



Updated April 2009

LYMEAID 4 KIDS Packet

Dear Physician, I hope you will read the enclosed material in order to determine if any of your patients is eligible to apply for funding or if you know of anyone willing to donate to help children get diagnosed/treated for Lyme disease. You must fill out the physician form and the parent/guardian must fill out the other forms, but all forms must be submitted through your office to the Lyme Disease Association. All checks will be payable to your practice. Thanks!

Enclosed is a packet of material regarding Lyme Disease Association's (LDA) fund, LymeAid 4 Kids (LA4K). The fund will provide monies for families who have no health coverage for their children for Lyme disease, so they cannot get diagnosed or treated for Lyme disease. Up to \$1,000 per child will be available to be applied for through the child's physician.

LDA created the fund in collaboration with internationally acclaimed, New York Times best-selling author Amy Tan, who has lent financial support with book tour donations. Her recent work, "The Opposite of Fate: A Book of Musings" includes a chapter on her fight against Lyme disease, including her difficulty in getting diagnosed. Ms. Tan opened the fund with a donation at the LDA/Columbia Philadelphia medical conference, November 2003. To date, LDA has awarded over \$135,000 in assistance to families for their children.

We hope that you will use the enclosed information to determine if you have a patient who is eligible for LA4K and to help the family apply for the monies.

Please display the LA4K notice in your office so that eligible families are aware of the fund.

Donations to the fund should be made payable to:
Lyme Disease Association, Inc.
PO Box 1438
Jackson, NJ 08527

All forms can be downloaded from www.LymeDiseaseAssociation.org

Thank you for your cooperation.

Pat Smith

President
Lyme Disease Association



Are you under 21 and without medical insurance coverage for Lyme disease?

Do you think you may have Lyme disease?

If you answered **yes** to both these questions

The Lyme Disease Association's
LymeAid 4 Kids fund may help you

- It can provide up to \$1,000 toward diagnosis and treatment
- It is available through any treating physician nationwide
- It is simple to apply for

**For further information, check with your physician or go to
www.LymeDiseaseAssociation.org**

Remember, early diagnosis and appropriate treatment can prevent you from developing chronic Lyme disease!

Lyme Disease Association
PO Box 1438
Jackson, NJ 08527
888-366-6611
Lymeliter@aol.com
www.LymeDiseaseAssociation.org

Parameters of the LymeAid 4 Kids Fund

- √ Applicants under the age of 21 are eligible to apply for up to \$1,000.
- √ The applicant shall possess neither medical insurance coverage for Lyme disease nor receive government assistance for medical treatment for Lyme disease.
- √ The Patient/guardian must sign a statement waiving medical privacy.
- √ The applicant/guardian shall sign a certified statement testifying that they are suffering from financial hardship.
- √ The applicant shall have a signed & dated doctor recommendation that the applicant is suffering from financial hardship, and that based on symptoms and history, Lyme & other tick-borne disease testing and/or treatment is necessary.
- √ All forms must be submitted by the doctor's office to LDA. Families fill out their form and give it to the physician. NO forms will be accepted directly from patients, only through the submitting doctor's office.
- √ All checks will be payable to the submitting physician's office only.
- √ Monies may be used for determining if a patient has Lyme disease or for treatment by and in the submitting doctor's office.
- √ The LDA retains the right to obtain the tax records and medical bills of the applicant and/or guardian and his/her spouse.
- √ The LDA retains the right to be reimbursed by the applicant if statements on application are proven false at any time.

Applicant Certification Form

TO: Lyme Disease Association, Inc.

FROM: _____
(Name of Applicant or Guardian of Applicant if Applicant is under the age of 18 years)

Re: _____
(Name of Applicant)

CERTIFICATION

Check the applicable boxes and fill in missing information

- I certify that I am unable to pay for my medical treatment due to financial hardship. I further certify that the financial documentation submitted with this certification accurately reflects my current income.¹
- I certify that I am unable to pay for the medical treatment of the Applicant due to financial hardship. I further certify that the financial documentation submitted with this certification accurately reflects my current income and that of my spouse.²

As proof of my financial hardship, I enclose the following documentation (✓):

- a copy of my Form W-2 that was provided to me by my employer last year and a copy of my spouse’s W-2 form;
- other: (LDA will have final determination if “other” is acceptable proof)

If the enclosed documentation does not reflect my current income, I agree to reimburse Lyme Disease Association, Inc. for the medical expenses it pays on behalf of the Applicant as well as any costs and expenses incurred by it to collect such amount. If I am a parent applicant, this certification applies to my income plus the income of my spouse.

Dated: Signature _____

Print Name:

¹ Applicant checks this box and signs certification if at least 18 years of age.

² Guardian checks this box and signs certification if Applicant is younger than 18 years of age.

LymeAid 4 Kids Physician Form

To the best of my knowledge, I, _____, believe that
(Physician's name)

(Patient's name) (the "Applicant") meets the following criteria:

1. The Applicant is under the age of 21 years;
2. The Applicant and the Applicant's family do not have any insurance coverage and do not qualify to receive governmental assistance for medical care.
3. The Applicant and the Applicant's family are unable to pay for testing and/or treatment for Lyme and/or other tick-borne diseases due to financial hardship.
4. Based on the symptoms, history, and medical examination of the Applicant, I believe that the Applicant needs to be tested and/or treated for Lyme and/or other tick-borne diseases.
5. Upon the request of Lyme Disease Association, Inc., I agree to provide it with a copy of the Applicant's medical bills relating to my examination and/or treatment of the Applicant.
6. *All checks should be made payable to _____.
(Name of Physician or practice group.)
7. I will send all forms to the Lyme Disease Association, including the Applicant certification form.

(Physician's signature **NO STAMPS ACCEPTED**)

(Date)

*** Checks will ONLY be made payable to the physician or practice group.**

Authorization for Release of Medical Records

**This signed note is my written authorization to release my medical records to:
Lyme Disease Association, Inc. PO Box 1438 Jackson, NJ 08527**

Patient Information (Print)

Name: _____

Address _____

Phone _____

Records to be released from applicant's Physician:

Physician Name _____

Address _____

Phone _____

Signature of Patient (or Guardian) _____

Date _____