The Shawn Nelson “Fight Like a Warrior” Medical Grant 2021

Please be aware that personal information is being asked of you. All personal information will remain confidential. Failure to provide all requested documentation will result in an immediate denial.

GRANT APPLICATION

Superior Mesenteric Artery Syndrome Research Awareness and Support, Inc. ("SMASRAS") provides up to $750 grants to assist program beneficiaries while they are under a treatment plan for Superior Mesenteric Artery Syndrome. **Please call 214-675-7938 or email staci.smas.npo@gmail.com for questions**

To apply for funds, do you meet these criteria?

Do you reside in the United States? _____YES _____ NO

Do you have insurance coverage for the proposed treatment? _____YES _____ NO
(Having insurance will not necessarily affect application approval)

Do you have a diagnosis of Superior Mesenteric Artery Syndrome (SMAS)?

_____YES _____ NO

Date diagnosis received: _____

Are you able to provide documentation to support your diagnosis?

_____YES _____ NO

If so, return with grant application

Are you currently receiving treatment for SMAS under the care of a physician?

_____YES _____ NO

Physician Name: _____

Address: _____

Phone Number: _____

By applying and/or receiving a grant I also agree to share nonprofit fundraisers with friends and family. I understand this is my way of "giving back" and ensuring that the nonprofit continues to have funds to assist other SMAS patients. _____YES _____ NO (Declining will not impact board's decision regarding grant approval)

*Applicants may earn no more than 300% of the current Federal Poverty Level and remain qualified for aid under SMASRAS programs. www.smasyndrome.org/grants to view poverty levels provided through Health and Human Services.

Even if you do not meet these guidelines, please apply because our restrictions may be lifted at any time.

Biographical Details:

Name: _____

Address: _____

_____

Email: _____

Daytime Phone: _____

Cell Number: _____

How did you hear about us/who referred you to us? _____

DOB: _____ Age: _____ Gender: _____ Male _____ Female

Employment Background

If a minor, guardians must fill out employment information

1. Are you working? _____yes _____no (skip to 2)

   Indicate name of your current employer (if not currently employed, indicate last employer): _____

   Address: _____

   Phone Number: _____

2. Are you currently in school? _____yes _____no

3. Are you married? _____yes _____no

   If married, indicate name of spouse's current employer (if spouse not currently employed, indicate spouse's last employer: _____

   Address: _____

   Phone Number: _____

4. What is your annual household income?

_____

***Please provide proof of income (SSDI/SSI, Tax Returns, Last 2 Pay Stubs)**

How many individuals are in the household? _____ (Provide Names, Ages and Relations in lines below)

_____

_____

_____

Do you receive any other assistance?

_____YES _____ NO

If yes, please explain_____

_____

Emergency Contact: please provide your emergency contact's information:

Name: _____

Email: _____

Daytime Phone: _____

Cell Number: _____

Address: _____

Grants will be used for:

$_____ Physician's bill related to SMAS treatment
$_____ Travel Expenses/Reimbursement (Hotel, Air Fare, Other)
$_____ SMAS related Medical Expenses

Please explain what funds will be used for and provide documentation i.e. Gas receipts, hotel bills, medical bills, medication receipts:

_____

TOTAL AMOUNT REQUESTING: _____

SMASRAS does not provide treatment; we provide funds. Funds are paid to service providers for the treatment of individuals diagnosed with Superior Mesenteric Artery Syndrome.

Please use this page and any additional pages to provide further information that you feel will assist your application.

Physician (Attest):

I verify that the undersigned applicant, _____, is a current patient undergoing treatment for SMAS or is about to begin a treatment plan for SMAS.

Print Physician Name: _____

Phone Number: _____

Medical Office/ Business Name: _____

Address: _____

_____ _____
Signature of Attending Physician Date

Read and Agree to Terms:

By signing below, I have read and agree to the General Grant Terms and Conditions found at: www.smasyndrome.org

Print Applicant Name: _____

_____ _____
Applicant Signature Date

If Applicant is a minor:

Parent/Guardian Name: _____

_____ _____
Parent/Guardian Signature Date

HIPAA AUTHORIZATION

STATEMENT OF INTENT

I, _____(Name), understand that the Health Insurance Portability and Accountability Act ("HIPAA") limits who can see my protected medical information. I intend for any agent named in this release to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164. I am executing this authorization because there may be certain healthcare information that is necessary for my medical providers to share with my agent under my healthcare power of attorney or with my partner if I am incapacitated.

AUTHORIZATION

I, _____ (Name), authorize the disclosure of any information governed by HIPAA to be provided to the authorized person identified below:
Name: _SMAS Patient Assistance_____
Address: PO BOX 555 Bonham, TX_____ Telephone: __903-227-0778

Accordingly, I hereby authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company, any medical information bureau, or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to the above-referenced authorized person without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition of any kind, including all information relating to the diagnosis and treatment of extremely personal/highly sensitive conditions including but not limited to HIV/AIDS, sexually transmitted diseases, mental illness, or substance abuse. The authority given to the authorized person shall supersede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information. The authority given herein expires only if I revoke this HIPAA Release in writing and deliver it to my healthcare provider. There are no exceptions to my right to revoke this HIPAA Release. This authorization is not affected by my subsequent incapacity or disability.

Print Applicant Name: _____

_____ _____
Applicant Signature Date

If Applicant is a minor:

Parent/Guardian Name: _____

_____ _____
Parent/Guardian Signature Date

Patient Advocate Form

Instructions:

1. Complete the form if you wish for SMAS Patient Assistance to act as your Patient Advocate
2. Make sure to give your health care provider a copy
3. Keep a copy in a safe place
4. Take this form with you if you are admitted to the hospital
5. Provide written documentation to smasras@gmail.com or PO BOX 555 to rescind permission

Patient's Name: _____ Signature: _____

Address: _____

My Advocate(s):

Name: Staci Gruber Signature: Staci Gruber

Phone: 214-675-7938

Name: Tara Williams Signature: Tara Williams

Phone: 214-697-7451

My Patient Advocate needs to be able to: (Check as many as apply):

- ☐ Be present, in person or on phone, when the doctor or provider speaks with me
- ☐ Be present, in the room or on phone, after an exam to write down information and instructions
- ☐ Ask questions about my health care and test results
- ☐ Get information on my behalf
- ☐ Access my medical health records

You will need to have your primary care physician or other SMAS treating physician sign off on this application for funds form. Prior to submitting application you will need to have your physician sign the attached form confirming your SMAS diagnosis. This would be a good time to talk with your primary care provider(s) and tell them about the treatment plan you are considering and ask any questions you may have.

To complete the application process please:

1. Fill out the entire application.
2. Obtain physician signature below.
3. Include medical records showing SMAS diagnosis
4. Sign the application.
5. Include copies of paystubs or SSDI/SSI and a copy of your most recent federal income tax return. If you did not file, please just state why and submit with application.
6. Provide any receipts necessary for reimbursement purposes (if applicable)
7. Return entire application via mail:

   SMAS Patient Assistance
   Attn: Grant Department
   PO BOX 555
   Bonham, TX 75418

8. In order to keep applications anonymous we request that you leave your name off the return address section of the envelope. You can instead use "SMAS Applicant."
9. Once you have mailed in your application please email staci.smas.npo@gmail.com stating that your application has been mailed. This is important because any communication regarding your application will be done through email only.

Please be aware that failure to fill out the entire application or failure to include all documentation needed could result in a delayed review and decision.

DISCLAIMER AND HOLD HARMLESS: If this website includes the name of any professional for the recipient's consideration to use their services, this information to recipient is not and should not be deemed to be a referral or recommendation of such service provider, practitioner or professional. Superior Mesenteric Artery Syndrome Research Awareness and Support, Inc., and their respective affiliates, agents, advisors, officers, directors, employees, members, managers, volunteers, agents and/or controlling persons (collectively, "SMASRAS"), have made no express or implied representations or warranties as to that professional other than the fact the professional may have indicated an interest in working with SMASRAS program beneficiaries. Other than the foregoing, SMASRAS disclaims all representations and warranties, whether express or implied, concerning the professional, including without limitation representations and warranties regarding the professional's competency, qualifications, skill and/or honesty. SMASRAS strongly encourages recipient to interview any such professional and at least one other professional and make an independent determination as to who to ultimately retain. Recipient accepts and assumes all risk stemming from the above disclaimers and agrees to hold SMASRAS harmless from and against all losses, liabilities, claims, demands, damages, actions, costs and expenses, including without limitation reasonable attorneys' fees, expert witnesses' fees, consultants' fees and related costs, that directly or indirectly arise out of recipient's use of the information disclosed to recipient hereunder. Applicant understands and agrees that SMASRAS grant awards must be used for the specific purpose for which they were awarded. Further, upon the written request of SMASRAS, Applicant agrees to provide to SMASRAS copies of invoices marked "paid" or receipts evidencing payment and or/use of the funds for their intended purpose. And, finally, Applicant agrees to return any unused portion of a SMASRAS grant award within ten (10) days of receiving a written request from SMASRAS to do so. Approved applicants must provide receipts within one year of approval to receive funding otherwise must reapply.