Women's Health Fund
Windom Area Health Foundation

POLICY

SCOPE: Windom Area Health

1. **PURPOSE**
   1.1. To establish a process for the allocation of funds contributed to the Women's Health Fund of the Windom Area Health (WAH) Foundation.

2. **POLICY**
   2.1. A fund of the WAH Foundation, called the Women's Health Fund, supports local women's health.
      2.1.1. One goal of this fund will be to provide financial support for mammography equipment and supplies for the WAH Imaging Department.

      2.1.2. A second goal will be to support local women's health by providing community education and financial support to patients undergoing women's health treatments for cancer.

         2.1.2.1. This may include, but is not limited to: gas cards, mortgage payments or rent, car payments, child care, prescriptions or other medical expenses, or preventative care for those individuals who may not otherwise have the means.

      2.1.3. Current patients with ties to local healthcare providers will be given preferential consideration for support awards.

      2.1.4. Applicants must be women in Cottonwood County or its surrounding counties undergoing cancer treatments.

      2.1.5. Multiple requests for assistance may be considered. However, funds cannot be applied for more than once in a 12-month period.

   2.2. The solicitation of contributions for this fund will be the responsibility of the WAH Foundation.

   2.3. The allocation of funds will be determined by voting members of the WAH Foundation Board.

   2.4. The Foundation Director will notify the Foundation Board when a request for the Women's Health Fund is received, and will supply all pertinent information to the Board prior to the next scheduled Foundation Board meeting. The Foundation Director will also have the responsibility to prepare a letter of response to the applicant.

3. PROCEDURE

3.1. Funds may be requested by contacting the Director of Foundation for an application packet. The materials will also be made available on the WAH website.

3.1.1. Applicants will submit a complete application, including supplemental documentation, to assist the Board in their decision-making process.

3.2. A majority vote of the members present will be required for each request of funds.

3.3. A quorum during a regular scheduled Board meeting, as reflected per Board By-Laws, will review each request for funds and make a decision.

3.3.1. All Personal Health Information (PHI) shall be removed from the application, prior to Board review.

3.3.2. The following considerations will be included in the determination of support awards:
3.3.2.1. Location of applicant's residence and primary healthcare provider;
3.3.2.2. Financial need;
3.3.2.3. Course of treatment; and
3.3.2.4. Resources available in the Fund.

3.3.3. If the request is approved, distribution of funds will be paid directly to a specified third-party versus the applicant.

3.3.4. Each applicant may be awarded up to $5,000. Exceptions may be granted by unanimous decision of the Foundation Board.

WOMEN'S HEALTH FUND
DIRECT ASSISTANCE APPLICATION

In order to apply for assistance through the Women's Health Fund, you must meet the criteria:

1. Reside in Cottonwood County or its adjacent surrounding counties;
2. Be a woman undergoing treatment for a cancer diagnosis; and
3. Have evidence of an unmet financial need.

Assistance will be provided by paying bills directly (utilities, rent, childcare, medical bills) or providing vouchers/gift cards. Direct payment to an applicant or towards credit card debt is not allowed. Applicants are eligible to receive up to $5,000 in assistance in a 12-month period. Applications are reviewed through a confidential process by the Women's Health Fund Committee, which is comprised of Foundation Board members. Additional pages can be attached.

APPLICANT INFORMATION

Name: DOB:

Address:

Phone: Email:

MEDICAL INFORMATION

Physician Name:

Physician Clinic Contact Number:

Clinical Diagnosis: Date cancer was diagnosed:

REQUEST INFORMATION

Total Amount Requested:

Please describe your situation prompting this request, including your course of cancer treatment:

What have you done to help manage this situation? (ex: used PTO, used up savings, acquired assistance from family or other organizations)

What will these funds assist with? (ex: travel expenses for treatment, offsetting utility bills due to change in income, childcare payments, etc.)

Is there any other information you would like for the committee to know about your situation?

FINANCIAL INFORMATION

All requests **must** provide the following supplemental documentation to help the Committee best understand your financial situation and consider your request:

- Copy of most recent paystub;
- Confirmation of cancer diagnosis and treatment from physician; and
- Copy of overdue bill (if applicable to request) needing payment assistance.

Please complete the following personal and financial questionnaire:

1. Number of dependents and ages:
2. Marital Status: ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*
3. Have you applied for funds through the Women's Health Fund in the past?
4. What kind of health insurance do you have?:
   a. Deductible:
5. Have you filed bankruptcy within the last 7 years? ☐ Yes ☐ No
6. Annual household income (gross):
7. Other sources of income (disability, child support, food stamps):
8. Total monthly expenses:
9. Total Debt (credit card bills, student loans, mortgage):
10. Last 30 days out-of-pocket medical expenses?:
11. Total accessible cash on hand (savings, checking, cash):
12. Total assets on hand (total value of home, cars, boat, etc.):
13. Have you received assistance or donation through other means? (Financial Assistance, GoFundMe, grants, other charitable efforts): ☐ Yes ☐ No ☐ Unknown
    a. If yes, please list the total income/assistance and their sources:
14. How did you hear about the Women's Health Fund?
    ☐ Family ☐ Friend ☐ Internet ☐ Other

15. *By checking this box, I certify that the information provided in this application is true to the best of my knowledge. I acknowledge that falsification of any information will disqualify me from funds consideration. I grant permission for the Foundation's Women's Health Fund Committee to confidentially review the information I have provided.*

Signature: Date: