The Mike & Sandy Ernsdorff Childhood Cancer Foundation

6776 Northwest Hwy Suite 1D
Chicago, IL 60631

P. (312) 515-9490
F. (312) 276-4524

info@compasstocare.org
www.compasstocare.org

COMPASS TO CARE APPLICATION PROCESS

Thank you for your interest in Compass to Care! We are dedicated to scheduling and paying specific travel needs for families seeking the best cancer care for their children. Parent(s) or guardian(s) that are in need of assistance, and meet the eligibility criteria, are requested to complete this referral form, as outlined below.

ELIGIBILITY CRITERIA

Compass to Care welcomes the requests of children with cancer and their families who meet the following eligibility requirements regardless of race, creed, gender, color, ethnic heritage, or sexual orientation:

- Your child is under the age of 18.
- Your child has been diagnosed with cancer.
- Your child is currently in active cancer treatment.
- Your family can demonstrate a financial need.

You must live in the Contiguous United States and your child must be treated in the Contiguous United States. We do not support international travel at this time.

COMPASS TO CARE APPLICATION PROCESS

Step 1: Your family completes the family section of the form (Pages 3 -6).

Step 2: Your child's Healthcare Provider will complete his/her section of this referral form (Page 7) and **fax it to the Compass to Care Office (312) 276-4524.**

Step 3: Compass to Care receives the documentation and completes the internal approval process, validating all parts of the application. Your family will be notified if any information is missing or needs clarification. If you are approved as a recipient of Compass to Care's assistance, your contract for service will be created and will clearly define all expenses Compass to Care will cover while seeking the cancer care for your child. If it is determined that you are not eligible for financial assistance, the Compass to Care Team will contact you directly. Please note, we reserve the right to deny or revoke assistance at any time and for any reason as determined by the organization.

Your family must be working with Healthcare Provider who will complete the Healthcare Provider section of this application. A Healthcare Provider is defined as a representative from the Hospital Social Services Department, the child's Doctor or another Healthcare Provider involved in the child's care. If a Healthcare Provider from a US-based hospital is not able to validate information contained in the application, family will be ineligible for assistance.

DOCUMENTATION REQUIRED

At any time, you may be asked to present the following documents:

- Proof of income
- Proof of household expenses
- Proof of medical debt
- A Social Security number or Driver's License Number

TRAVEL ASSISTANCE

Compass to Care's Travel Assistance Package, will include:

- A personal Cancer Travel Navigator to make all travel arrangements that meet your family's specific needs when traveling to seek cancer care for your child.
- Payments for one or several of the following expenses, based on your specific needs:
  - Airfare
  - Bus Fare
  - Car Rental
  - Gasoline
  - Lodging
  - Parking Fees
  - Taxi Fees
  - Tolls
  - Train Fare

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MAXIMUM LIFETIME BENEFITS
For the duration of a child's life, Compass to Care will provide financial assistance, not to exceed $5000.

THE SELECTION PROCESS
It is the goal of Compass to Care to provide travel assistance to all families that meet the appropriate criteria.

INFORMATION AUDIT
To ensure all information provided is true and accurate, Compass to Care may audit any family at any time. If your family is audited, you will be required to submit copies of all sources of income, all bills and proof of monthly expenditures, bank account statements, travel expenditures, etc. Please keep all of this information easily accessible so that the audit process can be completed quickly and efficiently. Failure to provide complete and truthful information is a basis for denial and revocation of support.

REQUEST FOR CHANGE
If at any time your child's travel requirements change, you will need to complete the Compass to Care Request for Change form. At that time, the Compass to Care team will reassess your situation and a new contract for service will be sent to the family, if eligible. We anticipate this occurring only when a travel requirement, such as the need to travel via air, changes.

NOTIFICATION OF INELIGIBILITY
If at any time, your family no longer meets the eligibility requirements, you are required to contact Compass to Care immediately and complete the Notification of Ineligibility, so that the funds we have generously received from our donors can be used in a manner consistent with our mission. You must notify Compass to Care if:

- Your child is no longer under the age of 18.
- Your child is in remission or no longer in cancer treatment.
- Your child is no longer traveling for cancer treatment.
- Your family is no longer in need of financial assistance.

PLEASE NOTE: Any child that is confirmed as a Compass to Care recipient prior to his or her 18th birthday will continue to receive assistance beyond his or her 18th birthday until either he or she reaches the age of 21 or until he or she has reached the maximum lifetime limit of $5000.

If you have any questions about our process or need further direction on completing the appropriate paperwork, please contact the Compass to Care office at (312) 515-9490.

Wishing you and your family good health and happiness,

Michelle M. Ernsdorff, MBA
Founder, CEO & Childhood Cancer Survivor

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REQUEST FOR ASSISTANCE

Both a Healthcare Provider and the child's parent or guardian must complete this referral form in order to be considered for assistance from Compass to Care. A Healthcare Provider is defined as a representative from the Hospital Social Services Department, the child's Doctor or another Healthcare Provider involved in the child's care. A referral form completed by an individual who is not a Healthcare Provider, as outlined above, will not be accepted.

Upon completion, please fax this form to the Compass to Care office at (312) 276-4524. You can also complete this form online at www.compasstocare.org. To be considered for assistance by Compass to Care all information must be completed.

THIS SECTION TO BE COMPLETED BY THE CHILD'S PARENT OR GUARDIAN ONLY

Name of Child _____

PARENT/GUARDIAN DETAILS

Name of Parent or Guardian _____

Marital Status of Parents/Guardians ☐ Single ☐ Married ☐ Divorced ☐ Co-habitants

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____

Ethnicity ☐ African American/ Black ☐ Asian American/Pacific Islander ☐ Caucasian/White ☐ Hispanic/Latino ☐ Native American/American Indian ☐ Other (Please Specify) _____

Number of Family Household Members _____

How did you hear about Compass to Care? _____

CHILD DETAILS

Child's Date of Birth _____ Gender ☐ Male ☐ Female

Type of Cancer _____ Date of Diagnosis _____

Stage of Cancer _____ Number of Relapses (if applicable) _____

CHILD'S TREATMENT REQUIRING TRAVEL

Reason for Travel ☐ Doctor's Appointments/Treatment ☐ 2nd Opinion

Type of Treatment. Please indicated chemotherapy, radiation, transplant, proton therapy or other:

Detailed cancer treatment plan that will require travel. Include how often, for how many days and for how long, etc.:

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Name of Child _____

DOCTOR'S DETAILS

Name of Doctor _____

Name of Medical Facility _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____

Email Address _____

INSURANCE DETAILS

Is Your Child Covered By Private Insurance?	☐ Yes ☐ No	Is Your Child Covered By A State Funded Insurance Plan (such as Medicaid)?	☐ Yes ☐ No
Does Insurance Provide Assistance for Lodging?	☐ Yes ☐ No	Does Insurance Provide Assistance for Meals?	☐ Yes ☐ No
Does Insurance Provide Assistance for Transportation?	☐ No	☐ Yes – If yes, please explain:	

TRAVEL DETAILS

Type of Travel ☐ Airplane ☐ Car ☐ Train ☐ Bus

What Is The Approximate Mileage From Your Home to The Doctor's Office or Treatment Facility? _____

If Traveling Via Airplane, What Is the Closest Major Airport To Your Home? _____

Will You Rent A Car? ☐ Yes ☐ No

People Traveling with Child

Name _____ Date of Birth _____ Relationship _____

Name _____ Date of Birth _____ Relationship _____

Name _____ Date of Birth _____ Relationship _____

INFORMATION TO SECURE A DEBIT CARD

To secure a debit card to be used for travel expenses, please provide the information from your Driver's License:

State _____ Number _____ Date Issued _____ Expiration _____

VALIDATION OF ELIGIBILITY REQUIREMENTS

Please validate that your family meets/has met the Compass to Care Eligibility Requirements.

My child is under the age of 18.	☐ Yes ☐ No	
My child has been diagnosed with cancer.	☐ Yes ☐ No	
I am in need of financial assistance for costs associated with traveling to seek the best cancer care for my child. (Please validate using Financial Need Worksheet on Next Page)	☐ Yes	☐ No
If Compass to Care chooses to audit my family and me, I will provide copies of all documents to validate my income, expenses, banking balances and travel expenses incurred while receiving assistance, and any other validating documents requested.	☐ Yes	☐ No

Please continue to PAGE 5 and complete the Financial Need Worksheet.

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FINANCIAL NEED WORKSHEET – TO BE COMPLETED BY THE CHILD'S PARENT OR GUARDIAN ONLY

Name of Child _____

This Financial Need Worksheet, below, estimates your income and expenses so we can validate your need for assistance from Compass to Care. It will be helpful to collect and organize household income and expenses (such as pay stubs, credit card statements and other bills) before you start this worksheet. You must certify that all information is factual and accurate and that you truly need assistance. Compass to Care will randomly audit its recipients. Any recipient may be audited and will be required provide all documents necessary to validate the information below.

MONTHLY INCOME

Please provide the household monthly income(s) below. Income 1 should represent the income of one parent or guardian. Income 2 could be the income of a second parent or guardian, if applicable.

	INCOME 1	INCOME 2 (If Applicable)
Take Home Pay	A.	G.
Disability Income	B.	H.
Social Security Income (SSI/SSDI)	C.	I.
Additional Work Insurance (such as AFLAC)	D.	J.
Alimony and Child Support	E.	K.
Income from Rental Property, Investments & Retirement	F.	L.
Please Add All Income (Lines A through L)	**TI**	

MONTHLY HOUSEHOLD EXPENSES

Mortgage or Rent	M.
Homeowner's or Rental Insurance	N.
Utilities (Electricity, Gas, Water, Sewage, Telephone)	O
Car (Loans & Insurance Only)	P.
Food	Q.
Child Care	R.
Alimony and Child Support	S.
Education (Tuition Only)	T.
Other Mandatory Monthly Living Expenses (Please Explain)	U.
Please Add All Expenses (Lines M through U)	**TE**

INCOME MINUS EXPENSES
Please refer to your calculations above.

ALL INCOME (TI)	
ALL EXPENSES (TE)	**Minus**
PLEASE SUBTRACT TI MINUES TE	**Equals**

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FINANCIAL NEED WORKSHEET (CONTINUED)

Name of Child _____

MEDICAL DEBT

What is Your Current Medical Debt _____

MONTHLY MEDICAL EXPENSES & INSURANCE

Co-payments for Office Visits & Current Medication _____

Health Insurance Premiums (Employer-sponsored & Private) _____

Other Monthly Medical Expenses for Household Members _____

BANKING BALANCES

Name of Bank for Checking Account _____ Checking Account Balance _____

Name of Bank for Savings Account _____ Savings Account Balance _____

Name of Bank _____ Other Account Balance _____

TOTAL BALANCE OF ALL ACCOUNTS (Please add B1, B2 and B3) **TB=** _____

OTHER SUPPORT

Are you receiving support from any of the following organizations? Or have you applied for support?

- ☐Alex's Lemonade Stand
- ☐National Children's Cancer Society (NCCS**)**
- ☐ProCure Foundation
- ☐Other – Please list _____

Is any individual or organization providing gas cards or food vouchers for you to use?

☐NO ☐YES – If yes please explain

Have you had a fundraiser to raise money to help you with expenses?

☐NO ☐YES – If yes how much money was raised?_____

Do you intend to have a fundraiser to raise money to help you with expenses?

☐NO ☐YES – If yes, when?_____

Please note that if any of these answers change, you are required to notify Compass to Care immediately, as it may affect our support of your travel needs.

By signing below, I agree that all information above is complete and accurate. If at anytime I no longer meet the above eligibility requirements, I must inform the Compass to Care staff and withdraw my request for assistance. I have also discussed my need with my child's Healthcare Provider and, prior to approval, he or she will complete and sign this referral form.

Name of Parent or Guardian _____

Signature of Parent or Guardian _____

Relationship to the Child _____

Date _____

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THIS SECTION TO BE COMPLETED BY THE CHILD'S HEALTHCARE PROVIDER ONLY

Name of Child _____

Hospital & Healthcare Provider Details

Name of Hospital or Medical Facility _____

Address _____

City _____ State _____ Zip Code _____

Healthcare Provider's Name _____ Healthcare Provider's Title _____

Healthcare Provider's Department _____ Healthcare Provider's Phone # _____

Healthcare Provider's Email Address _____ Relationship to Child _____

Patient Treatment Plan & Anticipated Travel Schedule

Please provide a detailed description of the child's treatment plan that will necessitate travel for the family. This travel schedule will be used to determine appropriate travel assistance for the family. Please include how often the family will travel, how many days and nights they will need to be at the medical center for each treatment, how many months, weeks, etc. the family will need to travel to complete the treatment. Feel free to attach a document outlining the information.

By signing below, I indicate all information above is complete and accurate and that I have reviewed the eligibility criteria with the child's parent(s) or guardian(s) to confirm they meet these requirements.

I also understand that, as the family's referral source, I may need to be involved in assisting Compass to Care in providing assistance to the family, including providing ongoing information about the family's need to travel for their child's cancer care.

_____ _____

Name of Healthcare Provider **Signature of Healthcare Provider**

_____

Date

Please fax completed form to Compass to Care at (312) 276-4524
or scan and email to info@CompassToCare.org

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COMPASS TO CARE FAMILY CONSENT FORM

I grant permission to Compass to Care and/or its representatives to use information artwork, photographs, emails, and/or letters that I provide of my child, my family, or myself for any publication, informational or promotional purposes, including promotion on the internet. In addition, I grant permission to Compass to Care and/or its representatives to photograph, audio record or videotape my child, my family or myself and use our names, images and/or voice recordings for any publication, informational or promotional purpose, including promotion on the internet.

I understand that any of the information, images or recordings of my child, my family or me may be used to inform families, volunteers, donors, the media, and general public about Compass to Care's programs, services and/or events.

I willingly give this authorization to support the efforts of Compass to Care to meet its mission to schedule and pay for families' travel arrangements required to seek the best cancer care for their children.

I understand that this authorization will continue until terminated, by me, in writing.

Signing the consent form is not a requirement to receive assistance from Compass to Care, but your participation is greatly appreciated.

Child's Name _____

Name of Parent or Guardian	**Signature of Parent or Guardian**	**Date**

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