

# COACH KILL CANCER FUND APPLICATION GUIDELINES



## Mission Statement

Improving the quality of life for needy individuals and families facing a financial burden resulting from the medical treatment of cancer and other childhood diseases.

## PROGRAM DESCRIPTION

**Eligibility Requirements:** Any person or family throughout the southern 16 Illinois counties (Randolph, Perry, Franklin, Hamilton, White, Jackson, Williamson, Saline, Gallatin, Union, Johnson, Pope, Hardin Alexander, Pulaski, and Massac) facing a financial burden resulting from the medical treatment of cancer and other childhood diseases. Financial assistance will be provided solely for the purpose of offsetting direct medical costs or for those expenses incurred in seeking medical care.

**Applications:** Applications are available at Southern Illinois Healthcare (SIH), Community Benefits Department or via the internet at [www.coachkillcancerfund.org](http://www.coachkillcancerfund.org). Applicants may request assistance for themselves only. Coach Jerry Kill, Rebecca Kill, and/or the Administrative Director of Community Affairs at SIH may also request assistance for a family, individual or charitable institution in need. Completed applications should be placed in a sealed envelope and mailed to Coach Kill Cancer Fund, P.O. Box 3988, Carbondale, IL 62902 or can be delivered to SIH at 1239 E. Main St., University Mall, Carbondale, IL 62901. The Administrative Director of Community Affairs at SIH may contact the applicant if additional information is needed.

**Approval/Disapproval of Applications:** Payments will be made directly to the institution requesting payment for services. If other arrangements are needed additional approval must be obtained. Adequate documentation will be necessary to process payment of funds. In being the best stewards of this fund, an attempt will be made to help as many individuals as possible; therefore all requests may not receive full funding. Only one application per individual will be considered within a 12-month period. All applications will be reviewed on their individual merit and awards will be based solely on need, and not on the identity of the applicant's medical provider or based upon any Donor's contributions. Assistance to applicants of the Fund will be awarded independent of donor contributions and all eligibility determinations will be determined on a first-come, first-served basis using objective criteria. Applicants may have selected his or her medical provider and would not be prohibited from changing providers even while receiving assistance from the Fund. Applicants or recipients of Fund proceeds will not be referred to any specific medical provider. The program will expand, rather than limit, a patient's access to care and freedom of choice for providers. Coach Jerry Kill and/or Rebecca Kill, the SIH Controller, and the Administrative Director of Community Affairs at SIH, or his designee will make final approval/disapproval.

**Confidentiality:** Only Coach Jerry Kill and/or Rebecca Kill, the SIH Controller, and the Administrative Director of Community Affairs at SIH will be aware of the name of applicant, and at NO time will this information be revealed to anyone privately or publicly without the consent of the applicant.

## **CONTRIBUTIONS**

The Coach Kill Cancer Fund is funded solely on donations made by generous contributors and fundraising efforts. Contributions can be made via the Internet at [www.coachkillcancerfund.org](http://www.coachkillcancerfund.org) or by mail at Coach Kill Cancer Fund, P.O. Box 3988, Carbondale, IL 62902-3988. No Donor will exert control over the Fund or its use of Donor contributions. Individuals will be awarded assistance without regard to any Donor's interests, without regard to any applicant's choice of medical providers, and based upon reasonable, verifiable, and uniform criteria. Donors will not be provided information that would allow them to correlate contributions with the use of medical services obtained by the applicant to the Fund. To ensure proper stewardship of the Fund, utilization of the Fund's resources will be monitored in order to maximize the impact to Fund beneficiaries and the community.

## **REPORTING AND ACCOUNTABILITY**

**Maintenance of Records:** Since contributions are made to the fund, it is important that proper reporting and accountability be assured. Completed applications are retained in a confidential and secure manner by the Administrative Director of Community Affairs at SIH and/or his designee.

**Monthly Reporting:** An accounting of funds received and disbursed is reported by the SIH accounting department and monitored monthly by Coach Jerry Kill and/or Rebecca Kill, the SIH Controller, and the Administrative Director of Community Affairs at SIH. At no time, unless authorized by the applicant, are the names of the applicants or recipients revealed.

**COACH KILL CANCER FUND**  
**APPLICATION**  
**CONFIDENTIAL**



**Please fill in as much information as possible. Please print or type:**

1. Name of applicant in need of assistance: \_\_\_\_\_  
(Last) (First) (Middle Initial)

2. Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

3. Birth date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SSN: \_\_\_\_\_

4. Insurance:  Yes  No

5. Family Income Information:  \$0 - \$20,000  \$20,000 - \$30,000  \$30,000 - \$40,000  \$40,000 - Above

6. Condition being treated for: \_\_\_\_\_

8. Name & address of physician: \_\_\_\_\_

9. Please provide specific information about what assistance is being applied for: \_\_\_\_\_

10. Attach bill(s) relating to reason expressed in #9 or explanation of specific need.

11. Amount requested: \$ \_\_\_\_\_

12. Check payable to: \_\_\_\_\_

**Release of information** – I give permission to SIH/Coach Kill Cancer Fund to disclose, consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rules and Regulations, all or any part of my medical record for treatment, payment or health care operations. This permission includes the release of medical information relating to my diagnosis, treatment and/or hospitalization for cancer and other childhood diseases. In addition I allow any health care provider, including any physicians and facilities to which I may be transferred, to provide information to SIH/Coach Kill Cancer Fund upon request, concerning my care, condition, and treatment, for quality improvement, risk management or verification purposes.

\_\_\_\_\_  
Signature of Applicant or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Printed name of Applicant or Legal Guardian)

**(Over)**

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**Personal Representative Authorization** - I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person named below. I also understand that if my Personal Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Authorized Representative

Place completed application in envelope addressed to Coach Kill Cancer Fund, P.O. Box 3988,  
Carbondale, IL 62902 or hand deliver to SIH at 1239 E. Main St., University Mall, Carbondale, IL 62901.

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**COACH KILL CANCER FUND USE ONLY**

Date: \_\_\_\_\_ Approved: \_\_\_\_\_ Check #: \_\_\_\_\_

Disapproved: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_  
Administrative Director of Community Affairs