



## LymeAid 4 Kids Packet



**2016**

Dear Physician,

Please read the enclosed material in order to determine if any of your patients are eligible to apply for funding. 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, Inc.(LDA). Note that new documentation now applies. All checks will be payable to your practice. If you know of anyone willing to donate to the LDA to help children get diagnosed/treated for Lyme disease, please let them know about the LA4K program. Thanks!

Enclosed is a packet of material regarding the 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 and cannot afford to get diagnosed or treated for Lyme disease. The fund permits awards up to \$1,000 per child to be used for diagnosis and treatment—funds which are applied for through the child's physician

LDA created the fund in collaboration with internationally acclaimed, New York Times best-selling author Amy Tan, whose work, "The Opposite of Fate: A Book of Musings" includes a chapter on her fight against Lyme disease, including her difficulty in getting diagnosed. To date, LDA has awarded ~\$273,000 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](http://www.LymeDiseaseAssociation.org)

Thank you for your cooperation.

*Patricia V. Smith*

Patricia Smith  
President



Lyme Disease Association, Inc.

## Parameters of the LymeAid 4 Kids Fund



- Applicants are eligible to apply for up to \$1,000 for children under the age of 21.
- The applicant shall possess neither medical insurance coverage for Lyme disease nor receive government assistance for medical treatment for Lyme disease. However, if the applicant has any existent private or government coverage which will not pay for the services of a physician who treats chronic disease for which the applicant is applying, that should be noted on the application and the application can still be considered for possible approval if all other conditions are met.
- The applicant/guardian must sign a statement waiving medical privacy.
- The applicant/guardian shall sign a certified statement testifying to financial hardship.
- The applicant/guardian shall have a signed & dated doctor recommendation that the applicant/guardian 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 the 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.
- Patients must be U.S. citizens.
- A patient may receive a LA4K award only ONE time.
- Families can only submit an application from one doctor for a particular child.
- **All LA4K checks will be payable to the submitting physician's office only.** LA4K Checks cannot be made payable to labs, pharmacies, or other medical entities.
- Money 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.
- The LDA is not responsible in any way for medical treatment received using LymeAid 4 Kids funds.



**Applicant Certification Form**



TO: Lyme Disease Association, Inc.

FROM: \_\_\_\_\_  
(Name of Applicant – Applicant is the Parent/ Guardian of the child under the age of 21 years or the name of the independent person between 18-21)

Re: \_\_\_\_\_  
(Name of Patient)

**CERTIFICATION**

*Check the applicable boxes and fill in missing information*

*Applicant checks this box and signs certification if at least 18 years of age and independent*

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 and that of my spouse, if any. OR

*Parent/Guardian checks this box and signs certification if patient is younger than 18 years of age or if patient is between 18-21 and still a dependent.*

I certify that I am unable to pay for the medical treatment of the patient 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, if any, and that of the patient if applicable.

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

First page of the most recent 1040 form(s) filed by the patient and/or parent/guardian as required in the checked box above. If married and filing jointly, one 1040 is sufficient. If married and filing separately, both 1040s must be included. If you yourself are employed but are also able to be claimed under someone else's return, first page of all pertinent returns must be sent.

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/guardian applicant, this certification applies to my income plus the income of my spouse.

Dated: \_\_\_/\_\_\_/\_\_\_

Signature of Applicant as appears on 1040 \_\_\_\_\_

Print Name of Applicant as appears on 1040: \_\_\_\_\_



## LymeAid 4 Kids Physician Form



To the best of my knowledge, I, \_\_\_\_\_, believe that  
(Print Physician's Name)

\_\_\_\_\_ meets the following criteria, and I agree to the following:  
(Print Patient's Name)

1. The Applicant is under the age of 21 years;
2. The patient does not have any insurance coverage for Lyme disease and does not qualify to receive governmental assistance for medical care or the patient is covered under existent private or government coverage which will not pay for the services of a physician who treats chronic Lyme disease for which the applicant/patient is applying,
3. The patient/parent/guardian is/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 patient in this application, I believe that the patient 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 patient's medical bills relating to my examination and/or treatment of the patient.
6. \*All checks should be made payable to \_\_\_\_\_.  
(Name of Physician or Practice Group)
7. I will directly send all forms to the Lyme Disease Association, including the Applicant certification form.
8. After the expenditure of the funds, I will send proof to the Lyme Disease Association that all the funds have been expended for the applicant either with an invoice showing the application of the funds to the applicant's account or some other concrete proof of expenditure. If all funds are not expended for the applicant, I will return the difference to the Lyme Disease Association within a year's time from my receipt of LymeAid 4 funds.

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

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print office Contact name & Phone number for LDA to verify)

\* 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 of Patient: \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

**Records to be released by Physician:**

Physician Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

**Signature:**

Signature of Patient (or Guardian) \_\_\_\_\_

Date \_\_\_\_\_



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

**Do you think you may have Lyme disease?**

**Are you experiencing financial hardship?**

If you answered **yes** to these questions

**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](http://www.LymeDiseaseAssociation.org)**

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

Lyme Disease Association, Inc.  
PO Box 1438, Jackson, NJ 08527  
888-366-6611  
[LDA@LymeDiseaseAssociation.org](mailto:LDA@LymeDiseaseAssociation.org)

