Application for the Nemaha County Catastrophic Medical Fund

The Nemaha County Catastrophic Medical Fund provides assistance to persons residing in Nemaha County, Kansas who are experiencing an unexpected financial hardship caused by extensive and/or catastrophic medical expenses due to COVID-19 (coronavirus). The maximum calendar year award is up to $500.00 per applicant (awards subject to funding availability). Preference given to those who's service or need can be addressed by a business or provider located in Nemaha County, Kansas. If approved, funds will be distributed directly to the vendor on your behalf.

First & Last Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

County: _____ Gender: _____ Date of Birth: _____

Phone: _____ Email: _____

☐ I have lived in Nemaha County, Kansas for at least 6 consecutive months immediately prior to the date of application
☐ I have an unexpected need related to my catastrophic illness

*Amount Requested:	
*How has COVID-19 (coronavirus) created a financial hardship:	
*Tell us about the unexpected need that you are requesting assistance for (invoice or estimate MUST be attached for application to be complete):	

*I understand that the records to be used or disclosed pursuant to this authorization may contain information subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. 65-5601 et seq., and K.S.A. § 65-6001 et seq. I authorize the confirmation of a catastrophic illness as verified by my physician and/or approved signing authorities. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that STEP does not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization is valid until such time as written revocation has been received by STEP. In addition, I understand that I may revoke this authorization at any time by notifying STEP in writing and that revocation of this authorization will not affect any action taken in reliance of this authorization before the written revocation was received. If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.

APPLICANT SIGNATURE: _____DATE: _____

Requests are funded at the sole discretion of the Advisory Committee and STEP Board; decisions are final and are not negotiable. It is the responsibility of the applicant to provide accurate information. Please allow 2 weeks to process application request.

Medical Authorization Form for the Nemaha County Catastrophic Medical Fund

SECTION 1—APPLICANT Authorization

FIRST and LAST NAME OF APPLICANT

Applicant authorizes release of information to:

☐ Nemaha County STEP Foundation*
P.O. Box 165
Seneca, KS 66538
Phone: (785) 294-0312

*Includes all Nemaha County STEP Foundation: Staff, Board, & Medical Fund advisory committee.

For the specific purpose of:

☐ Securing grant funding from the Medical Fund.

I understand this authorization may contain information subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. § 65-5601 et seq., and K.S.A. § 65-6001 et seq. I authorize the confirmation of a catastrophic diagnosis due to COVID-19 (coronavirus) as verified by my physician and/or approved signing authorities. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that STEP does not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization is valid until such time as written revocation has been received by STEP. In addition, I understand that I may revoke this authorization at any time by notifying STEP in writing and that revocation of this authorization will not affect any action taken in reliance of this authorization before the written revocation was received. **If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.**

Applicant Signature _____

DATE:

SECTION 2—MEDICAL PROVIDER Verification

Healthcare Provider Name, Address, & Phone

By signing this verification, I am confirming that the above-named applicant has a current catastrophic diagnosis due to COVID-19.

Print Name of Medical Authority

Medical Signature _____

DATE: