OUR MISSION

The Emergency Children's Help Organization, Inc., "ECHO" is a non-profit 501 (c)(3) organization dedicated to providing financial assistance to a child experiencing a challenging medical or living emergency. ECHO's goal is to help ease the burden financially, along with brightening the child's life during a time of crisis.

Applicant must be 18 years of age or younger experiencing a medical or living emergency.
Applicant must reside in one of the following locations:

❑ Staten Island, NY ❑ Essex County, NJ ❑ Hudson County, NJ ❑ Middlesex County, NJ

❑ Monmouth County, NJ ❑ Ocean County, NJ ❑ Union County, NJ

Please submit your completed application and any other correspondence to:

Emergency Children's Help Organization

3041 Veterans Road West | Suite 2 | Staten Island | NY | 10309

DOCUMENTS TO BE SUBMITTED

☐ Completed Application
A copy will be accepted to process the application.
However, you **MUST** submit the original application within 2 weeks of submitting your copy.

☐ Completed HIPAA form

☐ Completed Conflict of Interest Policy *(sign and return the last page only)*

☐ Copy of your valid Driver's License/Photo ID

☐ Confirmation letter from Physician (Diagnosis/Treatment)
(Please inform your physicians that the ECHO Staff will be contacting them to verify their letter)

☐ Copies of your most recent Bank Statements

☐ Copies of each of your recent Utility Bills

☐ Copies of additional monthly medical/living expenses
(i.e.; medical bills, invoices, etc.)

Please feel free to call or email us with any questions or concerns. We will be happy to assist you.

Tel: 718-967-9085 **Fax: 718-967-9087**

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Angie Galano	Administrator	echo.angie@yahoo.com

HIPAA – Instructions Sheet

For completing the Authorization for Release of Health Information Form

The attached form is required for release of Protected Health Information ("PHI") in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The purpose of this form is for establishing eligibility for a grant.

You must complete a HIPAA form for each of your child's physician(s)/pharmacist(s) listed on the grant application.

If you are requesting a grant for more than one child, you must complete a HIPAA form for each child and his/her physician(s)/pharmacist(s) listed on the grant application.

PLEASE PRINT CLEARLY

In the top section please print your child's name, address, date of birth and social security number.

Line #7 – Print the name and address of your child's physician/pharmacist.

Line #9a – Select what information you are willing to release.

Line #9b – Sign your initials and print the name of your child's physician/pharmacist

Line #12 – Print your name.

Line #13 – Print your relationship with the child.

At the bottom please sign your name and today's date.