2019 Medical & Therapy Equipment Grant Program

Life with multiple syndromes, handicaps, and disabilities is tough.

Through our grant program, we hope to alleviate some of the financial challenges faced by families of children diagnosed with complex and debilitating neurologic, metabolic, or genetic conditions.

- **Types of items considered** for this program are (but are not limited to): seating, mobility, transport, comfort, positioning, bathing, therapy tools, feeding, etc. Item must be no more than $1400 total.
- **$750 per grant maximum** per 12-month period
- Requires letter of medical necessity from primary pediatric specialist, pediatrician, therapist, or social worker
- Grants awarded (if approved) for purchase of new items and are paid directly to vendor.

Eligibility: We work directly with the families of medically fragile or special needs children, under 18 years of age, who are diagnosed with debilitating rare, neurologic, metabolic, or genetic conditions. Must live in Southern Nevada more than 50% of the time.

Application Deadline	Recipients Announced
February 28, 2019	March 21, 2019
May 31, 2019	June 21, 2019
August 31, 2019	September 21, 2019
November 30, 2019	December 21, 2019

Please share this information with your friends, patients and clients who may be able to benefit

Little Miss Hannah FOUNDATION

Additional copies of this application may be downloaded at
http://www.littlemisshannah.org/download

info@littlemisshannah.org
www.littlemisshannah.org

10624 South Eastern Avenue, Suite #A847
Henderson, Nevada 89052
Phone: 702-608-2488

2018-2019 Medical & Therapy Equipment Grant Program

A sweet girl and her amazing smile…

Our Little Miss Hannah Foundation was created in December 2011 in memory of Hannah Ostrea, a beautiful 3-year-old girl who lost her battle against Neuronopathic Gaucher's Disease, an extremely rare, debilitating, and life-limiting genetic metabolic disorder.

Despite the cruel progression of this disease, Hannah was an incredibly happy and charming little girl. Whether it was a doctor, therapist or someone passing by on the street, she had a way of hooking their hearts. It was easy to fall in love with the sweetheart of a girl with the big cheeks, curly brown hair and a heart as big as the sun.

Hannah's family and close friends created this foundation in order to help enhance the quality of life for local children with similar rare and medically complicated conditions as Hannah had. To read Hannah's story, please visit: http://www.littlemisshannah.org/hannahs-story

GUIDELINES: Medical and Equipment Financial Grant Program Details:

- Types of items considered for this program include:
  - Safety: Special needs car seats, feeding chairs, bath chairs, floor sitters
  - Therapy: Adaptive tricycles, therapy benches, mats, wedges, and swings; speech communication software
  - Medical: Feeding pumps, cooling vests and mattresses, seizure helmets, orthotics
  - For items not listed above, a letter of medical necessity will be required for consideration.
- Applicants who were not awarded previous grant requests may reapply at a later time to have their request reconsidered. Reconsidered grants must be submitted within 9 months after the first request.
- $750 cap per diagnosed child per 12-month-period. Applicants awarded previous medical grants during the same 12-month-period may apply for an additional grant as long as the medical grants combined total no more than $750.
- Grants will be reviewed by the Board of Directors four times per year and grants will be awarded at these meetings. Deadlines for each grant period will be posted on our website at http://littlemisshannah.org.
- Medical grants awarded will be paid directly to vendor for new equipment. Grants will not be awarded in the form of cash or check made payable to recipient.
- iPads and tablets will only be considered for active Little Miss Hannah kids (registered for more than 13 months and have been in person at a Little Miss Hannah event).
- Item(s) requested must be more than $150 each. Partial payment of items will be considered as long as the total cost is no more than $1400.
- Applicant must provide a valid email address as all communication regarding the status of the application will be by email.

Checklist:

1) Completed application with parent/guardian signature.
2) Letter of medical necessity from a licensed pediatrician, pediatric specialist, therapist or social worker for items not listed above

Little Miss Hannah FOUNDATION

info@littlemisshannah.org
www.littlemisshannah.org

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Life is not measured by
the number of breaths we take,
but by the moments that
take our breath away....

LITTLE MISS HANNAH'S MISSION:

Enhancing the quality of life for children diagnosed with rare,
life-limiting and complex medical conditions in Southern Nevada

Medical and Therapy
Equipment Grants

Family Support
and Activities

Rare Disease
Advocacy

Sibling College
Scholarships

Contact us today to learn more!

Get Services | Volunteer | Donate | Sponsor

We are a volunteer-staffed organization created
in memory of Little Miss Hannah Ostrea.
Read Hannah's story on our website.

Little Miss Hannah
FOUNDATION

info@LittleMissHannah.org
www.LittleMissHannah.org

10624 S. Eastern Avenue #A847
Henderson, NV 89052
Phone: 702-608-2488

We are a 501(c)(3) tax exempt nonprofit organization - EIN# 45-3993921

Family Registration Form

Return from by email, fax, or mail to: eligibility@littlemisshannah.org ~ Fax: 702-541-9957
Address: LMHF, 10624 S. Eastern Ave, #A847, Henderson, NV 89052
All fields must be filled in.

Eligible Child information

Name: _____ Birthdate: _____ / _____ / _____

Address/City/Zip: _____

Primary Diagnosis: _____ Gender: [ ] Male [ ] Female

Does your child travel out of Southern Nevada for medical care? [ ] Yes [ ] No

Program Group (check all that apply):

[_____] Child under 18 years old with rare disease (must be listed at rarediseases.org)
[_____] Child under 18 years old undiagnosed with complex medical needs, medically fragile
[_____] Child under 18 years old currently in pediatric hospice or palliative care
[_____] Child under 18 years old diagnosed with debilitating neurologic, metabolic, or genetic condition

Parent/Legal Guardian information

Name(s): _____ Email: _____

Phone: _____ Do you live with the child 50% or more of the time? Y N

Siblings

Are there siblings under 18 years old living at home with the eligible child?

If yes, how many? _____ What are their ages? _____

Support Interests

[_____] Financial Assistance (Grant Program)
[_____] Local resource assistance
[_____] Family events and activities
[_____] Support groups
[_____] Sibling activities
[_____] College scholarships

____ (initials) I understand that the Little Miss Hannah Foundation, a 501c3 nonprofit charitable organization, will not provide any medical advice or resources that are not publicly available. I understand that I may remove my family from this program at any time by notifying Little Miss Hannah Foundation in writing via email, fax, or mail. None of the information provided above will be shared with any outside parties and will remain the property of the Little Miss Hannah Foundation.

Parent/Legal Guardian signature: _____ Date _____ / _____ / _____

Little Miss Hannah FOUNDATION

Equipment Grant Application

Return from by email, fax, or mail to: eligibility@littlemisshannah.org ~ Fax: 702-541-9957
Address: LMHF, 10624 S. Eastern Ave, #A847, Henderson, NV 89052

Photos of application will not be accepted – must be a clean PDF or original.
All fields are required to be filled out for application to be considered.

Eligible Child information

Name: _____ Birthdate: _____ / _____ / _____

Address/City/Zip: _____

Primary Diagnosis: _____ Gender: [ ] Male [ ] Female

Does your child travel out of Southern Nevada for medical care? [ ] Yes [ ] No

Program Group (check all that apply):

[_____] Child under 18 years old with rare disease (must be listed at rarediseases.org)
[_____] Child under 18 years old undiagnosed with complex medical needs, medically fragile
[_____] Child under 18 years old currently in pediatric hospice or palliative care
[_____] Child under 18 years old diagnosed with debilitating neurologic, metabolic, or genetic condition

Parent/Legal Guardian information

Name(s): _____ Phone: _____

Email: _____ Primary Language Spoken: _____
(Must have valid email address to receive status notification)

I am the: [ ] Parent [ ] Grandparent [ ] Legal Guardian
Do you live with the child 50% or more of the time? [ ] Yes [ ] No

Support Services - Interests

[_____] Financial Assistance (Grant Program)
[_____] Local resource assistance
[_____] Family events and activities
[_____] Support groups
[_____] Sibling activities
[_____] College scholarships

How/where did you find us? Who referred you to us? _____

Application Checklist

_____ Completed application (5 pages) including email address, diagnosis, and signature
_____ Letter of medical necessity on why equipment requested is needed for items not covered in guidelines
_____ Equipment request details including where to purchase, size, color, etc. (on page 3)
_____ Medical information release form

Healthcare Professional Information

[ ] Pediatrician [ ] Peds Specialist [ ] Social Worker [ ] Case Manager

Name(s): _____ Phone: _____

Medical Organization: _____

Address/City/Zip: _____

Therapist (if applicable)

[ ] Physical [ ] Occupational [ ] Speech [ ] Early Intervention [ ] Other _____

Name(s): _____ Email: _____

Clinic Name: _____

Address/City/Zip: _____

Support Services – Siblings

Are there siblings under 18 years old living at home with the eligible child?

If yes, how many? _____ What are their ages? _____

Are any of the siblings in high school? Attending college? [ ] Yes [ ] No

Equipment Requested

Total Grant Amount Requested: $ _____ **(**equipment request must $750 or less)

Describe the item(s) you are seeking funding for. **Applications not providing exact brand and model number will not be considered. (You may attach website address or catalog pages to describe item).**

Item name, **size/color**	Where to purchase?	SKU or Item # (if available)	Cost

Equipment Requested (continued)

Describe the child's medical conditions and the hardships *in detail.*

_____

_____

_____

_____

Please describe, *in detail*, what ways will this contribute to an increased quality of life for the child and family?

_____

_____

_____

Please describe, *in detail*, how this item is being used or will be used (how often, medically necessary or medically convenient, etc.)

_____

_____

_____

Has this requested been submitted to an insurance company and/or Medicaid in the past?
If so, when and what was the outcome?

_____

_____

Follow up Requirements: Little Miss Hannah Foundation asks that you email or otherwise contact us with an update on how the grant positively impacted your child's life within 45 days. Little Miss Hannah Foundation will list grant awards on website, social media and in other print materials. Please specify if you do NOT want information shared.

Disclosure/Signature

MUST BE SIGNED, NOT TYPED

____ (initials) I declare that the information provided on this application for financial assistance is true and complete to the best of my knowledge.

____ (initials) I understand that I may be required to provide evidence of submitted information and that Little Miss Hannah Foundation may contact the medical facility for verification purposes.

____ (initials) I agree to allow Little Miss Hannah Foundation to use my name in announcements and related publications.

____ (initials) I understand that I will be notified by email as to the status of this application and have provided a valid email address.

____ (initials) I understand that the Little Miss Hannah Foundation will consider this grant request and, in turn, may or may not request this grant request.

____ (initials) I understand that the Little Miss Hannah Foundation, a 501(c)(3) nonprofit charitable organization, will not provide any medical advice or resources that are not publicly available. I understand that I may remove my family from this program at any time by notifying Little Miss Hannah Foundation in writing via email, fax, or mail. None of the information provided above will be shared with any outside parties and will remain the property of the Little Miss Hannah Foundation.

Parent/Legal Guardian signature: _____ Date ____ / ____ / _____

Parent/Legal Guardian Print: _____

Authorization to Release Medical Information

Return from by email, fax, or mail to: eligibility@littlemisshannah.org ~ Fax: 702-541-9957
Address: LMHF, 10624 S. Eastern Ave, #A847, Henderson, NV 89052

The purpose of the Little Miss Hannah Foundation program,
a 501(c)(3) nonprofit charitable organization,
is to provide families of children with complex medical conditions
with support and resources to help provide the best quality of life for the family.

To: _____ (Name and address of primary healthcare provider)

_____

_____

I hereby authorize the use/disclosure of my child's condition and treatment in order to determine eligibility for the Little Miss Hannah Foundation's grant program, which provides grants and other financial support to offset costs of equipment and related costs to enhance the quality of life of medically fragile and special-needs children and their families throughout Southern Nevada. For more information, please call 702-608-2488 or email eligibility@littlemisshannah.org.

ELIGIBILITY DETERMINATION: The Little Miss Hannah Foundation works directly with the families of children under 18 years of age who are diagnosed with debilitating neurologic, metabolic, or genetic conditions.

Eligible Child information

Patient Name: _____ Birthdate: _____ / _____ / _____

Parent/Legal Guardian: _____ Primary Diagnosis: _____

Address: _____

Phone Number: _____

_____ (initials) I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without prior written authorization except provided by law. I understand that a photocopy or fax of this authorization is as valid as the original. This authorization is valid for 270 days from the date of execution.

Parent/Legal Guardian Signature: _____

I have executed this document on the _____ day of _____ 20 __.