UnitedHealthcare children's foundation	JHCCF Grant Portal Parent Guide
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Purpose	The purpose of the Parent Guide is to assist parents/legal guardians when applying for a UnitedHealthcare Children's Foundation (UHCCF) grant. Questions can be emailed to <u>uhccfcustomerservice@uhc.com</u> .
Providers, social workers, or others	s assisting an applicant or grant recipient:

While we commend your commitment to your patient and their family, please be aware that <u>the parent/legal</u> <u>guardian is required to initiate and complete the grant application and payment request process</u> <u>independently.</u> Applying for the grant will require proof of eligibility.

Providers, social workers, or other proxies are not permitted to complete the application. However, you are more than welcome to recommend, support, and assist your patient and their family throughout the process.

If the family has a question about their grant or application, they will need to contact us directly.

### HealthSafe ID Information

The HealthSafe ID ("HSID") is a unique security identifier used to access multiple United Healthcare systems.

A HealthSafe ID is required to log in to the UHCCF Grant Portal. Determine your next step by reviewing the following scenarios.

- → You are a new user and have never signed into a United Healthcare system that required a HealthSafe ID for login; proceed to Eligibility Criteria.
- → You are a returning user with a previously created HealthSafe ID; proceed to Sign In Grant Portal.
- → You have an existing HealthSafe ID; or you are having trouble creating a HealthSafe ID; or you are receiving an error message; or you have lost your HealthSafe ID username or password information:
- $\rightarrow$  Use the Forgot HealthSafe ID/Forgot Password feature within the <u>Sign In Grant Application</u> link.
- $\rightarrow$  Access the <u>HealthSafe ID Technical Support Web Portal.</u>
- → Email UHCCF Customer Service (<u>uhccfcustomerservice@uhc.com</u>) and provide a description of your error message. Please provide a screenshot of your entire browser including the URL in the body of the email.

### Eligibility Criteria

Eligibility requirements appear on the "Complete Your Grant Application Here" website in the form of a series of questions. **Applicant must be able to answer YES to all questions.** 

- 1. Is your child 16 years of age or younger at the time of application?
- 2. Does your child have a Social Security Number issued by the Social Security Administration? (I-TIN numbers are NOT accepted.)
- Is your Adjusted Gross Income (AGI) as documented on Line 11 of the current year's Tax Return (Line 11 of IRS Federal Tax Form 1040) - at or under the following limits based on your family size? NO EXCEPTIONS will be made to these limits:
  - Family Size of 2 -- \$65,000 or less
  - Family Size of 3 -- \$100,000 or less
  - Family Size of 4 -- \$135,000 or less
  - Family Size of 5 or more -- \$170,000 or less
- 4. Is your child covered by commercial/private health insurance? (Plans purchased from the Healthcare Exchange are accepted, but the primary coverage CANNOT be Medicaid, CHIP, or any publicly state funded medical insurance.)
- 5. Are the medical services/items eligible for award and being received/purchased in the United States? (Please see our <u>exclusion list</u> that details items which would NOT be eligible.)

If the applicant meets all criteria, check the box that states: "I acknowledge that I am able to answer YES to all the questions above."

Note: Providers, social workers, or other proxies ARE NOT PERMITTED to complete the application. Applicants

must acknowledge that the recipient meets the criteria prior to proceeding in applying for a UnitedHealthcare Children's Foundation grant. **Applying for the grant will require proof of eligibility**.

Continue to Create HealthSafe ID.

## Create HealthSafe ID

After acknowledging the eligibility requirements are met, the blue "Create HealthSafe ID" is enabled.

Select the button to be redirected to the HealthSafe ID sign in page. Creating a HealthSafe ID is a one-time requirement.

Create HealthSafe ID by entering the	0
following details of the parent/legal guardian	UnitedHealthcare
who is applying for the grant:	children's 💋
First Name	foundation
Last Name	Create HealthSafe ID
Date of Birth	Already a User? Sign In * Required Fields
Email Address (must not be	First Name*
associated with another HSID)	
<ul> <li>Create HealthSafe ID (Username)</li> <li>Password (must be 12 characters)</li> </ul>	
<ul> <li>Confirm Password</li> </ul>	Last Name*
Phone Number	
Note: Personal information entered is the parent	Date of Birth* MMOD-YYYY
or legal guardian's details, NOT the child's	MM-DD-YYYY III
information. The email address and phone number entered will be used to communicate	
information regarding your application and	Email Address*
awarded grant(s) as well as securing your	
HealthSafe ID. Ensure it is an active email address and phone number.	
address and phone number.	Create HealthSafe ID* (Username)
Providers, social workers, or other proxies ARE	
NOT PERMITTED to complete the application.	Decement
	Password*
$\rightarrow$ Review the Terms of Use and Privacy	•
Policy to use the HealthSafe ID services	Confirm Password*
and agree to the terms by checking the	Commin Password
box.	©
→ Select "Continue."	Phone Number*
	■ +1 - SS5-555-5555
	You must agree to the Terms of Use <sup>®</sup> and
	Privacy Policy <sup>®</sup> to use the HealthSafe ID service. If you do not agree, do not use any
	aspect of the HealthSafe ID service.
	Continue
	Commue

You will receive an email from HealthSafe ID with an access code. → Enter the access code into the Enter Verification Code text box. If you did not receive a code after 1-2 minutes, confirm your email address is accurate in the message and either select "Resend Email" or "Update Email Address". → Select "Verify."	UnitedHealthcare   Children's   Coundation   Check your registered email address ( ) for the Verification (
<ul> <li>After entering your access code and allowing the system to verify, a message will display "Success" when verified correctly.</li> <li>→ Select "Continue."</li> </ul>	Success Email Address is verified. Continue
<ul> <li>The Verify Phone Number message displays.</li> <li>→ Select one of the methods to verify the phone number entered when creating your HealthSafe ID.</li> <li>Note: Via Text Message requires a mobile phone added in the phone number field when creating your HealthSafe ID.</li> </ul>	UnitedHealthcare children's foundation Verify Phone Number Select one of the following methods to verify your phone number. An automated text message or phone call will be sent to the phone number you provide for account confirmation and recovery purposes. If you select text message, messaging and data rates may apply. Via Text Message Via Call

<ul> <li>You will receive a text message or phone call from HealthSafe ID with an access code.</li> <li>→ Enter the access code into the Verification Code text box.</li> <li>→ Select "Verify."</li> <li>Note: If you did not receive a code after 1-2 minutes, confirm your phone number is accurate. Change to "Call" or "Message" or select "Resend Code" or "Update Phone Number."</li> </ul>	UnitedHealthcare children's foundation         Description         Description         We have sent you a text message with verification code on your registered phone number. Enter code below to complete the verification.         Verification Code         Waiting for Text Message?         Resend Code         Verify
	Call to Verify Update Phone Number
<ul> <li>After entering your access code and allowing the system to verify, a message will display "Success" when verified correctly.</li> <li>→ Select "Continue."</li> </ul>	Success Your Phone number is verified
<ul> <li>Agree or Decline Consent for My HealthSafe ID.</li> <li>→ Review the consent agreement and acknowledgment for using HealthSafe ID.</li> <li>→ Select "I Agree" to continue the application process and future usage of the UnitedHealthcare Children's Foundation (UHCCF) Grant Management system.</li> <li>Upon successful agreement, the user is brought to the Parent/Legal Guardian Profile.</li> </ul>	Wittelfeetback         Foundation         Standard         Consent For My HealthSafe ID         Using your HealthSafe ID to sign in to United Healthcare Children Foundation Grant Management means that United Healthcare Children Foundation Grant Management uses your HealthSafe ID account information to verify your access. We share the following information with United Healthcare Children Foundation Grant Management.         HealthSafe ID         Name         Date of Birth         Email Address         IAgree,         Ou acknowledge that this information is subject to United Healthcare Children Foundation Grant Management. Additionally, you acknowledge that this information is subject to United Healthcare Children Foundation Grant Management.         You acknowledge that your account information provided to United Healthcare Children Foundation Grant Management's privacy policy, which may be different from HealthSafe ID's privacy policy.         Ivgree       Decline

<u>Sign In – Grant Portal</u>	
$\rightarrow$ Sign in by entering your HealthSafe ID	
Username or Email Address.	Cian In
→ Enter your created Password.	Sign In
	Username or Email Address
Note: Select "Forgot HealthSafe ID" or "Forgot	
Password" if necessary.	
	Password
	٢
	Forgot HealthSafe ID? Forgot Password?
	Continue
Verify your identity by selecting one of the two methods available.	
two methods available.	UnitedHealthcare
• Via Taxt Magaza	children's foundation
<ul><li>Via Text Message</li><li>Via Call</li></ul>	Verify Your Identity
	torny four lacinity
Note: Via Text Message requires a mobile phone	Select one of the following methods to verify your identity.
added in the phone number field when creating	
your HealthSafe ID.	( Via Text Message )
	( Via Call )
	Back to Sign In
You will receive a text message or a phone	
call to the phone number associated with	
your account with an access code.	
	children's
$\rightarrow$ Enter the One Time Password (OTP) into	Access Code
the text box.	Access odde
	We have received your information. If it corresponds to an active HealthSafe ID
$\rightarrow$ If appropriate, select "Skip this step in the	account, you will receive a text message with One Time Password (OTP).
future if this is your private device."	One Time Password (OTP).
	Enter One Time Password
$\rightarrow$ Select "Continue."	
	Waiting for Text Message? Resend Code
Continue to the <u>Dashboard</u> .	
	Skip this step in future if this is your private device.
	Continue
	Return To Verify Identity Options
	House to very solidity options

## Parent/Legal Guardian Profile

The Parent Profile displays Parent Details used for verifying your identity, contacting you regarding your grant application and award, and mailing reimbursement payments.

Reference the image and table below when completing the Parent Profile.

#### **Important Notes:**

ONLY the child's parent or legal guardian can use the portal. Providers, social workers, or other proxies ARE NOT PERMITTED to complete an application or submit payment requests.

All fields with a red asterisk are required. Hover over the (i) to the right of field names for more information.

Parent/Legal Guardi	an Profil	e	
First Name *①		Middle Name	Last Name *①
Parent			Name
Email Address		Date of Birth *	Mobile Phone *
parentname@email.com			555555555
Social Security Number (S	SN) *①		
2 ******			
Mailing Address ①			
3 1234 Street Name, City Name	e, Stat		
Street 1 *①		Street 2 ①	City *①
1234 Street Name			City Name
State *①		ZIP/Postal Code *()	
State		12345	
How did you hear about	he UHCCF gi	rant program? *	
4 Select			~
<u> </u>			
Parent Details from HSID		ame, Last Name, Email ad auto-populate from HealthS	dress, Date of Birth, and Mobile Pho afe ID.
Social Security Number		ild are required to have a S	er. TINs are not accepted. Both paren Social Security Number to be eligible
Mailing Address	Enter y		ess. The additional address fields aι dress field.
How Did You Hear About	about t	he UHCCF grant program.	down menu to tell us how you heard
Save		you have verified all fields a to move to the Dashboard	re completed and correct, select

### Dashboard

The Dashboard displays Active Grants and Children previously entered in the portal with separate headers.

Reference the image and table below when viewing the dashboard.

Note: If this is the first time using the portal, a message of "There are no records to display" will appear in the Children table. If you have previously applied for a grant, select "Add Child & Start Application." When you enter your child's information, it should link the child's existing records in the system.

Celler chi fou	elinitosev ildren's Indation					Home   5 Parent	Name -
	hboard						•
	Active Grants <u>DOE, JANE 12312025</u> Child: Jane Doe <i>Approved Services:</i> Medical Drug - Prescription Medicati Services - Dr/Specialist Visits (includii that visit)		Grant End Date: D	eptember 25, 2024 ecember 31, 2025	Grant Awarded: \$1500.00 Total Used: \$0.00 Remaining Amount: \$1500. Payment History	00 New Payment Request	
20	Children					Add Child & Start Applic	ation
	Child's First Name	Child's Last Na	ame	Date Of Birth	Gender		
4	Jane	Doe		4/26/2017	Female		*
lf y	ou have any questions, please conta	ct us at <u>uhcefcustom</u>	erservice@uhc.com				
- Acti	ive Grants		<b>U</b>		all children linkeo ints heading.	d to the parent por	tal will
- Chi	ldren	All ch head		ed to the par	ent portal will ap	pear under the Ch	ildren
- Ado	d Child & Start Applica	tion Select porta		ld & Start Ap	plication" to add	a new child to the	e parent
- Chi	ld Profile				•	down arrow to acc oplications in prog	
- Par	ent Profile/Sign Out	Acce	ss the pare		sign out of the p	ortal by selecting	

# Add Child & Start Application

Select "Add Child & Start Application" if you've never applied for a grant before or if you do not see your child listed under the Children heading. This step will create the Child Profile.

## Add Child

Reference the image and table below to add the child's information.

			Sav
Child's First Name *①	Child's Last Name *	Date Of Birth *	Age ①
1	2	3 M/D/YYYY 1	= 4 -
Social Security Number *①	Gender *	Race *	
5 i.e. 123456789	6 Select		2

1 – Child's First Name	Enter the child's first name	as it appears on their birth ce	ertificate.
2 – Child's Last Name	Enter the child's last name	as it appears on their birth ce	rtificate.
3 – Date of Birth	Enter the child's date of bir	th using the MM/DD/YYYY for	rmat.
4 – Age	Age is auto-populated base	ed on date of birth.	
5 – Social Security Number	Enter the child's social sec	urity number.	
6 – Gender	Use the drop-down menu t	o select the child's gender.	
7 – Race	Use the magnifier to select	the child's race.	
		Lookup records	×
		Sea	rch Q
		Choose one record and click Select to continue <ul> <li>Name</li> </ul>	Created On
		American Indian or Alaska Native	5/16/2024 4:39 PM
	Race *	Asian	5/16/2024 4:39 PM
	( 2 )	Black or African American	5/16/2024 4:39 PM
		Hispanic or Latino Native Hawaiian or other Pacific Islander	5/16/2024 4:39 PM 5/16/2024 4:39 PM
		White (Non-Hispanic)	5/16/2024 4:39 PM
		Other	5/16/2024 4:39 PM
		Prefer Not to say	5/16/2024 4:39 PM
		Select	Cancel Remove value
8 – Save	Select "Save" to move to A	pplication.	

#### Child Profile

The Child Profile displays Active Grants and Child Details previously entered in the portal with separate headers.

Reference the image and table below when viewing the Child Profile.

Note: If this is the first time using the portal, a message of "There are no records to display" will appear in the Children table.

Children's Confidence	Home   Paren
Home > Child	
Active Grants	
2 Child Details	
Child's First Name *()	Child's Last Name * Date Of Birth * Age①
Jane	Doe 4/26/2017
Social Security Number *①	Gender * Race *
*****0000	Female V White (Non-Hispanic)
****0000	, ende
Grant Applications	
	3 Start Application
Grant Application	Application Status Created On 🦊 Submitted On
Grant Application - Jane Doe	Approved / Awarded 11/27/2024 4:54 PM 12/24/2024 5:29 PM 6
Previous Grants	
Name	Status Reason Amount Awarded Amount Remaining
Name 1	roof of Medical Needs (Prior to June 2024) Age Gender Id Created On
<b>T</b> I	
There are no records to display.	
Active Grants	Active grant information for the selected child will appear unde Active Grants heading.
	Ŭ
Child Details	Child details may be viewed in the Child Profile. If any change needed, email <u>uhccfcustomerservice@uhc.com</u> .
Otant Angliastics	
Start Application	Select " <u>Start Application</u> " if there is not an active grant and the meets the eligibility criteria.
Grant Application	Grant applications may be viewed under the Grant Application
	Note: "Application Status" will display:
	Draft: Application is not submitted by the applicant.
	Submitted/in Review: Submitted by applicant and in review I
	<ul> <li>Information Requested: Application needs to be edited and a An email is sent notifying you of changes or additional information</li> </ul>
	needed.
	<ul> <li>Nurse Review: Application is complete and under review by</li> </ul>
	<ul> <li>Nurse Review: Application is complete and under review by</li> <li>Pending Board Review: Application is awaiting the Board's of</li> </ul>

	Deferred: The Board has requested additional information before making a decision.
	<ul> <li>Denied: The Board has denied the application. The applicant must wait 12 months to reapply for the same services.</li> </ul>
5 – Edit/View	Applications in "Information Requested" status can be edited. Applications in all other statuses can be viewed in read-only mode.
6 – Previous Grants	Past grants (expired and/or exhausted) will appear under the Previous Grants heading.
7 – Historical Grant Applications / Proof of Medical Needs	Grant applications submitted prior to June 2024 will appear under the Historical Grant Applications Heading.

#### Application

Once the child is added to the portal, the child's details will display in the Child Profile. If an Active Grant was found in the portal with the same child's details, the Active Grant details will display at the top of the screen. If this child is eligible to start a new application, select "Start Application."

There are seven sections within the application. Required fields will be noted with a red asterisk "\*". The application is saved as a draft after the applicant selects "Save" on the first Details section.

CAUTION: The application will time out after 15 minutes of inactivity, resulting in a loss of information entered after idling. Please "Save" within 15 minutes to enable the auto-save feature for the rest of the application. After this point, the applicant can sign off at any time during the application process and can come back to edit the application prior to submission.

Important Note: There are three required documents that must be uploaded to each application. Failure to upload the documents will delay processing and may result in a grant application denial.

- 1. Federal tax return IRS Tax Form 1040.
  - a. W-2s, pay stubs, or state returns are not accepted.
  - b. If the return status is Married Filing Separately, the separate tax returns for both parents are required.
  - c. The person who claims the child as a dependent on their federal tax return must submit the application.
- 2. Front and back of child's commercial/private insurance card.
- 3. Physician's Certification of Medical Condition Form (available for download within application and under <u>Required Documents</u> on our website). The Medical Form must meet the following criteria:
  - a. The form MUST be completed by an M.D. (Doctor of Medicine), D.O. (Doctor of Osteopathic Medicine) or Au. D. (Doctor of Audiology) for hearing related requests.
     \*Forms signed by a Nurse Practitioner, Licensed Psychologist, Physician Assistant, or any health professional other than the above DO NOT fulfill this requirement.
  - b. The form MUST be signed within the last 6 months and include ALL the Medical Items or Services you are requesting the UHCCF grant to cover.

# Details

Reference the image and table below when filling out the Details section within the application.

Note: The child's information will pull from the information added in the <u>Add Child</u> section. The applicant cannot edit or update Child Information (Child First & Last Name) or Age. If any changes are needed, email <u>uhccfcustomerservice@uhc.com</u>.

Child's Information *	Age	Primary Residence	e of Child *①	
Jane Doe	7	1 Other		~
Child's Address ①				
Child Street Address *	Child City *	Child State *	٩	Child Zip Code *
Family Size *	Adjusted Gross Income as shown on Tax Form 1040) *	Tax Return (Line 11		
Family Story *①				
				li
6 Save				
Primary Residence of Child	Default response is the P	rimary/Legal G	iuardian Ad	dress.
<ul> <li>Child's Address, if different from parent/guardian's</li> </ul>	Select "Other" from the de from the parent/guardian' address fields auto-popul	s. Enter the Ch	nild's Addre	ss. The additional
from parent/guardian's	from the parent/guardian' address fields auto-popul	s. Enter the Ch ate based on t	nild's Addre he Child's A	ss. The additional Address field.
	from the parent/guardian' address fields auto-popul Enter the family size of th Family size is verified by a child to your family in th	s. Enter the Ch ate based on t e child using th the current year in current year	hild's Addre he Child's A ne drop-dov ar's tax retur , please sub	ss. The additional Address field. vn menu options. rn. If you have add
from parent/guardian's Family Size Adjusted Gross Income	from the parent/guardian' address fields auto-popul Enter the family size of the Family size is verified by a child to your family in the child's birth certificate or a Enter the AGI as docume	s. Enter the Ch ate based on t he child using th the current year adoption paper inted on line 11	hild's Addre he Child's A ne drop-dov ar's tax retur , please sub work.	ss. The additional Address field. vn menu options. rn. If you have add omit a copy of the
from parent/guardian's Family Size	from the parent/guardian' address fields auto-popul Enter the family size of the Family size is verified by a child to your family in the child's birth certificate or Enter the AGI as docume Return (IRS Tax Form 10	s. Enter the Ch ate based on t e child using th the current year adoption paper inted on line 11 (40).	hild's Addre he Child's A ne drop-dov ar's tax retur , please sub work.	ss. The additional Address field. vn menu options. rn. If you have add omit a copy of the
from parent/guardian's Family Size Adjusted Gross Income (AGI)	from the parent/guardian' address fields auto-popul Enter the family size of th Family size is verified by a child to your family in th child's birth certificate or Enter the AGI as docume Return (IRS Tax Form 10 Note: If the number is negat	s. Enter the Ch ate based on t e child using th the current year adoption paper inted on line 11 40). tive, enter "0."	he Child's Addre he Child's A ne drop-dov ar's tax retur y please sub work.	ss. The additional Address field. yn menu options. rn. If you have add omit a copy of the ent year's federal
from parent/guardian's Family Size Adjusted Gross Income	from the parent/guardian' address fields auto-popul Enter the family size of the Family size is verified by a child to your family in the child's birth certificate or Enter the AGI as docume Return (IRS Tax Form 10	s. Enter the Ch ate based on t e child using th the current year adoption paper ented on line 11 40). tive, enter "0."	he Child's Addre he Child's A ne drop-dov ar's tax retur please sub work. of the curr	ss. The additional Address field. vn menu options. rn. If you have addomit a copy of the ent year's federal at would be impor
from parent/guardian's Family Size Adjusted Gross Income (AGI) Family Story	from the parent/guardian' address fields auto-popul Enter the family size of th Family size is verified by a child to your family in th child's birth certificate or a Enter the AGI as docume Return (IRS Tax Form 10 Note: If the number is negat Tell us your family story. for the Board to consider CAUTION: The application resulting in a loss of infor 15 minutes to enable the	s. Enter the Ch ate based on t e child using th the current year adoption paper inted on line 11 40). tive, enter "0." Include any inf while reviewing on will time out mation entered auto-save feat	he Child's Addre he Child's A ne drop-dov ar's tax retur please sub work. of the curr ormation th g your appli after 15 min after idling ure for the i	ss. The additional Address field. wn menu options. rn. If you have addonit a copy of the ent year's federal at would be impor cation. nutes of inactivity, . Please "Save" w rest of the applica
from parent/guardian's Family Size Adjusted Gross Income (AGI)	from the parent/guardian' address fields auto-popul Enter the family size of th Family size is verified by a child to your family in th child's birth certificate or a Enter the AGI as docume Return (IRS Tax Form 10 Note: If the number is negat Tell us your family story. for the Board to consider CAUTION: The application resulting in a loss of infor	s. Enter the Ch ate based on t e child using th the current year adoption paper inted on line 11 40). tive, enter "0." Include any inf while reviewing on will time out mation entered <u>auto-save feat</u> Draft Applicati	he Child's Addre he Child's A ne drop-dov ar's tax retur please sub work. of the curr ormation th g your appli after 15 min after idling ure for the i	ss. The additional Address field. wn menu options. rn. If you have addonit a copy of the ent year's federal at would be impor cation. nutes of inactivity, . Please "Save" w rest of the applica

Upload Federal Tax Return – IRS I	Form 1040
Select the "magnifying glass" to upload your Federal Tax Return – IRS Form 1040. Reminders: a. W-2s, pay stubs, or state returns are not accepted. b. If the return status is Married Filing Separately, the separate tax returns for both parents are required. c. The person who claims the child as a dependent on their federal tax return must submit the application.	Federal 1040 Tax Form *① Child is not listed as a dependent on the attached tax form because they were born or adopted in the current year.
If applicable, select the check box next to "Child is not listed as a dependent on the attached tax form because they were born or adopted in the current year." Note: If check box is selected, the applicant will be required to attach the child's birth certificate/adoption paperwork and social security card.	
Select "New" to create a new tax return record.	Lookup records ×   Search Q   Choose one record and click Select to continue   ✓ Name   Created On     New     Select   Cancel   Remove value

Create a new record displays.	
$\rightarrow$ Contact Name defaults to the	Create a new record x
Parent/Guardian profile	· · · · · · · · · · · · · · · · · · ·
name (user is unable to edit	Contact *
this field).	
	Parent Name
$\rightarrow$ Enter the Tax Year.	Tax Year *
> Enter any notes you may	
→ Enter any notes you may want to add.	
want to add.	Notes Memo
$\rightarrow$ Select "Click to select file(s)."	
	1040 File *
$\rightarrow$ Choose the file(s) you want	
to upload.	Click to select file(s)
	Name Actions
→ Select "Upload."	Selected Files:
$\rightarrow$ Select "Save."	Upload
	Choad
	Save
Ensure your file is correctly	
highlighted and the check mark	Lookup records ×
next to the file name chosen for	
upload is enabled.	Search Q
· Coloct "Coloct" from the	Choose one record and click Select to continue
→ Select "Select" from the second Lookup records	✓ Name Created On
screen.	
$\rightarrow$ Select "Next" from the main	Parent Name - 2024 12/13/2024 5:08 PM
Details Tab to move to	
Insurance.	New         Select         Cancel         Remove value
•	

Insurance	
Select the "magnifying glass" to enter the child's insurance details.	The child is required to have insurance coverage from a commercial health plan, either through an employer or individually purchased.
Note: To meet the eligibility requirement, the child must have insurance coverage from a commercial health plan, either purchased through an employer or individually.	Child's Primary Insurance *① Child's Secondary Insurance① Previous Next
Select "New" to create a new insurance record.	Lookup records ×
	Search Q
	Choose one record and click Select to continue
	Identifier     Insurance Company Name     Created On
	New Select Cancel Remove value



Credentials *① 2 Select			
2 Select			
	~		
	Phone Number *		
	4		]
City *	State *		Zip Code *
		٩	
	- 4		
		an recomm	nending the servi
Select the credential	s of the physician usir	ng the drop	o-down menu.
•	,		
	. ,		
Note: Forms signed by	a Nurse Practitioner, Li		
requirements.	a nealth professional do	o not tuinin tr	le application
	e clinic where the rec	ommending	g physician
•	ndent physician type "Ind	dependent."	
Enter the physician's	phone number (num	bers only.	no dashes).
Enter the clinic's add	lress. The additional		
			vie
	(letters only, no spectropic of the credential         → M.D. (Doctor         → D.O. (Doctor         → Au. D (Doctor         Note: Forms signed by         Assistant, or other allier         requirements.         Enter the name of the         practices.         Note: If it is an indeper         Enter the physician's         Enter the clinic's add         based on the Clinic's	City*       State*         Enter the first and last name of the physici         (letters only, no special characters).         Select the credentials of the physician usir         → M.D. (Doctor of Medicine)         → D.O. (Doctor of Osteopathic)         → Au. D (Doctor of Audiology)         Note: Forms signed by a Nurse Practitioner, Li         Assistant, or other allied health professional do         requirements.         Enter the name of the clinic where the record         practices.         Note: If it is an independent physician type "Independent physician type "Independent physician type functional based on the Clinic's Address field.	City*       State*         Image: City*       Image: City*         Im

Medical Condition/Diagnosis Reference the image and table below when filling out the Medical Condition/Diagnosis section within the application.

Details 🖌 Insurance 🖌 Physician De	tails 🖌 Medical Condition / Diagnosis Services Requested Attachments Acknowledgement
Primary Diagnosis Category *	Has your child been evaluated by Early Childhood Intervention or Special Education Services (typically through the School District)? * Select
Specific Primary Diagnosis * 2 Secondary Diagnosis Category 3	Summary of Child's Medical Condition *①
Previous Next 6	
– Primary Diagnosis Category	Select the "magnifying" glass to launch the primary diagnosis category lookup. Scroll and use the arrows to locate the diagnosis category. Select the diagnosis category. Select "Select."
<ul> <li>Specific Primary Diagnosis</li> </ul>	Enter the specific primary diagnosis.
<ul> <li>Secondary Diagnosis</li> <li>Category</li> </ul>	Enter the secondary diagnosis category, if applicable.
<ul> <li>Has your child been evaluated by Early Childhood intervention or Special Education Services?</li> </ul>	Use the drop-down menu to answer whether your child has been evaluated by Early Childhood Intervention or Special Education Servic
<ul> <li>Summary of Child's Medical Condition</li> </ul>	Provide a description of your child's medical condition to help the boar reach a decision regarding your application. For example, medical history and treatment plan.
– Next	Select "Next" to move to Services Requested.

Services Requested						
The Services Requeste	d are the	medical ite	ems and/or s	ervices that will b	be funded by the	e grant.
Important Note: Only se listed on the Medical Fo covered by the grant. Reference the image ar	rm. Servi	ces listed o	on the Medic	al Form but not a	added into the a	application will not be
Details 🖌 Insurance 🗸	Physician D	Details 🖌 Me	dical Condition / Diag	gnosis 🖌 Services Requ	Jested Attachments	Acknowledgement
Grants are limited to a	n maximum of	\$5,000 per year a	and \$10,000 lifetime	2.	(1	• Add Service
Service Type Service	vice Item	Drug Name	Other Notes	Out of Pocket Amou	Not Covered by nt Insurance Due Exclusion	
(inclu	pecialist Visits uding services ng that visit)			\$1,000.00	No	2 •
Medical Drug		Prescription Medication Name(s)		\$1,500.00	No	•
					Total An	nount Requested
					<b>3</b> <del>5</del> 2,500.0	0
Download Medical For Template			elect file(s) ed Files:	Name	Actions	
			oad			
Previous Next	6					
1 – Add Service		Note: On one serv	ly services ad ice is being re		onsidered for the dd Service" for E	t. grant. If more than EACH service. Services
2 – Edit / Remove Servi	се	Select t	he drop-dow	n menu to edit or	remove a serv	ice request.
3 – Total Amount Reque		service.				entered for each
4 – Download Medical F Template	orm			al Form Templat		
		(Doctor o related re <b>Psychol</b>	of Osteopathic equests. <i>Forn</i> logist, Physic	າs signed by a Nເ	D. (Doctor of Aud Irse Practitione any health prof	diology) for hearing
5 – Upload Medical For	n 🗆	Select " Choose	Click to seled the file(s) yo			
6 – Next			Upload." Next" to mov	e to Attachments	3.	

Add Services	
Reference the image and table be	elow when adding services within the application.
Create	
Service Type *	Out of Pocket Amount *①
1	× Q 3
Service Item*	× Q 4 Not Covered by Insurance Due to Policy Exclusion
Upload Proof o	of Non-Coverage *
Click to sele file(s)	
Selecte Files: Upload	
6 Save	
1 – Service Type	<ul> <li>Select the "magnifying glass" to launch the "Service Type" lookup and select the service type category.</li> <li>→ Medical Therapy, Medical Services, Medical Equipment, Medical Drug, or Medical Supplies .</li> </ul>
	Note: When selecting "Medical Drug" as service type, enter the drug name in the text box. If approved, the grant will cover any prescription medication filled by a pharmacy.
2 – Service Item	Select the "magnifying glass" to launch the "Service Item" lookup and select the service item category.
	Note: When selecting an "Other" option, enter the specific service item in the text box.
3 – Out of Pocket Amount	Enter the amount you expect to pay out-of-pocket after insurance coverage for the duration of the grant. Grants are good for one year after approval.
4 – Not Covered by Insurance Due to Policy Exclusion	ONLY SELECT if services are not covered by the insurance as an exclusion to your insurance policy.
	Note: DO NOT SELECT if services are covered but payments apply to the deductible or out-of-pocket expenses.
	Select "Click to select file(s)." Choose the file(s) you want to upload. Select "Upload."
5 – Upload Proof of Non- Coverage	If applicable, upload Proof of Non-Coverage.
00101490	Note: This could be a copy of your benefit summary's exclusions list highlighting no coverage, a denial letter from your insurance company, or an Explanation of

	Benefits that shows no benefits are available. Retain this document for use after grant approval, as you will need to upload this with a Payment Request.
	Select "Click to select file(s)." Choose the file(s) you want to upload. Select "Upload."
6 - Save	Select "Save." Select "Next" to move to <u>Attachments</u> .

# Attachments

Ref	erence th	e image an	d table below v	vhen filling out the A	ttac	hments section w	vithin	the a	pplication.
Not	e: This is	not a requi	red section. Ap	plicant can use this s	sec	tion to add addition	onal ii	nform	ation that may
sup	port their	application	. Examples: Ph	notos of your family,	lette	ers from provider	s or s	chool	, etc.
5									0
	Details 🖌	Insurance 🗸	Physician Details 🗸	Medical Condition / Diagnosis	~	Services Requested 🗸	Attach	ments	Acknowledgement
	Attach Ad	ditional Documen	its						
	1		Click to select file(s)		Na	me	Actions		
		5	Selected Files:		Dia	gnosis Document.pdf	D :	Ł 🛍	
			Upload		Pho	to of Child.pdf	D :	Ł 🛍	
	·			······					
	Previous	Next 2							
					-				
			Sel	ect "Click to select fi	e(s	) "			
1 –	Upload F	iles	Cho	cose the file(s) you w ect "Upload."	•	,			
2 –	Next			ect Next to move to	Ack	nowledgement.			

Acknowledgement					
Read and acknowledge each s	ection a	nd add an electronic sig	nature.		
Note: Providers, social workers	s, or othe	er proxies ARE NOT PE	RMITTED to con	nplete the ap	plication.
Details 🖌 Insurance 🖌 Physician	n Details 🖌	Medical Condition / Diagnosis 🖌	Services Requested 🖌	Attachments 🖌	
Acknowledgement					
Submission of a completed grant app request for funds. If a grant is approve the Foundation's Board of Directors.		-			
I hereby certify that I am the parent or le to the best of my knowledge, the inform this application that any grant awarded I	ation provide	d by me in this application is true and c	orrect. I understand that if I	have made any misre	epresentations in
I acknowledge that I have consented to a in connection with this application.	and authorize	d the release of the medical and financi	al information and records <b>p</b>	provided to the Foun	dation for review
2 Medical & Financials Acknowledge	ment *				
Waiver of Liability					
I, for myself and on behalf of my child/w servants and employees from any and al			-		_
<ul> <li>v. 1 ic o ta / c c</li> <li>broad and inclusive as permitted by law continue to be valid and legally binding.</li> <li>Waiver of Liability *</li> </ul>	and that if any	y portion of this Agreement is declared			ons shall
Electronic Signature					
By entering your name in the space prov and to the Foundation's policies related			above related to the Ackno	owledgement and Wa	iver of Liability,
If awarded a grant through UHCCF, we fundraising event or similar project? P					ess release,
Select					~
Electronic Signature *					
Previous 5 Submit					
1 – Parent Acknowledgment		ad and acknowledge tha d who will receive the g		rent or legal	guardian of the
2 – Medical & Financials		ad and acknowledge the	e consent and au	thorization o	f financial and
Acknowledgment 3 – Waiver of Liability		dical records release. ad and acknowledge the	waiver of lighilit	N/	
5 - vvalvel Of Liability	Rea	au anu auknowieuge life		у.	
4 – Electronic Signature	Ans	swer the promotional qu	estion by using t	he drop-dow	n menu.
	Ent	er your name in the Ele	ctronic Signature	e text box.	

5 – Submit	Ensure that all information is complete and all required documents have been uploaded. After submitting, you will not be able to edit the application without affecting your grant start date. Select "Submit" to submit your application. Important Notes:
	Upon successful submission of the application, the following pop up will appear.
	Success!         Your form has been successfully submitted.         You will receive an email when your application has been reviewed.         Joure
	Once submitted, a Grant Manager will review your application within three to five business days. You will then receive an email (to the email provided in the Parent/Guardian profile) confirming completion of the application or requesting additional information.
	After Grant Manager review, your application will be reviewed by the UHCCF Board. Board meetings occur once per month. Therefore, a final decision of the grant application could take up to 45 days after Grant Manager review.

## Active Grant

Once the child is awarded a grant, the Active Grant information will display on the Dashboard and in the Child Profile. Select the grant shortcut (e.g. "DOE, JANE 12312025") or "Payment History" to open the grant details.

DOE, JANE 12312025		Grant Start Date: September 25, 2024	Grant Awarded: \$1500.00	
Child: Jane Doe	Age: 7	Grant End Date: December 31, 2025	Total Used: \$0.00	
Approved Services:				
Medical Drug - Prescription Medica	tion Name(s), Me	dical		
Services - Dr/Specialist Visits (includ	ding services durin	ng	Remaining Amount: \$1500.00	
that visit)			Payment History New Payment Reg	

Reference the image and table below when viewing an active grant.

-											
Gr	ant Detai	ls			Amount Awarded				Amount Remaining		
		DOE, JANE 12312025			\$ 1,500.00						
	Child				Grant Start Date			Grant End Date			
	Jane Doe				9/25/2024			-	12/31/2025		
	Grant Appl		٦								
	Grant Appli	cation - Jane I	D								
	Payment H	istory				New Payment Request					
3	Payee	Amount	Status Reason	Payment Method	Submitted Date	Child		Date of al Service	End Date of Medical Service	Region	
	Parent/G uardian	\$150.00	Paid	Zelle	1/7/2025	Jane Doe	1/1/202	25	1/1/2025	Central 4	
	Approved Services / Special Requests										
5	Name 🕇	• 			Service Item	Service T	уре	Drug Name	Approval Method	Approval Status	
	Medical Drug - Prescription Medication Name(s)					Medical Dr	ug	Prescription Medication Name(s)	Application	Approved	
	Medical Services - Dr/Specialist Visits (including services during that visit)				Dr/Specialist Visits (including services during that visit)	Medical Se	rvices		Application	Approved	
Grant Details				Gra	nt award d	etails ca	nnot l	be change	ed.		
compl					e: Grant start dates are calculated as 90 days before your application ppletion date. Grant end dates are calculated as the last day of the 12th hth following grant approval.						
New Payment Requests					Select to generate a new payment request.						
lev	•										

4 – Edit Payment Request	Select to update and resubmit a payment request following an email notifying you of changes or additional information needed.
5 – Approved Services / Special Requests	The grant will only cover services listed here and in your grant approval email, even if you applied for additional items not listed.

#### Payment Requests

Select "New Payment Request" on the child's Active Grant at the top of the Dashboard, in the Child Profile, or in the Payment History/Active Grant details.

### Important Notes:

Only dates of service occurring within the grant start and expiration date timeframe will be considered for the grant. There are no exceptions.

Payment requests for dates of service within the grant dates must be submitted within 30 days of the grant expiration date to be considered for payment. Any grant balance remaining after the grant payment window will be forfeited and revert to UHCCF.

### **Required Documents**

These must be uploaded to each payment request. Failure to upload the documents will delay processing and may result in a payment request denial.

- 1. A detailed **invoice** showing the child's name, date(s) of service, provider information, service rendered, and billed amount.
- 2. An **Explanation of Benefits (EOB)** from your insurance that shows the details of how they have processed the charges for the requested dates of service including the patient responsibility amount.
  - 1. If you choose to go to an out of network provider or a provider that does not accept insurance, you are responsible for submitting to your insurance for an EOB to be obtained.
  - 2. If you do not have coverage for the service, we need **proof of non-coverage**.
    - i. This is a document from your insurance company that confirms no benefits will be paid out for a service or product. It could be a copy of your benefit summary's exclusions list highlighting no coverage, a denial letter from your insurance company, or an Explanation of Benefits that shows no benefits are available.
- 3. **Proof of payment** (for reimbursement to the parent/guardian).
  - 1. Accepted proof of payment: receipt, provider invoice showing payment, front and back of *cashed* check, bank or credit card statement.

There are two payment options:

- 1. Reimbursement to the parent/guardian via check or Zelle.
- 2. Payment to the provider directly via check.
  - a. If we have not sent a provider payment before, we will need a copy of their W-9 to get them set up in our system.

	ow when creating a new payment requ						
Add Payment Request							
Who Do We Need to Send Payment To? *	Start Date Medical Service, Item or	End Date Medical Service, Item or					
1 Select	Procedure Received or Purchased *	Procedure Received or Purchased *					
Enter Reimbursement Amount *							
4	]						
Select the Approved Grant Service you are	Additional Information	Additional Information					
requesting payment for *	16						
<u> </u>		<i>b</i>					
Provider Invoice/Bill *	Explanation of Benefits (EOB) or Proof of Non-Coverage						
Click to select Name	*						
file(s)	Click to select						
Selected	file(s)						
Files:	Selected						
10.0	Files:						
Upload							
·	Upload						
9 guidelines previously communicated to Signature *	me. *	o the best of my knowledge, within the grant					
9	me. *	o the best of my knowledge, within the grant					
Signature *							
9 Signature * 10 Submit Payment Request Who Do We Need to Send	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," add	" from the drop-down list.					
9 Signature * 10 Submit Payment Request Who Do We Need to Send Payment To?	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," add required information.	ı" from the drop-down list. ditional fields show up for additiona					
Signature * Signature * Who Do We Need to Send Payment To? Start & End Dates of Medical	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," add	" from the drop-down list. ditional fields show up for additiona <b>date of service</b> in MM/DD/YYY					
<ul> <li>Signature *</li> <li>Submit Payment Request</li> <li>Who Do We Need to Send Payment To?</li> <li>Start &amp; End Dates of Medical Service, Item or Procedure Received or Purchased</li> </ul>	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," add required information. Select the calendar icon or enter the format. If requesting payment for a sin in both fields.	n" from the drop-down list. ditional fields show up for additiona <b>date of service</b> in MM/DD/YYY ngle date of service, enter that o					
<ul> <li>Signature *</li> <li>Submit Payment Request</li> <li>Who Do We Need to Send Payment To?</li> <li>Start &amp; End Dates of Medical Service, Item or Procedure Received or Purchased</li> </ul>	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," ad required information. Select the calendar icon or enter the format. If requesting payment for a sin	" from the drop-down list. ditional fields show up for additiona <b>date of service</b> in MM/DD/YYY ngle date of service, enter that o nt request.					
9 Signature * 10 Submit Payment Request Who Do We Need to Send Payment To? Start & End Dates of Medical Service, Item or Procedure Received or Purchased Reimbursement Amount	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," add required information. Select the calendar icon or enter the format. If requesting payment for a sin in both fields. Enter the dollar amount of the payme Note: Payment amount must match on th "Patient Responsibility" on the EOB.	" from the drop-down list. ditional fields show up for additiona <b>date of service</b> in MM/DD/YYY ngle date of service, enter that o nt request. le invoice and the amount shown a					
Signature * Signature * Who Do We Need to Send Payment To? Start & End Dates of Medical Service, Item or Procedure Received or Purchased Reimbursement Amount	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," ad required information. Select the calendar icon or enter the format. If requesting payment for a sin in both fields. Enter the dollar amount of the payme Note: Payment amount must match on th "Patient Responsibility" on the EOB. Select "Check" or "Zelle" from the dro (This box only shows when "Parent/Guar	" from the drop-down list. ditional fields show up for additiona <b>date of service</b> in MM/DD/YYY ngle date of service, enter that o nt request. he invoice and the amount shown a p-down list.					
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Signature * Signature * Who Do We Need to Send Payment To? Start & End Dates of Medical Service, Item or Procedure Received or Purchased Reimbursement Amount Payment Method	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," add required information. Select the calendar icon or enter the format. If requesting payment for a sin in both fields. Enter the dollar amount of the payme Note: Payment amount must match on th "Patient Responsibility" on the EOB. Select "Check" or "Zelle" from the dro (This box only shows when "Parent/Guar to Send Payment To?") Enter the phone number or email add account. Note: If your Zelle payment does not go t mailed to you instead.	a" from the drop-down list. ditional fields show up for additional <b>date of service</b> in MM/DD/YYY ngle date of service, enter that of nt request. the invoice and the amount shown a p-down list. dian" is selected for "Who Do We I Iress associated with your Zelle hrough, a check will automatically					
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Signature * Signature * Submit Payment Request Who Do We Need to Send Payment To? Start & End Dates of Medical Service, Item or Procedure Received or Purchased Reimbursement Amount Payment Method Zelle Payment Information	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," ad required information. Select the calendar icon or enter the format. If requesting payment for a sin in both fields. Enter the dollar amount of the payme Note: Payment amount must match on th "Patient Responsibility" on the EOB. Select "Check" or "Zelle" from the dro (This box only shows when "Parent/Guar to Send Payment To?") Enter the phone number or email add account. Note: If your Zelle payment does not go t mailed to you instead. (This box only shows when "Parent/Guar to Send Payment To?")	" from the drop-down list. ditional fields show up for additional <b>date of service</b> in MM/DD/YYY ngle date of service, enter that of nt request. he invoice and the amount shown a p-down list. dian" is selected for "Who Do We I Iress associated with your Zelle hrough, a check will automatically dian" is selected for "Who Do We I					
<ul> <li>Signature *</li> <li>Submit Payment Request</li> <li>Who Do We Need to Send Payment To?</li> <li>Start &amp; End Dates of Medical Service, Item or Procedure Received or Purchased Reimbursement Amount</li> <li>Payment Method</li> <li>Zelle Payment Information</li> <li>Approved Grant Service</li> </ul>	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," add required information. Select the calendar icon or enter the format. If requesting payment for a sin in both fields. Enter the dollar amount of the payme Note: Payment amount must match on the "Patient Responsibility" on the EOB. Select "Check" or "Zelle" from the dro (This box only shows when "Parent/Guar to Send Payment To?") Enter the phone number or email add account. Note: If your Zelle payment does not go t mailed to you instead. (This box only shows when "Parent/Guar to Send Payment To?") Select the "magnifying glass" to select are requesting payment for.	a" from the drop-down list. ditional fields show up for additional <b>date of service</b> in MM/DD/YYY ngle date of service, enter that of nt request. he invoice and the amount shown a p-down list. dian" is selected for "Who Do We I Iress associated with your Zelle hrough, a check will automatically dian" is selected for "Who Do We I					
<ul> <li>Signature *</li> <li>Submit Payment Request</li> <li>Who Do We Need to Send Payment To?</li> <li>Start &amp; End Dates of Medical Service, Item or Procedure Received or Purchased Reimbursement Amount</li> <li>Payment Method</li> <li>Zelle Payment Information</li> </ul>	Select "Provider" or "Parent/Guardian Note: If you select "Parent/Guardian," adv required information. Select the calendar icon or enter the format. If requesting payment for a sin in both fields. Enter the dollar amount of the payme Note: Payment amount must match on th "Patient Responsibility" on the EOB. Select "Check" or "Zelle" from the dro (This box only shows when "Parent/Guar to Send Payment To?") Enter the phone number or email add account. Note: If your Zelle payment does not go t mailed to you instead. (This box only shows when "Parent/Guar to Send Payment To?") Select the "magnifying glass" to select	" from the drop-down list. ditional fields show up for additional <b>date of service</b> in MM/DD/YYY ngle date of service, enter that of nt request. ie invoice and the amount shown a p-down list. dian" is selected for "Who Do We I ress associated with your Zelle hrough, a check will automatically dian" is selected for "Who Do We I et the approved grant service your					

8 – Provider Invoice/Bill	Upload a detailed invoice showing the child's name, date(s) of service, provider information, service rendered, and billed amount.				
9 – Explanation of Benefits (EOB) or Proof of Non- Coverage	Upload an <b>Explanation of Benefits (EOB)</b> from your insurance that shows the details of how they have processed the charges for EACH requested date of service, including the patient responsibility amount. Note: Letters from providers are not accepted. If you choose to go to an out of network provider or a provider that does not accept insurance, you are responsible for submitting to your insurance for an EOB to be obtained. If you do not have coverage for the service, upload <b>proof of non-</b> <b>coverage</b> . Note: This is a document from your insurance company that confirms no benefits will be paid out for a service or product. It could be a copy of your benefit summary's exclusions list highlighting no coverage, a denial letter from your insurance company, or an Explanation of Benefits that shows no benefits are available.				
10 – Proof of Payment	Upload a receipt, provider invoice showing payment, front and back of <i>cashed</i> check, or your bank or credit card statement. (This only shows when "Parent/Guardian" is selected for "Who Do We Need to Send Payment To?")				
11 – Parent/Legal Guardian Attestation and Signature	Read and acknowledge the parent/legal guardian attestation. Enter your name in the Signature text box. Note: Providers, social workers, or other proxies ARE NOT PERMITTED to submit payment requests.				
12 – Submit Payment Request	Select "Submit Payment Request" to submit. Upon successful submission of the application, the following pop up will appear.				
	Important Notes: Once submitted, a Grant Manager will review your request within three five business days. You will then receive an email approving, denying, requesting additional information for your payment request.				
	After approval, your payment will be issued within 14 business days.				