax to:

By Fax: 905- 469-1850 (ATTN: DEBRA Canada, MAF REQUEST)

By Post: (please note: this option may result in significant delay in response from our committee)

ATTN: DEBRA Canada MAF Request
1500 Upper Middle Rd, Unit #3
PO Box 76035
Oakville, ON, L6M 3H5

If you have any further questions, please contact:

Erin Hoyos, Secretary/Administrative Officer: ehoyos@debracanada.org

MEDICAL ASSISTANCE FUND REQUEST

Application Form

I am: ☐ **The Applicant / EB Patient** *(complete section 1)*

☐ **The Applicant's Representative** *(complete section 1 and 2)*

Is this an Emergency Request?

Yes ☐ No ☐

1. Applicant's Details

Applicant's name:	
Applicant's address:	
Date of Birth:	Mobile:
Email address:	Day Phone:

2. Details of Applicant's Representative

Application made by:	
Relationship to applicant:	
☐ **I can confirm that the applicant is aware that I am completing this form on his/her behalf and that he/she is aware of the information contained in it.** _____ **Representatives Signature** _____ **Applicant's Signature**	
Representatives address:	
Applicants Date of Birth:	Representatives Mobile (optional):
Representatives Email address:	Representatives Day Phone:

3. Medical Information

Type of EB:
Sub-type (if known)
☐ Doctor's letter with confirmation of diagnosis attached

4. Previous Request For Assistance:

Has the applicant previously requested Medical Assistance funding from DEBRA Canada?

Yes ☐ No ☐

Was the previous request approved?

Yes ☐ No ☐

If "Yes", date of previous application/submission: _____ (year, month, day)

If "Yes" and request was approved, please state amount of funding received : $_____

5. Funding Amount Requested:

Total Amount of funding applied for:	**$**
If your application is unsuccessful, would you like it re-submitted for consideration in the following calendar year?	**Yes** ☐ No ☐

*****Please attach all receipts, invoices, estimates, insurance statements or other information verifying the cost of the item requested (MUST be enclosed to consider request).

6. Financial Information: **Please note: this information will not be shared with any outside parties. It will only be used to determine financial need.**

What is the recipients/applicants household income (per year)?

$_____per annum.

How many people live in the recipient's household? _____

What are the average monthly out of pocket expenses for EB care?

$_____ per month

***Please provide proof of income and monthly expenses (i.e. Receipts from suppliers etc).**

7. Provincial/Private Insurance Information

Does provincial health care coverage provide partial coverage?

Yes ☐ No ☐

If "Yes", please specify amount: $_____

Does the applicant have private health insurance?

Yes ☐ No ☐

If "Yes",

Who is the Insurer/name of insurance company _____

Specify amount covered by private insurance $_____

***include a copy of the insurance company review/approval**

If insurance company has declined, please explain their reason below:

***include a copy of the insurance company decline notice**

8. Purpose of Funding

Provide a detailed explanation of how this item/request will assist with the quality of life of the EB patient and their family.

Please give as much information as possible to support your application. Consider the following questions:

- *Where?*
- *What?*
- *Why?*
- *How much?*

CHECK LIST:

Have you completed and included the following:

☐ **Completed application form (all relevant fields filled in).**

☐ **A doctor's letter with confirmation of EB diagnosis.**

☐ **All receipts, invoices, estimates, insurance statements or other information verifying the cost of the item(s) requested (MUST be enclosed to consider request).**

☐ **Proof of income statement**

☐ **Proof of insurance company coverage approval or decline (if applicable)**

☐ **Proof of monthly expenses related to EB care (i.e. receipts from suppliers)**

☐ **A detailed explanation of how this item/request will assist with the quality of life of the EB patient and their family.**

Please return to the by email fax or post to:

Email: ATTN: Medical Assistance Fund Liaison Officer
debra@debracanada.org
Subject: Medical Assistance Fund Request

Otherwise by mail or fax to:

By Fax: 905- 469-1850 (ATTN: DEBRA Canada, MEDICAL ASSISTANCE FUND REQUEST)

Postal Address: DEBRA Canada (Medical Assistance Fund Committee)
1500 Upper Middle Rd, Unit #3, PO Box 76035
Oakville, ON
L6M 3H5

(Please note: postal option may result in longer response time from our committee)

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Application must be reviewed by both the Medical Assistance Fund Liaison and Committee Panel:

Received Date: ***Medical Assistance Fund Liaison***	*Name:*
Comments:	
Reviewed by: ***DEBRA Canada Officer***	*Lead Name:*
Comments:	

MAF Request Approved		
$	*Signed:*	*Date:*
Comments:		
Request declined	*Signed:*	*Date:*
Rationale:		

Applicant informed of outcome	
Signed:	*Date:*
Telephone ☐ *Email* ☐ *Letter* ☐ *Applicant wishes for grant request to be resubmitted the following calendar year* ☐	

Payment details
Payment due date:
Cheque ☐ Credit Card ☐ Direct Payment ☐