Hafa Adai!

We are pleased that you have taken the time to learn about the TakeCare Foundation, Inc., ("Foundation") Individual Medical Grant Program.

The Foundation is comprised of employees of TakeCare and Veiovis/FHP devoted to charitable causes that enhance the health, wellness and welfare of individuals, families and our community. The employee driven organization plays a major role in assisting in the selection process of the medical grant awards.

To assist you with your submission, included in the packet are the guidelines, frequently asked questions and answers, a HIPAA Release Form and a "sample" letter to give your primary physician to complete on his/her clinic company stationary. ***It is important to know that incomplete applications will automatically be declined.***

As a company, we believe that giving back to the community is essential in promoting a "healthy" environment for Guam and our neighboring islands.

If you have any questions or concerns, please feel free to contact the Foundation via email to tc.foundation@takecareasia.com.

Sincerely,

Arvin Lojo
President

Individual Medical Grant Assistance Program

Assistance is provided for conditions such as cancer, heart disease, end stage renal disease and blood disorders. Other extenuating medical conditions will be taken into consideration and reviewed by the Foundation on a case by case basis.

Frequently Asked Questions and Answers.

1. **Who may apply?**

   U.S. citizens or permanent residents living on Guam and the Northern Mariana Islands.

2. **Who's not eligible to apply?**

   Employees of TakeCare, Veiovis and members of the Foundation are not eligible to apply.

3. **When are applications reviewed?**

   The review process for applications are done quarterly (four (4) times a year). Applications must be received as follows:

   1st Quarter – Must be received January 2nd – 31st
   2nd Quarter – Must be received April 1st – 30th
   3rd Quarter – Must be received July 1st – 31st
   4th Quarter – Must be received October 1st – 31st

   - *Applications received outside of the above dates, will automatically be declined.*
   - *Applications received by USPS or other courier service outside the above dates, will automatically be declined.*
   - *The Foundation **will not hold or roll over** applications received outside the above dates for the next quarter.*

4. **Who reviews the applications?**

   Applications are reviewed by the Foundation Committee to determine if each submission is complete and meets the guidelines. If an application is incomplete, it will automatically be declined.

5. **What documents are required?**

   - *A signed and completed application*

- *Letter from attending physician on his/her official company clinic letterhead with logo (Sample template of letter included in packet).*
- *Completed and signed HIPAA release form.*
- *Passport or valid government identification showing U.S. citizenship status or Green Card I.D. holder.*
- *If applicant is unable to sign the application and HIPAA form, their designated power of attorney (POA), can sign on his/her behalf. Copy of POA must be included in the submission of the application.*
- *If an infant or child under the age of 18, a copy of the birth certificate must be included in the submission of the application.*

Note: Committee may contact applicant's primary physician for additional information for further clarification.

6. When are grants awarded?

Grants are awarded during the last month of the quarter and applicants are notified by phone, email and letter mailed by USPS.

7. How often can I apply for the grant?

You can apply once in a twelve-month period. However, this does not atomatically guarantee that you will be awarded a grant. The Committee reserves the right to place a limit on how often an applicant can receive funds. More importantly, since this is an employee driven program, grants are awarded based on the availability of funds.

8. What can the grant funds be used for?

Funds can be used to assist with medical expenses not covered by their insurance company or for any out-of-pocket expenses to cover personal needs (i.e., adult diapers, Ensure or similar brand products, over the counter medication or other items deemed necessary for medical condition).

9. How do I submit my application?

You may submit your application using one of the following methods.

1. *Email:* *tc.foundation@takecareasia.com*
2. *Fax:* *(671) 647-3551*
3. *Drop Off or Mail:* *TakeCare Insurance Company, Inc.*
   Baltej Pavilion, Suite 308
   415 Chalan San Antonio
   Tamuning, Guam 96913
   Attention: TakeCare Foundation, Inc.

Note: If mailing, we do not go by the post mark date. See question number 3 for valid time frame.

TakeCare FOUNDATION

Do not leave any section of this application blank. If it is not applicable, please write Not Applicable or N/A. Failure to complete the application in its entirety, will automatically decline your submission.

Date: _____ Grant Amount: _____
(Maximum amount $500)

Name of Applicant:_____
Print: First, MI, Last

Applicant's Date of Birth: _____

Guardian: _____ (if applicant under the age of 18 years)
Print: First, MI, Last

Relation to applicant: _____

Mailing Address: _____

Home Address: _____How long?_____

Email Address:_____

Home Number:_____ Cell Number:_____

Work Number: _____

Applicant's Status: [ ]Unemployed [ ]Self-Employed [ ]Veteran [ ]Student

[ ]Retired/Senior Citizen [ ]Infant/Child

If employed, name of employer:_____

Name of alternate contact:_____

Relationship: _____ Contact number:_____

Email address: _____

Information contained in the Individual Grant Packet are subject to change at any time without notice.

The protection of privacy and the confidentiality of health insurance has always been a top priority. We recognize that you depend upon us to safeguard your personal information and uphold your privacy rights. Therefore, it is only by signing the application and HIPAA Release form that we will share your personal information with those involved in the review of your grant application.

1. Have you applied for medical assistance with TakeCare Foundation? _____

   If yes, list all dates and amount of grant award?_____

2. Do you have medical insurance? _____

3. If yes, please list your medical insurance carrier (s).

   _____

4. Physician name (s) and contact number (s): _____

5. Describe in detail reason for applying:

   _____

   _____

   _____

6. List other agencies you have requested assistance from or are currently receiving assistance and the amount (s), example: Guam Cancer Care: $200 in February 2016.

   _____

   _____

   _____

_____

Signature of Applicant or Guardian

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HIPAA RELEASE FORM

Applicants Full Name	Applicants Social Security Number
Mailing Address	Applicants Date of Birth
City, State Zip Code	Applicants Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

The following specific person (name of attending physician) at (name of clinic), is authorized to disclose information about me:

Name of physician: _____Name of Clinic: _____

Contact Number: _____

The following company may receive disclosure of protected health information about me:

TakeCare Foundation, Inc.
415 Chalan San Antonio, Suite 308
Tamuning, Guam 96913

_____

Signature of Applicant Date

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(LETTER MUST BE ON PHYSICIAN'S OFFICIAL CLINIC LETTERHEAD WITH LOGO)

Date: _____

TakeCare Foundation, Inc.
415 Chalan San Antonio
Baltej Pavilion, Suite 308
Tamuning, Guam 96913

RE: Medical Assistance

Dear Sir/Madam:

This is to certify that _____ is under my medical care here at _____.

Medical condition: _____

_____

Date of birth: _____

Any assistance the Foundation can offer to help with medical expenses not covered by the insurance company will be appreciated.

Sincerely,

_____
Print Name of Physician

_____
Signature