Gemassist Brain Awareness Foundation

Instructions and Application Process:

1. Complete these forms for financial assistance in their entirety.

2. Email a copy of the completed forms to gemassistbrain@gmail.com

Or mail it to: **Gemassist Brain Awareness**
Attn: Financial Aid
5900 Gerardia Lane
Prospect, KY 40059

3. An independent panel will review applications and choose candidate(s) on a quarterly basis.

4. Approved candidate(s) will be notified in writing of their financial award within the first week of January, April, July, and October.

5. Candidate(s) can apply for assistance no more than two times annually.

Per Household a maximum of $250.00 and minimum $100.00 will be given directly to the medical facility chosen by the candidate(s) for their treatment.

All rights reserved by the Foundation to deny any application that is incomplete, misleading or false.

All applications are in standing with the laws of the state or city, where applicable. Gemassist Brain Awareness Foundation, Co. does not discriminate on the basis of race, sex, gender identification, sexual orientation, national origin, native language, religion, age, disability, marital status, citizenship, genetic information, pregnancy, or any other characteristic protected by law.

Gemassist Brain Awareness Foundation

FINANCIAL ASSISTANCE APPLICATION

Contact Information

Full Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____ Marital Status: _____

Address: _____

City:_____ State: _____ Postal Code: _____

Details

Type of Brain/Spinal Injury, Condition, Illness: _____

Medical Facility where seeking care: _____ Contact Number: _____

Profession: _____ Net Salary: _____ Pay Frequency: _____

Spouse's Profession_____ Net Salary: _____ Pay Frequency: _____

Please list any Additional Income (Disability, Pension, Social Security, etc): _____

Number of Children: _____ How many children are financially dependent on applicant? _____

Please list the full names and birthdays of any financial dependents: _____

Do you have Health Insurance? _____ Type of Insurance: _____

Do you own or rent your home? _____ Monthly Rent/Mortgage: $_____

If Mortgage: Interest Rate %: _____ Mortgage Balance: $_____

Monthly Car Payment(s): $_____ Monthly Car Insurance Payment: $_____

Total Credit Card Debt: $_____

Please list remaining Balance on any additional Loans or Mortgages: _____

Approximate Monthly Utilities (Gas, Water, Electric): $_____

Please tell us about your personal journey and your need for financial assistance:

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified in writing to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Gemassist Brain Awareness Foundation ("the Foundation") reserves the right to change the privacy policy as allowed by law.
- The Foundation has the right to restrict the use of the information but the Foundation does not have to agree to those restrictions.
- The applicant has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The Foundation may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you about your Gemassist Financial Application?

YES_____ NO_____

May we leave a message on your answering machine at home or cell phone voicemail about your Gemassist Financial Application?

YES_____ NO_____

May we discuss your medical condition or your Gemassist Financial Application with any member of your family? (For household applications)

YES_____ NO_____

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by:_____
(PRINT NAME PLEASE)

Signature:_____ Date: _____

Witness:_____ Date: _____