ECHO

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 ❑ Bergen County, NJ ❑ 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
- ☐ Letter from Physician(s) confirming diagnosis and/or treatment
  (Please inform the physician(s) that ECHO Staff will be contacting them to verify their letter)
- ☐ Copies of any invoices submitted for payment
- ☐ Copy of the first page of your bank statement(s)

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**

Denise M. Stallone	Administrative Director	denise@echoorganization.org
Angie Galano	Administrator	angieg@echoorganizatin.org
Marissa Meduri	Administrator	marissa@echoorganization.org

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.

ECHO
GRANT APPLICATION

EMERGENCY CHILDREN'S HELP ORGANIZATION

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

Tel: 866-755-ECHO (3246) . Fax: 718-967-9087

THIS FORM MUST BE NEATLY PRINTED

GRANT REQUESTED FOR: ☐ MEDICAL EXPENSES ☐ MEDICAL EQUIPMENT ☐ OTHER _____ **DATE:** _____
PLEASE GIVE DISCRIPTION

CHILD'S INFORMATION

Name: _____ (First / Middle / Last) Date of Birth: _____ Gender: ☐ Male ☐ Female

Ethnic Origin: ☐ Asian/Pacific Islander ☐ Black/African American/Caribbean ☐ Hispanic/Latino ☐ Middle East/Near East ☐ Native American ☐ White/European

****YOU MUST SUBMIT WITH THIS APPLICATION A COPY OF YOUR VALID DRIVERS LICENSE OR PROOF OF ID/ADDRESS****

PARENT OR LEGAL GUARDIAN INFORMATION ("PARENT A") Relationship to child: ☐ Mother ☐ Father ☐ Other _____

Name: _____ (First / Middle / Last) Marital Status: _____

Address: _____ (Street) Home Phone: _____ Cell Phone: _____

_____ (City / State / Zip) Work Phone: _____ Email: _____

Employer: _____ Address: _____ Phone: _____

_____ (City / State / Zip)

PARENT OR LEGAL GUARDIAN INFORMATION ("PARENT B") Relationship to child: ☐ Mother ☐ Father ☐ Other _____
(This section must be completed)

Name: _____ (First / Middle / Last) Marital Status: _____

Address: (If different) _____ (Street) Home Phone: _____ Cell Phone: _____

_____ (City / State / Zip) Work Phone: _____ Email: _____

Employer: _____ Address: _____ Phone: _____

_____ (City / State / Zip)

PLEASE LIST OTHER CHILDREN IN THE FAMILY:

•Name: _____ Date of Birth: _____ •Name: _____ Date of Birth: _____

•Name: _____ Date of Birth: _____ •Name: _____ Date of Birth: _____

MEDICAL INFORMATION

WE RESERVE THE RIGHT TO REQUEST MEDICAL RECORDS AND OR LETTERS FROM PHYSICIANS

Do you have Health Insurance? ☐ Yes ☐ No If yes, please provide the following information:

Name of Insurance carrier: _____ Name of Policy Holder: _____ State: _____

1. Name of Child's Physician: _____ Address: _____ (Street / City / State / Zip) Phone: _____

2. Name of Child's Physician: _____ Address: _____ (Street / City / State / Zip) Phone: _____

3. Name of Child's Pharmacist: _____ Address: _____ (Street / City / State / Zip) Phone: _____

FOR INTERNAL USE ONLY:

County: ❑ **Richmond, NY** ❑ **Bergen, NJ** ❑ **Essex, NJ** ❑ **Hudson, NJ** ❑ **Middlesex, NJ** ❑ **Monmouth, NJ** ❑ **Ocean, NJ** ❑ **Union, NJ**

APPLICATION # _____ **DATE RECEIVED** _____ **DATE APPROVED/DENIED** _____ **GRANT ISSUED** _____

THIS SECTION MUST BE NEATLY PRINTED

PLEASE GIVE A DETAILED EXPLANATION FOR THE BASIS OF THIS GRANT REQUEST SUCH AS:

(I) HOW DOES THE CHILD MEET WITHIN ECHO'S GENERAL GRANT CRITERIA. (III) RANGE OF FUNDING BEING REQUESTED. (II) BASIS FOR FINANCIAL NEED.

IF YOU ARE REQUESTING A GRANT FOR FINANCIAL ASSISTANCE DUE TO YOUR CHILD'S MEDICAL CONDITION, YOU MUST SUBMIT WITH THIS APPLICATION A LETTER FROM YOUR CHILD'S PHYSICIAN STATING HIS OR HER DIAGNOSIS, PROGNOSIS, TREATMENT PLAN AND OR THE REASON FOR ANY MEDICAL EQUIPMENT NEEDED.
YOU MUST ALSO SUBMIT A COMPLETED HIPAA FORM.

PLEASE PROVIDE THE FOLLOWING ADDITIONAL INFORMATION

THE INFORMATION PROVIDED WILL BE USED SOLELY FOR THE PURPOSE OF QUALIFYING THE APPLICANT FOR A GRANT FROM ECHO AND WILL BE KEPT STRICTLY PERSONAL AND CONFIDENTIAL.

SECTION A: RESIDENCE		*SECTION B: ASSESTS*		*SECTION C: LIABILITIES*	
Do you own a home? ☐ Yes ☐ No		Bank Account Balances	$_____	Credit Card Balances	$_____
If yes, Enter the value of your home:	$_____	Investment Balances	$_____	Personal Loans	$_____
		Other _____	$_____	Other _____	$_____
Deduct your outstanding Mortgage Balance	$(_____)	Other _____	$_____	Other _____	$_____
Total Section A	**$_____**	**Total Section B**	**$_____**	**Total Section C**	**$_____**

CALCULATE YOUR NET WORTH

Enter the amount you listed in Section (A) above:	$_____
Enter the amount you listed in Section (B) above:	$_____
Add your amounts from Section (A) and Section (B):	$_____
Deduct the amount you listed in Section C above:	$(_____)
THIS IS YOUR NET WORTH	**$_____**

COMBINED HOUSEHOLD MONTHLY INCOME:
MONTHLY

Net Salary/Wages:	$_____
Public Aid:	$_____
Pension:	$_____
Disability:	$_____
Grants:	$_____
Food Stamps	$_____
Other Assistance:	$_____
Other Income:	$_____
TOTAL	**$_____**

HOUSEHOLD MONTHLY EXPENSES:
Enter the amount you pay each month, excluding medical expenses.

Mortgage/Rent:	$_____	E-Z Pass:	$_____
Gas/Heating:	$_____	Medical Insurance:	$_____
Electric:	$_____	Medical Bills:	$_____
Water:	$_____	Co-Pays:	$_____
Telephone:	$_____	Prescriptions:	$_____
Cable TV:	$_____	Groceries:	$_____
Cell Phone:	$_____	Credit Cards:	$_____
Car Payments:	$_____	Personal Loans:	$_____
Car Insurance:	$_____	_____ Other	$_____
Gas (Car):	$_____	_____ Other	$_____
Parking:	$_____		
		TOTAL	**$_____**

MONTHLY EXPENSES RELATED ONLY TO YOUR MEDICAL / LIVING EMERGENCY

Medical Bills:	$_____
Medical Equipment:	$_____
Co-Pays:	$_____
Prescriptions:	$_____
Lodging:	$_____
Gas (Car):	$_____
Parking:	$_____
E-Z Pass:	$_____
_____ Other	$_____
_____ Other	$_____
TOTAL	**$_____**

How did you hear about ECHO?

☐ Internet Search ☐ Advertisement: _____ (Please specify) ☐ Recommended by: _____ (Please list name and phone number)

Have you received financial assistance from any other organization? If so, please list name of organization, date of assistance and amount received.

_____

_____

REFERENCES:

PLEASE LIST 3 REFERENCES. PLEASE INFORM THE REFERENCES THAT THEY WILL RECEIVE A PHONE CALL FROM ECHO'S STAFF TO VERIFY YOUR APPLICATION

(1)	(2)	(3)
_____ Name	_____ Name	_____ Name
_____ Phone	_____ Phone	_____ Phone

FOR INTERNAL USE ONLY: REFERENCE VERIFICATION

REFERENCE (1) VERIFIED – DATE: _____ REFERENCE (2) VERIFIED – DATE: _____ REFERENCE (3) VERIFIED – DATE: _____

PLEASE READ AND ACKNOWLEDGE BY INITIALING EACH PARAGRAPH AND SIGNING AT THE BOTTOM. THIS FORM MUST BE ALSO BE SIGNED BY WITNESS.

_____ By signing below, I certify and represent that the information that I have provided for this Grant Application is true, accurate, complete, and not misleading.

_____ I/We authorize Emergency Children's Help Organization (ECHO) and its Agents to independently investigate and authenticate the truth and accuracy of any and all information provided.

_____ Investigation and verification shall include but not be limited to, all information provided on the Grant Application, supporting letters, bank statements, invoices, primary resources, and field investigation with report thereof.

_____ Additionally, I/we understand, agree, and consent to ECHO reviewing and discussing my Grant Application with supporting documentation to such third parties as ECHO determines necessary for the purpose of evaluation, investigation, and confirmation of the contents therein. Such third parties may include, but not be limited to ECHO's Executive Committee, Board of Directors, accountant(s) and/or attorney(s).

_____ Additionally, I/We understand, agree, and consent to ECHO, at its sole and absolute discretion, reporting or disclosing the contents of an investigation to a third party for the well-being of any individual involved.

_____ I/We hereby indemnify and hold ECHO harmless from any and all claims relating to ECHO's investigation of any aspect of the Grant Application and the Grant Application process.

_____ I/We further understand, acknowledge, and agree that ECHO's issuance of a grant is within its sole and absolute discretion. ECHO reserves the right to deny any Grant Application for any reason in its sole and absolute discretion. Each Grant Application shall be evaluated on the information provided. Previous grants do not guarantee or ensure the approval of a future grant. An individual(s) can only apply for one grant at a time and apply for only one grant during any consecutive twelve (12) month period.

_____ Except as provided for herin and required by law, the ECHO Grant Application process is confidential.

_____ Any funds received from the ECHO will be used for the specific reason stated and represented on the Grant Application. If personal items or medical items/supplies are purchased with funds received from the ECHO, I/we agree to indemnify and hold ECHO harmless from any negative effects thereof.

_____ I/We consent to ECHO performing a criminal background check and performing a credit check, which shall include the ability to obtain a credit report.

_____ I/We agree to provide ECHO with additional documentation which supports the information set forth in my/our application and understand that knowingly, willingly, and voluntarily. Providing ECHO with inaccurate information may result in ECHO's commencement of legal actions against me/us to recover any grant which I/we receive along with ECHO's costs of collection and reasonable attorney fees.

_____ I/We have read and understand all of the aforementioned statements and representations.

_____ I/We understand that I/we have the right to review all of the statements and representations contained herein with legal counsel. I/We have either taken the opportunity to so review with counsel, or have waived such right.

_____ I/We knowingly, willing, and voluntarily agree to all of the aforementioned statements and proceed with the Grant Application and ECHO Application Process.

_____ To expedite the Grant Application, scanned signature(s) or electronic signature(s) may be used instead of original signature(s). My/our scanned or electronic signature(s) and/or initial(s) will be deemed binding on me/us. I/We intend to be bound by such scanned or electronic signatures(s), and waive any defenses to the enforcement of the provisions of this Grant Application based on such scanned or electronic signature(s).

_____ Any funds awarded under this Grant Application must be used within a period of twenty-four (24) months from the Approval Letter date ("Allocation Period"). In the event that the awarded funds are not fully used within the Allocation Period, any remaining funds shall revert back to ECHO. Upon the expiration of the Allocation Period, the applicants shall be required to re-apply for a new grant if they wish to obtain funding from ECHO for the same project or purpose. ECHO shall not be obligated to award a subsequent grant to any applicant who has failed to use the funds within the original Allocation Period.

_____
Signature of Parent or Legal Guardian ("Parent A")

_____
Date

Witnessed by: _____
Signature

_____
Print Name

_____
Date

_____
Address

_____
City State Zip

MEDIA PERMISSION

By submitting this application to ECHO I understand and agree that my and my co-applicant's name, image and/or likeness may be provided and/or disclosed to third parties, such as newspapers and other media organizations, for their publication and broadcast. I expressly authorize ECHO to provide and/or disclose my and my co-applicant's name, image and/or likeness to third parties, including media organizations, for their use and dissemination to the general public and agree to indemnify and hold ECHO harmless from any claims and damages arising there from.

_____
Signature of Parent or Legal Guardian ("Parent A")

_____
Date

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Board of Directors/Staff - Emergency Children's Help Organization, Inc., 3041 Veterans Road West, SI NY 10309

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)
to discuss my health information with my attorney, or a governmental agency, listed here:
Board of Directos/Staff - Emergency Children's Help Organziation, Inc.
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
❑ At request of individual ☑ Other: **Applicaton for a Grant**	**Expires upon denial of the grant application.**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Conflict of Interest Policy for the

EMERGENCY CHILDREN'S HELP ORGANIZATION, INC.

The purpose of the following policy and procedures is to prevent the personal interest of (i) Directors, (ii) members of all committees of the Board of Directors or of the Corporation, including advisory committees, whether or not such committee members are Directors of the Corporation, (iii) Officers, (iv) members of the Advisory Board, and (v) employees of the Corporation ("Key Persons") from interfering with the performance of their duties to the Emergency Children's Help Organization, Inc. ("Corporation"), or result in personal financial, professional, or political gain on the part of such Key Persons at the expense of the Corporation or its Directors, supporters, and other stakeholders. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

I. DEFINITIONS:

Conflict of Interest ("Conflict") means a conflict, or the appearance of a conflict, between the private interests and official responsibilities of a Key Person.

II. POLICY AND PRACTICES:

1. Full disclosure, by notice in writing, shall be made by each Key Person to the Corporation's audit committee or, if there is no audit committee, to the Corporation's full Board of Directors in the event of any conflict of interest including, but not limited to, the following:

a. A Key Person is related to another Key Person by blood, marriage or domestic partnership.

b. A Key Person or their organization or a family member of a Key Person stands to benefit from a Corporation transaction.

c. A Key Person's organization or family member receives grant funding from the Corporation.

d. A Key Person is a member of the governing body of a contributor to the Corporation.

2. Following full disclosure of a possible Conflict, including, but not limited to, any condition listed above, the audit committee or the Directors, as the case may be, shall determine whether a conflict of interest exists and, if so, shall vote to authorize or reject the transaction or take any other action deemed necessary to address the Conflict and protect the Corporation's best interests. Both votes shall be by a majority vote without counting the vote of any interested party, even if the disinterested voters are less than a quorum provided that at least one consenting voter is disinterested.

3. The existence and resolution of the conflict must be documented in the Corporation's written records, including in the minutes of any meeting at which the conflict was discussed or voted upon.

4. In addition to the requirements of Article 2 hereof, in the event that a transaction described in Article 1.b. is presented to the audit committee or the Directors, as the case may be, the audit committee or the Directors shall take the following action:

a. Prior to entering into the transaction, consider alternative transactions to the extent available.

b. In documenting the existence and resolution of the conflict, include the basis for the approval/rejection by the audit committee or the Directors, including its consideration of any alternative transactions.

5. An interested Key Person shall not be present at or participate in any discussion or debate or deliberation or vote of the audit committee or Directors, or of any committee or subcommittee thereof in which the subject of discussion is a contract, transaction, or situation in which there may be a perceived or actual conflict of interest. Additionally, an interested Key Person shall not attempt to influence improperly the deliberation or vote of which the subject is a contract, transaction, or situation in which there may be a perceived or actual conflict of interest.

6. Prior to the initial election of any Director or officer, or the hiring of any employee, and annually thereafter, such Key Person shall complete, sign and submit to the Secretary of the Corporation a written statement identifying, to the best of the Key Person's knowledge, any entity of which such Key Person is an officer, Director, Trustee, Member, owner (either as a sole proprietor or a partner), or employee and with which the Corporation has a relationship, and any transaction in which the Corporation is a participant and in which the Key Person might have a conflicting interest. Each Key Person shall annually resubmit such written statement. The Secretary of the Corporation shall provide a copy of all completed statements to the chair of the audit committee or, if there is no audit committee, to the chair of the Board.

7. Any person applying for any financial support from the Corporation ("Applicant") in any form, including, without limitation, by grant, loan, service, right or other benefit, shall be required to either (a) certify in writing that no Director, Officer, member of the Advisory Board, employee or agent of the Corporation or any member of their family, is a family member of the Applicant or has a close personal or business relationship with the Applicant, or (b) if any such relationship exists, make full disclosure of such facts. In the event of such a conflict, no grants or other benefit may be provided by the Corporation to the Applicant unless the Board strictly complies with the procedures set forth for addressing a conflict of interest in the Corporation's Conflict of Interest Policy.

EMERGENCY CHILDREN'S HELP ORGANIZATION, INC.

Applicant Conflict of Interest Disclosure Form

This form must be filed by any party applying for financial support of any kind from Emergency Children's Help Organization, Inc. ("Corporation"), as per the Corporation's Conflict of Interest Policy.

_____ No Director, Officer, member of the Advisory Board, employee or agent of the Corporation or any member of their family, is a family member of mine or has a close personal or business relationship with me.

_____ A Director, Officer, member of the Advisory Board, employee or agent of the Corporation or a member of their family, is a family member of mine or has a close personal or business relationship with me, as follows:

_____

_____

The undersigned, by their affixed signature, acknowledges that the Emergency Children's Help Organization, Inc. is relying on the truth of this Applicant Conflict of Interest Disclosure Form in considering my application for financial support.

Sign Name: _____

Print Name: _____

Date: _____