Welcome to the BB4K Family

Applying & Criteria

Enclosed you will find a fairly self-explanatory application. Please fill it out as completely as possible as your request cannot be processed until all information and attachments are complete.

- Only families in the Greater Cincinnati/Tri-State area are eligible for BB4K grants at this time.
- BB4K grants funds for children up to the age of 18.
- Grants are not approved/denied based on income but we do need to know about your financial picture.
- Pre-approval by our board of directors can take up to a month and a half.
- Pre-approval, or approved pending funds, means that the application has met all of the BB4K criteria and that the search for funds to fulfill the need can begin. \textit{It does not mean that the funding is available.}
- Once pre-approved, your child’s fundraising page, if you agreed to him/her having one, will be put on our website.
- All grant funds will be distributed through a third-party.
- We cannot pay for debt already incurred before you have applied.

Other important points

- Requests for accessible vans, due to their expense, can sit on our waiting list for a very long time. It is very difficult to find funds for this need.
- Our funding comes in by several different means, including private foundations, individual donors and BB4K events.
- We make every effort to get the funds to the child who has been waiting the longest and/or has the most urgent need.
- Often funds come in that are directed to a specific child or a specific program, such as therapy or hearing and communication.
- Many time donors go online and donate their funds to a specific child that touches them, or that they know. All of the funds donated to a specific child go towards that child’s need

We consider every child and family that comes to us for help part of our Building Blocks for Kids family and will make every effort to fund your child’s need and/or find other resources to help you on your journey. If you have any questions or concerns along the way, feel free to contact us at any time.

Most of our families stay in contact with us long after their child’s need has been met and we love updates and stories about how our Building Blocks kids are doing.

We will also add you to our mailing list so you can hear about BB4K events and opportunities.

Lastly, we have a BB4K Families \textit{only} Facebook group. Our families on that page exchange or sell equipment, ask for advice, share about events in the community, and more. If you are interested in joining that page, please add Dynette Clark as a Facebook friend and she will be sure to add you to the Building Block Families page.
In addition to the Grant Application, the following documents must also be submitted. Failure to include all supporting documentation will result in a delay or inability in processing your request.

____ Completed Building Blocks For Kids Grant Application form.**

____ Physician’s Certification of Medical Condition and Need (included in this packet) **

____ Medical summary, documentation or record of your child’s health care history and current condition. **

____ Evidence of the family’s financial situation.** Provide a document, written and signed by you, stating your lack of ability to pay and why and/or include most recent Federal Income Tax return, copies of past 4 check stubs, etc.

____ Letter of denial from insurance/Medicaid when applicable.

____ Letter from doctor or hospital confirming inability to pay when applicable.

____ Cincinnati Children’s Release Form when applicable.

____ Information on the procedure/apparatus requested.

____ A photo of the child** (to be published only if release to do so is signed) Please include even if we are not to use it publicly, Photo can also be emailed to bbkids@bb4k.org

____ Consent/refusal (on page 2) to allow your child’s picture, story, and/or name on the Building Blocks website, in our newsletter, or in the media. **

I hereby certify that all above information submitted and the statements I have made are true, and agree that any false information, misrepresentation, or omission of facts may result in cancellation or immediate dismissal of my application and possible prosecution.

Signature: [Signature]

Date: [Date]

** No exceptions
Consent Form

Building Blocks for Kids depends on public donations and we are accountable to our supporters. We need to promote and share the pictures and stories of children they have helped. Your cooperation and willingness to share your stories would be very much appreciated.

**We only use your child’s first name in any external media or print materials.**

_____ You MAY use my child’s picture/name/story on the website, in the media, across social media platforms, in the Meet-A-Need Program, and/or in a Building Blocks newsletter.

_____ You may use my child’s picture and story but please change his/her name.

_____ You may use my child’s name and story but please do not use his/her picture.

_____ I do NOT want my child’s picture/name/story used on the website, in the media, across social media platforms, in the Meet-A-Need Program, and/or in a Building Blocks newsletter.

I understand that:

- *There are no guarantees that my child’s request will be funded through this program.*

- *Participation in the Meet-a-Need program is not required in order to be eligible for a grant from BB4K.*

**Signature:__________________________**

**Date:__________________________**

**Information about the Meet-A-Need Program**

Because of the great demand from families like yours, BB4K has formed a program called Meet-A-Need through which a business, family, church, etc. can choose to fulfill some or all of the need for a specific child that has been approved pending funds. These needs will be shared with businesses and groups who have expressed an interest in directly making an impact for a particular child.

Once the Grant Committee has pre-approved your application, they decide, based on the request and the funds available, whether to place the request in the Meet-A-Need program. If funds become available before your child’s request is fulfilled, BB4K will complete the request.

**We do ask, should your request be fulfilled through the Meet-A-Need program, that you would write a thank you note from you and your child (with a picture if possible) to the group who met your need and send it to the Building Blocks for Kids office for us to deliver to your donor(s).**
Building Blocks for Kids Grant Application

A parent or guardian must complete this application in full before the board will review the case. Please print and be sure to include all additional documents listed on the Grant Application Submittal Checklist. All information submitted is confidential.

Questions? Please contact: Dynette Clark (dynette@bb4k.org)
513.770.2900 Phone
513.297.0605 Fax
BBKids@BB4K.org

Child's Information
Name __________________________ Age ________ DOB _____________ Gender _____

Clinical Information
Diagnosis __________________________

Child's age at onset of illness ___________ Year of Diagnosis ______________________

Description/history of child’s illness or health condition ____________________________________________________________

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

Fun Information
Please tell us some fun things about your child (likes, accomplishments, etc.) and your family

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

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_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________
Request
- Please fill in appropriate information related to your request below.
- It is only necessary to fill in the relevant categories.
- Building Blocks requires that money be sent directly to the treatment provider, apparatus, company, hospital, etc. and not directly to the recipient family.
- If you are listing needs in more than one program area, please number those needs in order of importance and/or urgency.

Therapy ($5000 max) ~ includes adaptive bikes and sensory equipment
- Type of therapy/treatment/equipment ____________________________
- Purpose ____________________________
- Number of treatments/visits ___________ Cost per treatment/visit $ ____________________________
- Will doctor/organization participate with Building Blocks through a discount? ____________________________

Hearing & Communication ~ Devices/programs that help a child interact with his/her world.
- Type of device ____________________________ Estimated life of device ______
- Cost of device $ ____________________________ Is a used device an option? ____________________________
- School or Program ____________________________ Cost $ ____________________________

Building/Home Modifications ($7500 max) **Please include any contractor quotes.
- Description of Need ____________________________ Cost $ ____________________________
- Will contractor participate with Building Blocks through a discount? ____________________________

Medical or Adaptive Equipment/Supplies/Medication

Equipment Request ~ medical or adaptive equipment
- Type of equipment ____________________________ Estimated life of equipment? ______
- Cost of equipment $ ____________________________ Is used equipment an option? ____________________________

Supply Request ~ special formula, medication, diapers (if child is older than 4), etc.
- Name of supply needed ____________________________
- Purpose ____________________________
- Size (if applicable) _________ Number of months needed ________ Cost per month $ ____________________________
- Will provider participate with Building Blocks through a discount? ____________________________
Caring for Kids ~ Miscellaneous needs that improve the quality of life for children with special needs.

Displacement (Travel) Request

If displacement funding is provided, the receipts must be provided to Building Blocks verifying how the funding has been utilized. The funding will be paid directly to a third party whenever possible. Please note that funding will only be granted to the candidate and one parent/guardian. In addition, a letter will be required from the doctor or medical specialist recommending the treatment be handled outside of the child’s city of residence.

Purpose of travel ____________________________________________________________

Travel between which cities __________________________________________________

Method of transportation (please fill in the appropriate information):

☐ Car    ☐ Plane    ☐ Train    ☐ Public Transportation

Number of roundtrips ______   Estimated roundtrip mileage (if by car) _____________________________

Number of individuals ______   Cost/adult $_______________ Cost/child $________________________

Number of nights ______      Type of lodging _________________________________________________

Cost per night $_____      Is charitable housing (such as Ronald McDonald House) an option? _________

Miscellaneous Request ~ Therapy/service dog, respite care, etc.

Description of Need _________________________________________________________________

Purpose ___________________________________________________________ Cost $_____________________

Mobility/Transportation ~ Transportation assistance required for a child’s medical needs to be met.

$7500 max for vehicle and equipment. $5000 max for vehicle only or equipment only

Equipment (lifts, tie downs, etc)

Type of equipment _________________________________________________________________

Cost $________________________ Will provider participate with Building Blocks through a discount? _________

Estimated life of equipment? _____________ Is used equipment an option? _________________________

Vehicle  **Please note that grants for vehicles are limited each year. New vehicles are not an option.**

Description of Need _________________________________________________________________

Maximum amount of cash that family can give as a down payment $______________________________

Maximum amount family can give for 12 – 18 monthly payments $______________________________

We would like a vehicle with no more than _________________ miles on it.
If grant is awarded, who will receive payment? Company Name

Address

City ___________________________ State ___________ Zip ________________

Contact Person Name ___________________________ Email Address ___________________________

Phone ___________________________

How will this request improve the child’s life? ____________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Any additional information relevant to the request ____________________________________________________________________________

__________________________________________________________________________

Total amount requested from Building Blocks for Kids $__________________________

Date funding is needed ________________ Explain ______________________________________

__________________________________________________________________________

How did you hear about Building Blocks for Kids? ______________________________________

Have you received financial assistance from Building Blocks previously? ______________________

If so, please list what year, amount, and what the grant was used for:
__________________________________________________________________________

__________________________________________________________________________
If you are working with a therapist, social worker or family financial advisor for funding please give his/her name and phone number:

____________________________________________________________________________________

Name/address/phone number of physician(s) associated with current care
____________________________________________________________________________________
____________________________________________________________________________________

Annual household income $__________________ (documentation must be provided)

Type of health insurance coverage ______________________________________________________

Out-of-pocket medical expenses in the last year for candidate $____________________________

Do you currently receive funds/assistance from any of the following (please circle all that apply):

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<th>BCMH</th>
<th>Social Security</th>
<th>MR/DD</th>
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If so, in what amount(s): ______________________________________________________________

If funding been sought from additional sources, please list from whom? ______________________

____________________________________________________________________________________

If funding has been received, from whom and in what amount? ______________________________

____________________________________________________________________________________

**Family Information**

Name of Primary Caregiver ___________________________ Relationship to Child _______________

Phone Number(s) __________________________________________________________

Address ________________________________________________________________

City ___________________________ County _____________ State _________ Zip __________

Place of Employment _________________________________________________________

Occupation ________________________________________________________________

Email address _____________________________________________________________
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<th>Additional Parent Name</th>
<th>Relationship to Child</th>
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<th>First name(s) and age(s) of siblings</th>
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I hereby release, hold harmless and indemnify Building Blocks For Kids, its directors, trustees, officers, employees, volunteers and agents from and against all claims, liabilities, losses, costs, damages or expenses, including reasonable attorney fees and litigation expenses, resulting from or in connection with any treatment, medication, apparatus, transportation, lodging or other benefit that is awarded to me by Building Blocks For Kids pursuant to my grant request. In addition, I certify that all of the information that I have submitted and all of the statements that I have made in support of this grant request are true, and I agree that any false information, misrepresentation or omission of facts by me may result in the cancellation or immediate dismissal of my application and that Building Blocks reserves the right to take any necessary action to recover any benefits, or the value of any benefits, awarded to me in reliance upon such false information, misrepresentation or omission of facts.

Signature: ________________________________

Date: ________________________________
Physician’s Certification of Medical Condition & Need

Child’s Information (To be completed by the child’s parent/legal guardian)
Child’s Name: ____________________________________________________________

Child’s Date of Birth: ____________________________________________________

Parent/Legal Guardian Name: _____________________________________________

Parent/Legal Guardian Address: ____________________________________________

Child’s Medical Information (To be completed by the child’s physician)
The parent/legal guardian of the child listed above has applied for a grant with Building Blocks for Kids (BB4K). Please complete the following medical information. This information is required before a grant application can be considered.

Child’s Primary Diagnosis/Diagnoses: ______________________________________
Child’s Secondary Diagnosis/Diagnoses: _____________________________________

How are the current diagnoses impacting the child’s life? (check all that apply):

☐ Medically
☐ Physically
☐ Socially
☐ Psychologically/Behaviorally
☐ Other: _______________________________________________________________

I recommend the following (indicate and describe all that apply) and describe why they are needed:

☐ Medical and/or Surgical Treatments or Procedures: __________________________

☐ Durable or Disposable Items/Equipment: _________________________________

☐ Therapy(ies): _________________________________________________________

If the therapy being recommended is a drug, formula, or medical food, has the manufacturer’s representative been contacted for assistance? Please provide details:

☐ Other: __________________________________________________________________

Page 9
The goal of these therapies/treatments is:

__________________________________________________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________________________________________________

Has the child previously received these therapies/treatments?

__________________________________________________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________________________________________________

If yes, have they been effective?

__________________________________________________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________________________________________________

Additional notes/comments:

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

**Physician Information – Items marked with an (*) are required in order to process this form.**

*Physician Name: ____________________________________________________________

*Physician Title: ____________________________________________________________

Provider I.D. #: ___________________________________________________________

Address: __________________________________________________________________

City/State/Zip: _____________________________________________________________

Telephone: ______________________________________________________________

Email: __________________________________________________________________

*Signature and Date: ____________________________________________________________

Thank you for taking the time to complete this information. Please return this form back to the child’s parent/legal guardian or email the completed form directly to BB4K at bbkids@bb4k.org or fax to BB4K at 513-297-0605.

Please visit our website at [www.bb4k.org](http://www.bb4k.org) to learn more about Building Blocks for Kids and the grants we provide.
Authorization for Use and/or Disclosure of Protected Health Information

MEDICAL RECORD #: ___________________ CSN / ACCT #: ___________________ (completed by CCHMC)

This form authorizes Cincinnati Children’s Hospital Medical Center to use and/or disclose protected health information in the manner described below and is voluntary. Cincinnati Children’s will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.

Please note that each section of the form must be completed in its entirety. Failure to specify (including dates) will delay the processing of your request.

Patient Name: ___________________ Gender: □ Male □ Female

Last: ___________________ First: ___________________ Middle: ___________________ Maiden (if applicable): ___________________

Date of Birth: ___________________ Phone: ( ) ___________________

Parent/Guardian/Requestor Completing Form: ___________________

Requestor Email Address (optional): ___________________

Note: Email addresses will be utilized strictly to facilitate the processing of your request. No protected health information will be conveyed in this manner.

Name: ___________________ Organization (if applicable): ___________________

Street Address: ___________________

City/State: ___________________ Zip Code: ___________________ Telephone: ( ) ___________________

Information May Be: □ Mailed □ Reviewed Only □ Discussed via Telephone □ In Person Meeting □ Picked Up By: ___________________

□ Verbal communication only; no records needed.

Requests greater than 500 pages will be provided in an electronic format saved to disc unless specifically requested to be on paper.

For copy requests greater than 100 pages, the requestor may choose to receive the medical record on a disc at a 50% discount. If you would like the record provided in an electronic format, please indicate by checking one of the following: □ Yes □ No

Records are to be released for the following purpose(s): (Select all that apply)

□ Medical Care □ Attorney/Legal □ Personal □ Insurance □ Disability/SSI □ Other: ___________________

Purpose:

Dates of Treatment/Particular Illness/Admission Requested:

□ Patient/Physician Abstract – pertinent information generally used for continued care/personal use. (See the reverse of this form for information regarding what is included in a Patient/Physician Abstract.)

□ Discharge Summary □ Emergency Department Record □ X-Ray Reports, Labs or Other Tests

□ History & Physical □ Immunizations □ Consultation Reports, Specify MD:

□ Operative Reports □ Registration Sheets □ Outpatient Clinic Notes, Specify Clinic(s):

□ Other: ___________________

Note: Psychotherapy notes must be requested through a separate authorization.

Information to Release

Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed or, if specified, on the following date, event or condition (complete if desired): ___________________. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department at the address below. Please refer to Cincinnati Children’s Notice of Privacy Practices. If Cincinnati Children’s requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

I, the undersigned, hereby authorize Cincinnati Children’s Hospital Medical Center to use and/or disclose information from my (or give relationship) medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Signature of Patient: ___________________ Date: ___________________

(if 18 years of age or older OR is an emancipated minor)

Signature of □ Parent/ □ Legal Guardian (check one): ___________________ Date: ___________________

Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.

Submit

Please verify that all sections are completed in full. Upon completion, please send the form to:

Cincinnati Children’s Hospital Medical Center 3333 Burnet Avenue, ML 5015 Cincinnati, Ohio 45229-3039

OR Fax the form to: (513) 636-6729

M1000 HIC 04/12 Form F01a Request Has Been Fulfilled: □ Yes, Initials _______ Date _______

*DTM000*