CPABLE Application for Financial Assistance

CPABLE exists to support children and families by helping with the additional expenses that come with caring for a child with cerebral palsy or similar childhood onset neurological conditions. We believe these children deserve to have the highest quality of life and to live their best life!

To be considered for CPABLE funds, all applicants must complete the CPABLE Application for Financial Assistance packet. Any information not provided could result in a delay of your request or eliminate your request from being considered.

CPABLE is not intended to act as a supplemental insurance policy and there may be limitations on what items will be reimbursed. Each application will be individually reviewed on a case-by-case basis and payment is not guaranteed.

CPABLE reserves the right to modify the eligibility criteria and disbursement policy at any time and without notice. Reimbursement of an expense by CPABLE does not guarantee reimbursement for the same or similar expense in the future.

p: 701.498.9773

PO Box 4142
Bismarck, ND 58502

WWW.CPABLE.ORG
INFO@CPABLE.ORG

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CPABLE Eligibility Criteria

Eligibility Criteria:[1]

- Diagnosis of cerebral palsy or similar childhood onset neurological condition deemed permanent in nature. The onset of condition must have occurred on or before the applicant's eighteenth birthday.
- Under the age of 21 on date of application.
- Exhaust all sources of financial assistance including insurance, Medicaid, etc.
- Expenses must have been incurred within one year from the date of application.
- Must reside in one of the following North Dakota counties:

○	Burleigh	○	Dunn
○	Emmons	○	Grant
○	Kidder	○	Logan
○	McIntosh	○	McKenzie
○	McLean	○	Mercer
○	Morton	○	Mountrail
○	Oliver	○	Sioux
○	Stark	○	Stutsman
○	Ward	○	Williams

Eligible Expenses Include:
(Paid to vendor or individual with required documentation.)

- Insurance co-pays.
- Approved non-traditional therapies are limited to $1,500.00 annually.
- Adaptive equipment and medical equipment related to the diagnosis.
- Recreational adaptive equipment and opportunities.
- Medical related travel including mileage per IRS guidelines and per diem food and lodging.
- Home modification up to $10,000. Limited to every 3-year period. Must provide 2 contractor bids and the lower amount will be awarded.
- Vehicle modification up to $10,000. Must provide one estimate. Limited to every 5-year period.

[1] The Board of Directors and/or Disbursement Committee reserves the right to modify the eligibility criteria at any time and without notice. In addition, any of the above criteria may be waived in the event good cause is demonstrated and granting an application would not adversely impact the fund or the applicants qualifying under the eligibility criteria.

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CPABLE Application

Patient Name: ____

Patient Date of Birth: ____

Address: ____

____

Parent/Guardian's Name: ____

Telephone: ____

Address: (if different from patient): ____

____

Email: ____

Medical Information

Patient's Diagnosis: ____

____

Primary Physician: ____

- Clinic/Hospital: ____

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Other Physicians & Clinic/Hospitals (if applicable): ______________________________

____

____

Physical Therapist: ____

Facility: ____

Occupational Therapist: ____

Facility: ____

Speech Language Pathologist: ____

Facility: ____

Other: ____

Facility: ____

Insurance Information

Primary Insurance: ______________________

Secondary Insurance: _____________________

Tertiary Insurance: ________________________

If you have Medicaid, are you on a waiver? ☐ Yes ☐ No

If yes, what waiver are you on? _______________

____

Financial Assistance Request

1. Expense you are requesting financial assistance for: ______________________

   ____

   ____

2. Cost of expense: ____

3. Amount insurance will cover, if applicable: _______________________________

4. Amount of funds you are requesting from CPABLE: ________________________

5. Are you receiving any other financial assistance (ex: GABR Funds) for this request:

   ☐ Yes ☐ No

   If yes, please list where the assistance is from & the amount you are receiving:

   ____

6. If funds are awarded, name/vendor for payment to be remitted to & address:

____

____

You must attach copies of the following, as applicable, to qualify for assistance from CPABLE:

- Proof of price/cost of requested expense
- A prescription/order signed by a physician, physician assistant, or nurse practitioner.
- Supporting documentation from a physician, physician assistant, nurse practitioner, physical therapist, occupational therapist, speech language pathologist, etc. substantiating the need for the request

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- A copy of your Explanation of Benefits (EOB) from your insurance company.
- A copy of the appeal letters or an explanation of why an appeal is not appropriate for services denied by insurance.
- Proof of receipt for payments of therapy, services, or equipment.
- At least two estimates for home modifications.
- At least one estimate for vehicle modifications.

I understand that the CPABLE Disbursement Committee will review and discuss my application and requested attachments in the decision process for fund allocation. I am aware that any information not provided, could eliminate my request from being considered.

Funds will be disbursed on a pro-rated basis to qualified applicants, based on available dollars. I understand that an application for funds does NOT guarantee funds will be awarded. I understand that should the amount of the funds received by CPABLE be greater than the actual cost, I will return/reimburse CPABLE for the excess funds.

CPABLE will keep the information in this application confidential, however, I understand that I am releasing the medical information contained in this application and that this application will be seen by the members of the CPABLE Disbursement Committee and/or CPABLE Board Members.

CPABLE does not guarantee the privacy and security of electronic communications. Electronic communications can be intercepted, forwarded, circulated, stored, or even changed without the knowledge of the sender of recipient. There is a risk that any protected health information (PHI) contained in electronic communications may be misdirected, disclosed, or intercepted by an unauthorized recipient. Email addresses can be entered incorrectly resulting in a communication being sent to an unintended recipient. By providing your email address and/or submitting the application and/or documentation electronically you are willing to accept these risks.

Electronic communications are unencrypted (unsecure). You are responsible for providing the correct information and notifying CPABLE of any changes to your information. CPABLE is not liable for electronic communications that are not received due to technical failure or for improper disclosures of PHI.

Name ________________________ Relation to Patient ________________________

Signature ________________________ Today's Date ________________________

Completed applications can be sent by mail or email.

Mail: CPABLE
Attn: Disbursement Committee
PO Box 4142
Bismarck, ND 58502

Email: info@cpable.org