Kool Kid Alliance
Helping Children with KDVS

It is our mission to promote awareness of Koolen-de Vries Syndrome (KdVS), and to assist families and caregivers of persons with KdVS with medical expenses, assistive technology, and other resources needed for medical, developmental, emotional, and educational growth.

Please return this completed form to:

Kool Kid Alliance
P.O. Box 928
Arden, NC 28704

or

Scan and email to:
tedneedham@koolkidalliance.com

Criteria for Submission:

- All responses must be printed legibly and/or typed, with all pages returned. Incomplete applications will not be considered and returned to applicant for completion.
- Applicants must be parents or legal guardians/caregivers of a person with Koolen-de Vries Syndrome (KdVS).
- Applicants must demonstrate a need for the assistance requested.
- Applicants must exhaust all other options (insurance, Medicaid, etc.) prior to requesting assistance.
- Funds/assistance may only be distributed within the United States.

If you have any questions or require assistance please contact our office at 1-828-333-7453. Thank you for submitting your request to Kool Kid Alliance!

Section 1: Kool Kid Information **Date:**________________

Last Name:____________________________ First Name:_________________________

Birthdate: (MM)____(DD)_____(YYYY)______ Male_____ Female_____

Citizenship: ____

Section 2: Family Information

Parent/Legal Guardian #1

Last Name:____________________________ First Name:_________________________

Address:________________________City:_______________State:______Zip:_______

Home Phone:______________________ Cell Phone:____________________________

Email Address:____

Parent/Legal Guardian #2

Last Name:____________________________ First Name:_________________________

Address:________________________City:_______________State:______Zip:_______

Home Phone:______________________ Cell Phone:____________________________

Email Address:____

Section 3: Household Information

Child Lives With:______________________ Number of Guardians in Household:_____

Number of Dependent Children in Household: _____

Section 4: Assistance Request Form (Complete Only the Section(s) Requested)

<u>Request for Treatment/Services (surgeries, procedures, therapy, etc.)</u>

Type of Treatment: ____

Number of Treatments/Visits: ________ Cost per Treatment/Visit: $__________

Company/Provider Receiving Funds: ____

Address:________________________City:_______________State:______Zip:_______

<u>Request for Medication (attach additional pages if needed)</u>

Name of Medication: ________________________ Dosage:_______ Frequency:______

Number of Months Needed:________ Cost per Month: $__________

Company/Provider Receiving Funds: ____

Address:________________________City:_______________State:______Zip:_______

<u>Request for Equipment/Supplies (attach additional pages if needed)</u>

Type of Equipment/Supplies:____

Retail Cost of Equipment: $________ Price After Discount: $__________

Company/Provider Receiving Funds: ____

Address:________________________City:_______________State:______Zip:_______

Section 5: Additional Information

Health Insurance:____

Last Year's Out of Pocket Medical Expenses for the Child $______________________

Has funding been requested from additional sources? Yes____ No____

If Yes, Please List Provider and Amount/Item Requested and if Received:

____

Have you applied and/or received assistance from Kool Kid Alliance before? Yes No

If so, when? Was your request granted?

____

Medical Information (health care professionals associated with requested care)

Physician/Therapist Last Name:______________________First:__________________

Title (DO,MD,etc) _________

History of Illnesses/Health Conditions:_______________________________________

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Why should Kool KId Alliance assist you and your family at this time? (i.e.:job loss, medical bills,etc.)

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Kool Kid Alliance
Required: Consent to Release Information and Affirmation

Client Name:________________________________ Date:___________________

I acknowledge that refusal to provide necessary documentation or to answer an interviewer's question will disqualify me and my household for assistance. Any false or misleading information provided in writing or verbally will disqualify me and my household for assistance. I certify that all information provided to Kool Kid Alliance, Inc., either in writing or verbally, is correct and true to the best of my knowledge. I give permission for Kool Kid Alliance, Inc. staff to verify information by contacting any party I have listed or verbally mentioned in the process of seeking assistance. Any discrepancies between my application information and verification efforts will be provided to me for clarification. I release Kool Kid Alliance from any liability or legal responsibility that may arise from the verification process.

Child's Name:__________________________________ DOB:_________________

Parent/Guardian Signature_________________________ Date:_________________

Address:_____________________City:_______________State:_______Zip:_____

Kool Kid Alliance
Hold Harmless Agreement

Whereby I, (full name)____________________agree, that should I receive goods and/or services from Kool Kid Alliance, Inc. (KKA) as a result of this assistance request, I do so entirely of my own initiative, risk and responsibility. Therefore, in consideration of KAA approving my request and providing requested goods and/or services I do hereby, for myself, all those on behalf of whom I may have made the request, my or their heirs, executors and assigns, release and forever discharge KKA and any of its affiliates, or subsidiaries and all of its officers, agents and employees, acting officially or otherwise, from any and all claims, demands, actions, or causes of action on account of my death, or any injury to me or to those on behalf of whom I may have made the request, or my personal property, which may occur for any cause, including negligence of any type. Therefore, neither KKA nor its affiliates or subordinates, officers, agents, and employees shall be or will become liable

or responsible for any loss, injury, or damage to any person, property, or otherwise in connection with any goods or services resulting directly or indirectly from any defect in or misapplication of said goods and/or services including any breakdown in machinery or equipment. Nor shall KKA or its affiliates or subsidiaries, officers, agents and employees be or become liable or responsible for any additional expenses or liability sustained or incurred by recipient of goods and/or services as a result of any of the foregoing causes. Additionally, I acknowledge that the welfare and safety of any and all of my minor children who might be the beneficiaries of goods and/or services provided by KKA will be my sole responsibility and add my consent on their behalf that all stipulations and contingencies as stated above are applicable to them as well.

Child’s Name:______________________________________ DOB:___________________

Parent/Guardian Signature___________________________ Date:__________________

Address:_______________________City:_________________State:________Zip:_____

Kool Kid Alliance
Application Checklist

Applicant Name:_______________________________ Date:____________________

Use this checklist to ensure that you have successfully completed all portions of the application requirement. Documents listed below must be submitted with this application for the application to be considered.

☐Complete application;

☐Request qualifies as valid health care/developmental/educational need;

☐Proof of KdVS diagnosis;

☐Copy of prescription (if requesting medication);

☐Verification of illness/condition specific to the request for funding (i.e.: history of hearing loss if requesting replacement hearing aid);

☐First page of your most recent federal income tax return or W2;

☐Income verification (unemployment,Social security disability, other);

☐Letter from the provider on letterhead showing the original cost and the price after discount (if discount is available);

☐Letter of denial from the insurance company or policy showing exclusion.