UnitedHealthcare children's foundation	JHCCF Grant Portal Parent Guide
	Table of Contents
1. HealthSafe ID Information	
2. Eligibility Criteria	
3. Create HealthSafe ID	
4. Sign In – Grant Portal	
5. Parent/Legal Guardian Pro	file
6. Dashboard	
7. Add Child & Start Application	on
8. Child Profile	
9. Application	
10. Details	
Upload Federal Tax Return	
11. Insurance	
Upload Insurance Card	
12. <u>Physician Details</u>	
13. Medical Condition/Diagnos	<u>s</u>
14. <u>Services Requested</u>	
Add Services	
15. <u>Attachments</u>	
16. <u>Acknowledgement</u>	
17. <u>Active Grant</u>	
18. <u>Payment Requests</u>	
Create Payment Request	
Purpose	The purpose of the Parent Guide is to assist parents/legal guardians when applying for a UnitedHealthcare Children's Foundation (UHCCF) grant. Questions can be emailed to <u>uhccfcustomerservice@uhc.com</u> .
Providers, social workers, or others	assisting an applicant or grant recipient:

While we commend your commitment to your patient and their family, please be aware that <u>the parent/legal</u> <u>guardian is required to initiate and complete the grant application and payment request process</u> <u>independently.</u> Applying for the grant will require proof of eligibility.

Providers, social workers, or other proxies are not permitted to complete the application. However, you are more than welcome to recommend, support, and assist your patient and their family throughout the process.

If the family has a question about their grant or application, they will need to contact us directly.

### HealthSafe ID Information

The HealthSafe ID ("HSID") is a unique security identifier used to access multiple United Healthcare systems.

A HealthSafe ID is required to log in to the UHCCF Grant Portal. Determine your next step by reviewing the following scenarios.

- → You are a new user and have never signed into a United Healthcare system that required a HealthSafe ID for login; proceed to Eligibility Criteria.
- → You are a returning user with a previously created HealthSafe ID; proceed to Sign In Grant Portal.
- → You have an existing HealthSafe ID; or you are having trouble creating a HealthSafe ID; or you are receiving an error message; or you have lost your HealthSafe ID username or password information:
- $\rightarrow$  Use the Forgot HealthSafe ID/Forgot Password feature within the <u>Sign In Grant Application</u> link.
- → Access the <u>HealthSafe ID Technical Support Web Portal.</u>
- → Email UHCCF Customer Service (<u>uhccfcustomerservice@uhc.com</u>) and provide a description of your error message. Please provide a screenshot of your entire browser including the URL in the body of the email.

### Eligibility Criteria

Eligibility requirements appear on the "Complete Your Grant Application Here" website in the form of a series of questions. **Applicant must be able to answer YES to all questions.** 

- 1. Is your child 16 years of age or younger at the time of application?
- 2. Does your child have a Social Security Number issued by the Social Security Administration? (I-TIN numbers are NOT accepted.)
- Is your Adjusted Gross Income (AGI) as documented on Line 11 of the current year's Tax Return (Line 11 of IRS Federal Tax Form 1040) - at or under the following limits based on your family size? NO EXCEPTIONS will be made to these limits:
  - Family Size of 2 -- \$65,000 or less
  - Family Size of 3 -- \$100,000 or less
  - Family Size of 4 -- \$135,000 or less
  - Family Size of 5 or more -- \$170,000 or less
- 4. Is your child covered by commercial/private health insurance? (Plans purchased from the Healthcare Exchange are accepted, but the primary coverage CANNOT be Medicaid, CHIP, or any publicly state funded medical insurance.)
- 5. Are the medical services/items eligible for award and being received/purchased in the United States? (Please see our <u>exclusion list</u> that details items which would NOT be eligible.)

If the applicant meets all criteria, check the box that states: "I acknowledge that I am able to answer YES to all the questions above."

Note: Providers, social workers, or other proxies ARE NOT PERMITTED to complete the application. Applicants

must acknowledge that the recipient meets the criteria prior to proceeding in applying for a UnitedHealthcare Children's Foundation grant. **Applying for the grant will require proof of eligibility**.

Continue to Create HealthSafe ID.

## Create HealthSafe ID

After acknowledging the eligibility requirements are met, the blue "Create HealthSafe ID" is enabled.

Select the button to be redirected to the HealthSafe ID sign in page. Creating a HealthSafe ID is a one-time requirement.

Create HealthSafe ID by entering the	0
following details of the parent/legal guardian	UnitedHealthcare
who is applying for the grant:	children's 💋
First Name	foundation
Last Name	Create HealthSafe ID
Date of Birth	Already a User? Sign In * Required Fields
Email Address (must not be	First Name*
associated with another HSID)	
<ul> <li>Create Realtinsale ID (Osemanie)</li> <li>Reseword (must be 12 characters)</li> </ul>	
<ul> <li>Confirm Password</li> </ul>	Last Name*
Phone Number	
Note: Personal information entered is the parent	Date of Birth* MMOD-YYYY
or legal guardian's details, NOT the child's	MM-DD-YYYY III
number entered will be used to communicate	
information regarding your application and	Email Address*
awarded grant(s) as well as securing your	
HealthSafe ID. Ensure it is an active email address and phone number	
address and phone number.	Create HealthSafe ID* (Username)
Providers, social workers, or other proxies ARE	
NOT PERMITTED to complete the application.	Decement
	Password
$\rightarrow$ Review the Terms of Use and Privacy	•
Policy to use the HealthSafe ID services	Coofirm Paceward*
and agree to the terms by checking the	Commin Password
box.	©
→ Select "Continue "	Phone Number*
	■ +1 - SS5-555
	You must agree to the Terms of Use <sup>®</sup> and
	Privacy Policy <sup>®</sup> to use the HealthSafe ID service. If you do not agree, do not use any
	aspect of the HealthSafe ID service.
	Continue
	Commue

You will receive an email from HealthSafe ID with an access code. → Enter the access code into the Enter Verification Code text box. If you did not receive a code after 1-2 minutes, confirm your email address is accurate in the message and either select "Resend Email" or "Update Email Address". → Select "Verify."	UnitedHealthcare   Children's   Foundation   Check your registered email address ( ) for the Verification (
<ul> <li>After entering your access code and allowing the system to verify, a message will display "Success" when verified correctly.</li> <li>→ Select "Continue."</li> </ul>	Success Email Address is verified. Continue
<ul> <li>The Verify Phone Number message displays.</li> <li>→ Select one of the methods to verify the phone number entered when creating your HealthSafe ID.</li> <li>Note: Via Text Message requires a mobile phone added in the phone number field when creating your HealthSafe ID.</li> </ul>	UnitedHealthcare children's coundation         Coundation         Description         Select one of the following methods to verify your phone number.         An automated text message or phone call will be sent to the phone number you provide for account confirmation and recovery purposes. If you select text message, messaging and data rates may apply.         Via Text Message         Via Call

<ul> <li>You will receive a text message or phone call from HealthSafe ID with an access code.</li> <li>→ Enter the access code into the Verification Code text box.</li> <li>→ Select "Verify."</li> <li>Note: If you did not receive a code after 1-2 minutes, confirm your phone number is accurate. Change to "Call" or "Message" or select "Resend Code" or "Update Phone Number."</li> </ul>	UnitedHealthcare children's construction         Coundation         Definition code on your registered phone number. Enter code below to complete the verification.         Verification Code         Waiting for Text Message?         Resend Code         Verification Code
After antering second and allowing	Call to Verify Update Phone Number
After entering your access code and allowing the system to verify, a message will display "Success" when verified correctly. → Select "Continue."	Success
	Your Phone number is verified
Agree or Decline Consent for My HealthSafe ID.	UnitedHealthcare
<ul> <li>→ Review the consent agreement and acknowledgment for using HealthSafe ID.</li> <li>→ Select "I Agree" to continue the application process and future usage of the UnitedHealthcare Children's Foundation (UHCCF) Grant Management system.</li> </ul>	Consent For My HealthSafe ID Using your HealthSafe ID to sign in to United Healthcare Children Foundation Grant Management means that United Healthcare Children Foundation Grant Management uses your HealthSafe ID account information to verify your access. We share the following information with United Healthcare Children Foundation Grant Management. HealthSafe ID Name Date of Birth Email Address I Agree, On providing your consent, you allow HealthSafe ID to share your account information with United Healthcare Children Foundation Grant Management. Additionally, you acknowledge that this information is subject to United Healthcare Children Foundation Grant Management's privacy policy that may be different from HealthSafe ID.
brought to the <u>Parent/Legal Guardian Profile</u> .	You acknowledge that your account information provided to United Healthcare Children Foundation Grant Management's subject to United Healthcare Children Foundation Grant Management's privacy policy, which may be different from HealthSafe ID's privacy policy.

<u>Sign In – Grant Portal</u>	
$\rightarrow$ Sign in by entering your HealthSafe ID	
Username or Email Address.	Olara ha
→ Enter your created Password.	Sign in
	Username or Email Address
Note: Select "Forgot HealthSafe ID" or "Forgot	
Password" if necessary.	
	Password
	٥
	Forgot HealthSafe ID? Forgot Password?
	Continue
Verify your identity by selecting one of the	(K
two methods available.	UnitedHealthcare
	children's
<ul> <li>Via Text Message</li> </ul>	roundation
Via Call	Verify Your Identity
	Select one of the following methods to verify
Note: Via Text Message requires a mobile phone	your identity.
added in the phone number field when creating	Via Tast Magaza
	Vid lext message
	Via Cali
	Back to Sign In
You will receive a text message or a phone	
call to the phone number associated with	
your account with an access code.	
	foundation
$\rightarrow$ Enter the One Time Password (OTP) into	Access Code
the text box.	
	We have received your information. If it
$\rightarrow$ If appropriate, select "Skip this step in the	account, you will receive a text message with
future if this is your private device."	One Time Password (OTP).
	Enter One Time Password
→ Select "Continue."	
	Waiting for Text Message? Resard Code
Continue to the Dashboard.	Taking for fore modeling in the serie of the
	Skip this step in future if this is your private device.
	Continue
	Return To Verify Identity Options

## Parent/Legal Guardian Profile

The Parent Profile displays Parent Details used for verifying your identity, contacting you regarding your grant application and award, and mailing reimbursement payments.

Reference the image and table below when completing the Parent Profile.

#### **Important Notes:**

ONLY the child's parent or legal guardian can use the portal. Providers, social workers, or other proxies ARE NOT PERMITTED to complete an application or submit payment requests.

All fields with a red asterisk are required. Hover over the (i) to the right of field names for more information.

Parent/Legal Guard	an Profil	e	
First Name *①		Middle Name	Last Name *()
Parent			Name
Email Address		Date of Birth *	Mobile Phone *
parentname@email.com			555555555
Social Security Number (	5SN) *①		
2 *******			
Mailing Address 🕕			
3 1234 Street Name, City Name	e, Stat		
Street 1 *①		Street 2 ①	City *①
1234 Street Name			City Name
State *()		ZIP/Postal Code *①	
State		12345	
How did you hear about	the UHCCF g	rant program? *	
4 Select			~
Parent Details from HSID	First N fields a	ame, Last Name, Email ad auto-populate from HealthS	dress, Date of Birth, and Mobile Pho afe ID.
Social Security Number	Enter y and ch a gran	our Social Security Numbe ild are required to have a S t.	er. TINs are not accepted. Both paren Social Security Number to be eligible
Mailing Address	Enter y popula	our complete Mailing Addr te based on the Mailing Ad	ess. The additional address fields au dress field.
How Did You Hear About	Select about	a response from the drop- the UHCCF grant program.	down menu to tell us how you heard
Save	Once y "Save"	ou have verified all fields a to move to the Dashboard	are completed and correct, select

### Dashboard

The Dashboard displays Active Grants and Children previously entered in the portal with separate headers.

Reference the image and table below when viewing the dashboard.

Note: If this is the first time using the portal, a message of "There are no records to display" will appear in the Children table. If you have previously applied for a grant, select "Add Child & Start Application." When you enter your child's information, it should link the child's existing records in the system.

						Home   5	Parent Name -
Dashboard							
Active Grant	s						^
DOE, JAN Child: Jane Do Approved Servi Medical Drug Services - Dr/S that visit)	E 12312025 e eces: Prescription Medication   pecialist Visits (including s	Age: <b>7</b> Name(s). Medical services during	Grant Start Date: <b>S</b> Grant End Date: <b>D</b>	eptember 25, 2024 ecember 31, 2025	Grant Awarded: \$1500.0 Total Used: \$0.00 Remaining Amount: \$19 Payment Hist	00 00.00 Dry New Payment F	Request
2 Children						Add Child & S	*
Child's First	Name	Child's Last Na	ame	Date Of Birth	Gen	der	
4 Jane	I	Doe		4/26/2017	Fema	le	~
If you have any qu	estions, please contact u	is at <u>uhccfcustom</u>	<u>erservice@uhc.com</u>				
- Active Grants	3	Activ appe	e grant info ar under th	ermation for a e Active Gra	all children link ants heading.	ed to the pare	nt portal will
- Children		All ch head	nildren linke ing.	ed to the par	ent portal will a	appear under t	he Children
- Add Child &	Start Applicatio	on Seleo porta	ct " <u>Add Chi</u> I.	ld & Start Ap	oplication" to a	dd a new child	to the parent
Child Profile		Selec	ct the child' profile Thi	s first name s is where v	or use the dro	p-down arrow	to access the
- Parent Profile	e/Sign Out	Acce	ss the pare	ent profile or t to the Pare	sign out of the ent Name.	portal by sele	ecting the drop-

# Add Child & Start Application

Select "Add Child & Start Application" if you've never applied for a grant before or if you do not see your child listed under the Children heading. This step will create the Child Profile.

## Add Child

Reference the image and table below to add the child's information.

			Sa
Child's First Name *①	Child's Last Name *	Date Of Birth *	Age①
	2	3 M/D/YYYY	■ 4 -
Social Security Number *①	Gender *	Race *	-
io: 123456789	6 Select	~ <b>7</b>	2

1 – Child's First Name	Enter the child's first name a	as it appears on their birth	n certificate.
2 – Child's Last Name	Enter the child's last name a	as it appears on their birth	n certificate.
3 – Date of Birth	Enter the child's date of birt	h using the MM/DD/YYY	/ format.
4 – Age	Age is auto-populated base	d on date of birth.	
5 – Social Security Number	Enter the child's social secu	rity number.	
6 – Gender	Use the drop-down menu to	select the child's gender	
7 – Race	Use the magnifier to select	the child's race.	
		Lookup records	×
			Search Q
		Choose one record and click Select to continue Name	Created On
		American Indian or Alaska Native	5/16/2024 4:39 PM
	Race *	Asian	5/16/2024 4:39 PM
	( a )	Black or African American	5/16/2024 4:39 PM
		Hispanic or Latino	5/16/2024 4:39 PM
		Native Hawaiian or other Pacific Islander	5/16/2024 4:39 PM
		White (Non-Hispanic)	5/16/2024 4:39 PM
			5/16/2024 4:39 PM
		Prefer Not to say	5/16/2024 4:39 PM
		Select	Cancel Remove value
8 – Save	Select "Save" to move to Ar	oplication.	

#### Child Profile

The Child Profile displays Active Grants and Child Details previously entered in the portal with separate headers.

Reference the image and table below when viewing the Child Profile.

Note: If this is the first time using the portal, a message of "There are no records to display" will appear in the Children table.

Consentionars children's foundation	Home   Parent Na
Home > Child	
Active Grants	
Child Details	
Child's First Name *()	Child's Last Name * Date Of Birth * Age ①
Jane	Doe 4/26/2017
Social Security Number *①	Gender * Race *
*****0000	Female V White (Non-Hispanic)
Grant Applications	
orant Applications	3 Start Application
Grant Application	Application Status Created On J Submitted On
Creat Application Jane Dee	
Grant Application - Jane Doe	Approved / Awarded 11/2//2024 4:54 PM 12/24/2024 5:29 PM 5
Previous Grants	
Name	Status Reason Amount Awarded Amount Remaining
Name <b>↑</b>	Age Gender Id Created On
There are no records to display.	·
Active Grants	Active grant information for the selected child will appear under t Active Grants heading.
Child Details	Child details may be viewed in the Child Profile. If any changes a needed, email <u>uhccfcustomerservice@uhc.com</u> .
Child Details Start Application	Child details may be viewed in the Child Profile. If any changes a needed, email <u>uhccfcustomerservice@uhc.com</u> .         Select " <u>Start Application</u> " if there is not an active grant and the changes the <u>eligibility criteria</u> .

	<ul> <li>Deferred: The Board has requested additional information before making a decision.</li> </ul>
	• Denied: The Board has denied the application. The applicant must wait 12 months to reapply for the same services.
5 – Edit/View	Applications in "Information Requested" status can be edited. Applications in all other statuses can be viewed in read-only mode.
6 – Previous Grants	Past grants (expired and/or exhausted) will appear under the Previous Grants heading.
7 – Historical Grant Applications / Proof of Medical Needs	Grant applications submitted prior to June 2024 will appear under the Historical Grant Applications Heading.

#### Application

Once the child is added to the portal, the child's details will display in the Child Profile. If an Active Grant was found in the portal with the same child's details, the Active Grant details will display at the top of the screen. If this child is eligible to start a new application, select "Start Application."

There are seven sections within the application. Required fields will be noted with a red asterisk "\*". The application is saved as a draft after the applicant selects "Save" on the first Details section.

CAUTION: The application will time out after 15 minutes of inactivity, resulting in a loss of information entered after idling. Please "Save" within 15 minutes to enable the auto-save feature for the rest of the application. After this point, the applicant can sign off at any time during the application process and can come back to edit the application prior to submission.

Important Note: There are three required documents that must be uploaded to each application. Failure to upload the documents will delay processing and may result in a grant application denial.

- 1. Federal tax return IRS Tax Form 1040.
  - a. W-2s, pay stubs, or state returns are not accepted.
  - b. If the return status is Married Filing Separately, the separate tax returns for both parents are required.
  - c. The person who claims the child as a dependent on their federal tax return must submit the application.
- 2. Front and back of child's commercial/private insurance card.
- 3. Physician's Certification of Medical Condition Form (available for download within application and under <u>Required Documents</u> on our website). The Medical Form must meet the following criteria:
  - a. The form MUST be completed by an M.D. (Doctor of Medicine), D.O. (Doctor of Osteopathic Medicine) or Au. D. (Doctor of Audiology) for hearing related requests.
     \*Forms signed by a Nurse Practitioner, Licensed Psychologist, Physician Assistant, or any health professional other than the above DO NOT fulfill this requirement.
  - b. The form MUST be signed within the last 6 months and include ALL the Medical Items or Services you are requesting the UHCCF grant to cover.

# Details

Reference the image and table below when filling out the Details section within the application.

Note: The child's information will pull from the information added in the <u>Add Child</u> section. The applicant cannot edit or update Child Information (Child First & Last Name) or Age. If any changes are needed, email <u>uhccfcustomerservice@uhc.com</u>.

Child's Information *	Age	Primary Residence	e of Child *①	
Jane Doe	7	1 Other		~
Child's Address				
Child Street Address *	Child City *	Child State *		Child Zip Code *
Family Size *	Adjusted Gross Income as shown Tax Form 1040) *	on Tax Return (Line 11	of IRS Federal	
Family Story *①				
6 Save				
Primary Residence of Child	Default response is the	Primary/Legal G	uardian Ad	dress
		, ,		01055.
Child's Address, if different from parent/guardian's	Select "Other" from the from the parent/guardia address fields auto-pop	drop-down list if n's. Enter the Cl ulate based on t	the child's a hild's Addre he Child's A	address is differents. Ss. The additional Address field.
Child's Address, if different from parent/guardian's Family Size	Select "Other" from the from the parent/guardia address fields auto-pop	drop-down list if n's. Enter the Cl ulate based on t the child using th	the child's a nild's Addre he Child's A	address is differents. The additional Address field.
Child's Address, if different from parent/guardian's Family Size	Select "Other" from the from the parent/guardia address fields auto-pop Enter the family size of Family size is verified by a child to your family in child's birth certificate o	drop-down list if n's. Enter the Ch ulate based on t the child using th y the current year the current year	the child's a nild's Addres he Child's A ne drop-dov ar's tax retur , please sub work.	address is differents. The additional Address field. Address field. Address field. Address field. Address field. Address field.
Child's Address, if different from parent/guardian's Family Size Adjusted Gross Income (AGI)	Select "Other" from the from the parent/guardia address fields auto-pop Enter the family size of Family size is verified by a child to your family in child's birth certificate o Enter the AGI as docum Return (IRS Tax Form 1	drop-down list if n's. Enter the Ch ulate based on t the child using th y the current year the current year <u>r adoption paper</u> nented on line 17 040).	the child's a hild's Addre he Child's A ne drop-dov ar's tax retur , please sub work. I of the curr	address is differents. The additional ss. The additional address field. In menu options. In If you have ad omit a copy of the ent year's federal
Child's Address, if different from parent/guardian's Family Size Adjusted Gross Income (AGI)	Select "Other" from the from the parent/guardia address fields auto-pop Enter the family size of Family size is verified by a child to your family in child's birth certificate o Enter the AGI as docum Return (IRS Tax Form 1 Note: If the number is neg	drop-down list if n's. Enter the Ch ulate based on t the child using th y the current year the current year <u>r adoption paper</u> nented on line 17 040). ative, enter "0."	the child's a hild's Addres he Child's A ne drop-dov ar's tax retur , please sub <u>work.</u> I of the curr	address is differents. The additional ss. The additional address field. In menu options. In If you have ad omit a copy of the ent year's federal
Child's Address, if different from parent/guardian's Family Size Adjusted Gross Income (AGI) Family Story	Select "Other" from the from the parent/guardia address fields auto-pop Enter the family size of Family size is verified by a child to your family in child's birth certificate o Enter the AGI as docum Return (IRS Tax Form 1 Note: If the number is neg Tell us your family story for the Board to conside	drop-down list if n's. Enter the Ch ulate based on t the child using th y the current year r adoption paper nented on line 17 040). ative, enter "0."	the child's a hild's Addres he Child's A ne drop-dov ar's tax retur , please sub work. I of the curr ormation the g your appli	address is different ss. The additional address field. In menu options. If you have ad omit a copy of the ent year's federal at would be import cation.
Child's Address, if different from parent/guardian's Family Size Adjusted Gross Income (AGI) Family Story	Select "Other" from the from the parent/guardia address fields auto-pop Enter the family size of Family size is verified by a child to your family in child's birth certificate o Enter the AGI as docum Return (IRS Tax Form 1 Note: If the number is neg Tell us your family story for the Board to conside CAUTION: The applicat resulting in a loss of info 15 minutes to enable th	drop-down list if n's. Enter the Ch ulate based on t the child using th y the current year <u>r adoption paper</u> nented on line 1 <sup>-7</sup> 040). ative, enter "0." . Include any inf er while reviewing ion will time out prmation entered	the child's a hild's Addres he Child's A ne drop-dow ar's tax retur please sub work. I of the curr ormation the g your appli after 15 mir l after idling ure for the r	address is differents. The additional address field. In menu options. If you have ad omit a copy of the ent year's federal at would be import cation. In the sof inactivity, Please "Save" w rest of the applica
Child's Address, if different from parent/guardian's Family Size Adjusted Gross Income (AGI) Family Story Save	Select "Other" from the from the parent/guardia address fields auto-pop Enter the family size of Family size is verified by a child to your family in child's birth certificate o Enter the AGI as docum Return (IRS Tax Form 1 Note: If the number is neg Tell us your family story for the Board to conside CAUTION: The applicat resulting in a loss of info 15 minutes to enable th Select "Save" to create feature for the rest of th	drop-down list if n's. Enter the Ch ulate based on t the child using th y the current year <u>r adoption paper</u> nented on line 17 040). ative, enter "0." . Include any inf er while reviewing ion will time out prmation entered a Draft Applicati e application.	the child's a hild's Addres he Child's A ne drop-dow ar's tax retur , please sub work. I of the curr ormation the g your appli after 15 mir after idling ure for the n on and enal	address is differents. The additiona address field. In menu options. If you have ad omit a copy of the ent year's federal at would be import cation. Thutes of inactivity, Please "Save" work of the application.

Upload Federal Tax Return – IRS I	Form 1040
Select the "magnifying glass" to upload your Federal Tax Return – IRS Form 1040. Reminders: a. W-2s, pay stubs, or state returns are not accepted. b. If the return status is Married Filing Separately, the separate tax returns for both parents are required. c. The person who claims the child as a dependent on their federal tax return must submit the application.	Federal 1040 Tax Form *① Child is not listed as a dependent on the attached tax form because they were born or adopted in the current year.
If applicable, select the check box next to "Child is not listed as a dependent on the attached tax form because they were born or adopted in the current year." Note: If check box is selected, the applicant will be required to attach the child's birth certificate/adoption paperwork and social security card.	
Select "New" to create a new tax return record.	Lookup records ×   Search Q   Choose one record and click Select to continue   ✓ Name   Created On     New     Select   Cancel   Remove value

Create a new record displays.	6
$\rightarrow$ Contact Name defaults to the	Create a new record
Parent/Guardian profile	
name (user is unable to edit	Contact *
this field).	Proved News
	Parent Name
$\rightarrow$ Enter the Tax Year.	Tax Year *
> Enter any notes you may	
$\rightarrow$ Enter any notes you may want to add	
want to add.	Notes Memo
$\rightarrow$ Select "Click to select file(s)"	
	1040 Eile *
$\rightarrow$ Choose the file(s) you want	
to upload.	Click to select file(s)
	Name Actions
→ Select "Upload."	Selected Files:
$\rightarrow$ Select "Save."	Linload
	Choad
	Save
Ensure your file is correctly	
highlighted and the check mark	Lookup records ×
next to the file name chosen for	
upload is enabled.	Search Q
· Coloct "Coloct" from the	Choose one record and click Select to continue
$\rightarrow$ Select Select from the	Name Created On
screen.	
$\rightarrow$ Select "Next" from the main	Parent Name - 2024 12/13/2024 5:08 PM
Details Tab to move to	
Insurance.	New         Select         Cancel         Remove value
· · · · · · · · · · · · · · · · · · ·	

Insurance	
Select the "magnifying glass" to enter the child's insurance details.	The child is required to have insurance coverage from a commercial health plan, either through an employer or individually purchased.
Note: To meet the eligibility requirement, the child must have insurance coverage from a commercial health plan, either purchased through an employer or individually.	Child's Primary Insurance *①  Child's Secondary Insurance①  Previous Next
Select "New" to create a new insurance record.	Lookup records ×
	Search Q
	Choose one record and click Select to continue
	Identifier     Insurance Company Name     Created On
	New Select Cancel Remove value



Reference the image and table	below when filling out the	e Physician Details se	ction withir	the application.
Physician Information				
Physician's Name *	Credentials *()			
1	2 Select	~		
Clinic Information				
Clinic's Name *		Phone Number *		
3		4		
Clinic's Address	1			
Address *	City *	State *		Zip Code *
			٩	
Previous Next 6				
– Physician's Name	Enter the first and la	st name of the physici	an recomm	ending the services
- Thysician's Name	(letters only, no spec	cial characters).	anneconni	lending the services
2 – Credentials	Select the credential	s of the physician usir	ng the drop	-down menu.
	$\rightarrow$ M.D. (Doctor	of Medicine)		
	$\rightarrow$ D.O. (Doctor	of Osteopathic)		
	→ Au. D (Docto Note: Forms signed by	r of Audiology) v a Nurse Practitioner. Li	censed Psv	chologist Physician
	Assistant, or other allie	ed health professional do	o not fulfill th	e application
	requirements.			
B – Clinic's Name	practices.	e clinic where the rec	ommenainę	g pnysician
	Note: If it is an indeper	ndent physician type "Ind	dependent."	
– Phone Number	Enter the physician's	phone number (num	bers only, r	no dashes).
– Clinic's Address	Enter the clinic's add	ress. The additional	address fie	lds auto-populate
	based on the Clinic's	Address field.		
1 – Next	Select "Next" to mov	e to Medical Condition	<u>ns/Diagnos</u>	<u>is</u> .

Medical Condition/Diagnosis Reference the image and table below when filling out the Medical Condition/Diagnosis section within the application.

Details 🖌 Insurance 🖌 Physician De	tails 🖌 Medical Condition / Diagnosis Services Requested Attachments Acknowledgement
Primary Diagnosis Category *	Has your child been evaluated by Early Childhood Intervention or Special Education Services (typically through the School District)? * Select
Specific Primary Diagnosis * 2 Secondary Diagnosis Category 3	Summary of Child's Medical Condition *①
Previous Next 6	
– Primary Diagnosis Category	Select the "magnifying" glass to launch the primary diagnosis category lookup. Scroll and use the arrows to locate the diagnosis category. Select the diagnosis category. Select "Select."
<ul> <li>Specific Primary Diagnosis</li> </ul>	Enter the specific primary diagnosis.
<ul> <li>Secondary Diagnosis</li> <li>Category</li> </ul>	Enter the secondary diagnosis category, if applicable.
<ul> <li>Has your child been evaluated by Early Childhood intervention or Special Education Services?</li> </ul>	Use the drop-down menu to answer whether your child has been evaluated by Early Childhood Intervention or Special Education Servic
<ul> <li>Summary of Child's Medical Condition</li> </ul>	Provide a description of your child's medical condition to help the boar reach a decision regarding your application. For example, medical history and treatment plan.
– Next	Select "Next" to move to Services Requested.

Services Rec	queste	d					
The Services	Reque	sted are th	e medical i	tems and/or s	services that will	be funded by th	ne grant.
Important Not listed on the N covered by th Reference the	te: Only Medical e grant e image	y services a I Form. Se t. e and table	added here rvices listed below whe	will be consid on the Medio n filling out th	dered for grant fu cal Form but not ne Services Requ	unding. Services added into the uested section v	s requested must be application will not be within the application.
Details 🗸	Insuranc	e 🖌 Physicia	n Details 🖌 🛛 N	ledical Condition / Dia	agnosis 🖌 Services Rec	quested Attachments	Acknowledgement
Grants	s are limite	d to a maximum	of \$5,000 per yea	r and \$10,000 lifetim	ie.		Add Service
Service	Туре	Service Item	Drug Name	Other Notes	Out of Pocket Amo	Not Covered I unt Insurance Du Exclusion	by e to Policy
Medical S	ervices	Dr/Specialist Visi (including service during that visit)	ts es		\$1,000.00	No	2 -
Medical D	lrug		Prescription Medication Name(s)		\$1,500.00	No	~
						Total A	mount Requested
						<b>3</b> <del>\$</del> 2,500.	00
Downl	load Medica	al Form	Medical Form	· · · · · · · · · · · · · · · · · · ·			
-	lemplate	- 5	Click to	select file(s)	Name	Actions	
		_	Select	ed Files:			
			U	pload			
Previous	Next	6					
1 – Add Servi	6		Select	"Add Service	" to create a new	v service reque	et
			Note: C	only services a	dded here will be	considered for the	e grant. If more than
			one ser	vice is being re	equested, select "	Add Service" for	EACH service. Services
			request	ed must be list	ted on the Medica	I Form.	
2 – Edit / Rem	nove S	ervice	Select	the drop-dow	n menu to edit c	or remove a ser	vice request.
3 – Total Amo	ount Re	equested	This fie service	eld will auto-c e.	alculate the out-	of-pocket totals	entered for each
4 – Download	Medic	al Form	Downlo	oad the Medio	cal Form Templa	ate to send to th	e child's doctor.
Template			Noto: T	ho form MUST	- ha completed by	an M.D. (Dester	of Modicipa) D.O.
			(Doctor	of Osteopathi	c Medicine) or Au.	D. (Doctor of Au	idiology) for hearing
			related	requests. For	ms signed by a N	lurse Practitione	er, Licensed
			Psycho the abo	ologist, Physic ove DO NOT fi	cian Assistant, o ulfill this require	r any health pro ment.	ressional other than
5 – Upload M	edical	Form 🛛	Select	"Click to sele	ct file(s)."		
			Choos	e the file(s) y	ou want to uploa	d.	
			Select	"Upload."			
6 – Next			Select	"Next" to mov	ve to <u>Attachmen</u>	<u>IS</u> .	

Add Services	
Reference the image and table be	low when adding services within the application.
Create	
Service Type *	Out of Pocket Amount *①
1	× Q 3
Service Item*	X Q A Not Covered by Insurance Due to Policy Exclusion
Upload Proof o	of Non-Coverage *
Click to sele file(s)	ect Name
Selecte Files: Upload	d
6 Save	
1 – Service Type	<ul> <li>Select the "magnifying glass" to launch the "Service Type" lookup and select the service type category.</li> <li>→ Medical Therapy, Medical Services, Medical Equipment, Medical Drug, or Medical Supplies .</li> </ul>
	Note: When selecting "Medical Drug" as service type, enter the drug name in the text box. If approved, the grant will cover any prescription medication filled by a pharmacy.
2 – Service Item	Select the "magnifying glass" to launch the "Service Item" lookup and select the service item category.
	Note: When selecting an "Other" option, enter the specific service item in the
3 – Out of Pocket Amount	Enter the amount you expect to pay out-of-pocket after insurance coverage for the duration of the grant. Grants are good for one year after approval.
4 – Not Covered by Insurance Due to Policy Exclusion	ONLY SELECT if services are not covered by the insurance as an exclusion to your insurance policy.
	Note: DO NOT SELECT if services are covered but payments apply to the deductible or out-of-pocket expenses.
	Select "Click to select file(s)." Choose the file(s) you want to upload. Select "Upload."
5 – Upload Proof of Non-	If applicable, upload Proof of Non-Coverage.
00101490	Note: This could be a copy of your benefit summary's exclusions list highlighting no coverage, a denial letter from your insurance company, or an Explanation of

	Benefits that shows no benefits are available. Retain this document for use after grant approval, as you will need to upload this with a Payment Request.
	Select "Click to select file(s)." Choose the file(s) you want to upload. Select "Upload."
6 - Save	Select "Save."
	Select Next to move to <u>Attachments</u> .

# Attachments

Ref	erence th	e image an	d table below v	vhen filling out the A	ttac	hments section w	vithin t	he a	pplication.
Not	e: This is	not a requi	red section. Ap	plicant can use this	sec	tion to add addition	onal in	form	ation that may
sup	port their	application	. Examples: Ph	notos of your family,	lette	ers from provider	s or so	hool	, etc.
									0
	Details 🖌	Insurance 🗸	Physician Details 🖌	Medical Condition / Diagnosis	~	Services Requested 🗸	Attachm	ents	Acknowledgement
	Attach Ad	ditional Documer	its						
	1		Click to select file(s)		Na	me	Actions		
		5	Selected Files:		Dia	gnosis Document.pdf	Ŀ₹	Û	
			Upload		Pho	to of Child.pdf	Ŀ₹	Û	
	·								
	Previous	Next 2							
					-			-	
			Sal	act "Click to salact f		.) "			
1 –	Upload F	iles	Che	pose the file(s) you	van	t to upload.			
			Sel	ect "Upload."					
2 –	Next		Sel	ect Next to move to	Ack	nowledgement.			

cknowledgement	
ead and acknowledge each se	ection and add an electronic signature.
ote: Providers, social workers	, or other proxies ARE NOT PERMITTED to complete the application.
Details 🗸 Insurance 🖌 Physician	Details 🖌 Medical Condition / Diagnosis 🖌 Services Requested 🖌 Attachments 🖌
Acknowledgement	
Submission of a completed grant appli request for funds. If a grant is approve the Foundation's Board of Directors.	cation does not guarantee that the UnitedHealthcare Children's Foundation ("Foundation") will approve the d for disbursement for the child's benefit, the grant will be limited to the services and amount specified by
I hereby certify that I am the parent or leg to the best of my knowledge, the informa this application that any grant awarded b	al guardian of the child with the legal right to execute and make the representations contained herein, and state that ation provided by me in this application is true and correct. I understand that if I have made any misrepresentations in y the Foundation in response to this application may be immediately rescinded and revoked by the Foundation.
Parent Acknowledgement *	
I acknowledge that I have consented to a in connection with this application.	nd authorized the release of the medical and financial information and records provided to the Foundation for review
Medical & Financials Acknowledgen	aent *
Waiver of Liability	
I, for myself and on behalf of my child/wa servants and employees from any and all	ird, do hereby expressly and knowingly fully release and discharge the Foundation, and its directors, officers, agents, claims and liability resulting from: i) injury, damages or losses which I, or my minor child/ward, may have or accrue
broad and inclusive as permitted by law a continue to be valid and legally binding.	nd that if any portion of this Agreement is declared invalid, for whatever reason, the remaining portions shall
Electronic Signature	
By entering your name in the space provi and to the Foundation's policies related t	ded below, you are agreeing to the provisions of the above related to the Acknowledgement and Waiver of Liability, o the review and award of grants.
If awarded a grant through UHCCF, wo fundraising event or similar project? Pl	uld you and your child be willing to help us to promote our charitable efforts in a brochure, press release, EASE NOTE: You may always decline any opportunity we contact you about. *
Select	~
Electronic Signature *	
Previous 5 Submit	
Doront Acknowledgment	Pood and acknowledge that you are the percent or legal guardian of the
– Parent Acknowledgment	child who will receive the grant.
– Medical & Financials	Read and acknowledge the consent and authorization of financial and
Acknowledgment	medical records release.
<ul> <li>Waiver of Liability</li> </ul>	Read and acknowledge the waiver of liability.
<ul> <li>Electronic Signature</li> </ul>	Answer the promotional question by using the drop-down menu.
	Enter your name in the Electronic Signature text box.

5 – Submit	Ensure that all information is complete and all required documents have been uploaded. After submitting, you will not be able to edit the application without affecting your grant start date. Select "Submit" to submit your application. Important Notes:
	Upon successful submission of the application, the following pop up will appear.
	Success! Your form has been successfully submitted. You will receive an email when your application has been reviewed.
	Once submitted, a Grant Manager will review your application within three to five business days. You will then receive an email (to the email provided in the Parent/Guardian profile) confirming completion of the application or requesting additional information.
	After Grant Manager review, your application will be reviewed by the UHCCF Board. Board meetings occur once per month. Therefore, a final decision of the grant application could take up to 45 days after Grant Manager review.

## Active Grant

Once the child is awarded a grant, the Active Grant information will display on the Dashboard and in the Child Profile. Select the grant shortcut (e.g. "DOE, JANE 12312025") or "Payment History" to open the grant details.

DOE, JANE 12312025		Grant Start Date: September 25, 2024	Grant Awarded: \$1500.00	
Child: Jane Doe	Age: 7	Grant End Date: December 31, 2025	Total Used: \$0.00	
Approved Services:				
Medical Drug - Prescription Medica	tion Name(s), Me	dical		
Services - Dr/Specialist Visits (includ	ding services durin	ng	Remaining Amount: \$1500.00	
that visit)	-			

Reference the image and table below when viewing an active grant.

-												
Gr	ant Details				Amount	Award	led		Amount Remaining			
	DOF JANE 12312025				\$ 1 500 00							
	Child Jane Doe Grant Application				Grant Start Date					Grant End Date		
					9/25/20			-	12/31/2025			
	Grant Application - Jane D											
	Payment History											
			Ctatus	Dourmont	Cubm	itted		Clark	Dete of	End Data of		
3	Payee	Amount	Reason	Method	Date	illeu	Child	Medi	cal Service	Medical Service	Region	
	Parent/G uardian	\$150.00	Paid	Zelle	1/7/202	25	Jane Doe	1/1/20	)25	1/1/2025	Central South	~
	Approved Services / Special Requests											
5	Name 🕇				Service It	tem	Service 1	Гуре	Drug Name	Approval Method	Approval Sta	atus
	Medical Drug - Prescription Medication Name(s)						Medical Dr	ug	Prescription Medication Name(s)	Application	Approved	
	Medical Services - Dr/Specialist Visits (including services during that visit)				Dr/Speciali Visits (inclu services du that visit)	st Iding Iring	Medical Services			Application	Approved	
Grant Details Gi			Gra	Grant award details cannot be changed.								
			Note com mon	Note: Grant start dates are calculated as 90 days before your application completion date. Grant end dates are calculated as the last day of the 12th month following grant approval								
New Payment Requests			Sele	Select to generate a new payment request.								
Payment History				View the grant payment history. "Status Reason" will update as your payment is processed. Emails are sent notifying the parent/guardian								

4 – Edit Payment Request	Select to update and resubmit a payment request following an email notifying you of changes or additional information needed.
5 – Approved Services / Special Requests	The grant will only cover services listed here and in your grant approval email, even if you applied for additional items not listed.

#### Payment Requests

Select "New Payment Request" on the child's Active Grant at the top of the Dashboard, in the Child Profile, or in the Payment History/Active Grant details.

### Important Notes:

Only dates of service occurring within the grant start and expiration date timeframe will be considered for the grant. There are no exceptions.

Payment requests for dates of service within the grant dates must be submitted within 30 days of the grant expiration date to be considered for payment. Any grant balance remaining after the grant payment window will be forfeited and revert to UHCCF.

### **Required Documents**

These must be uploaded to each payment request. Failure to upload the documents will delay processing and may result in a payment request denial.

- 1. A detailed **invoice** showing the child's name, date(s) of service, provider information, service rendered, and billed amount.
- 2. An **Explanation of Benefits (EOB)** from your insurance that shows the details of how they have processed the charges for the requested dates of service including the patient responsibility amount.
  - 1. If you choose to go to an out of network provider or a provider that does not accept insurance, you are responsible for submitting to your insurance for an EOB to be obtained.
  - 2. If you do not have coverage for the service, we need **proof of non-coverage**.
    - i. This is a document from your insurance company that confirms no benefits will be paid out for a service or product. It could be a copy of your benefit summary's exclusions list highlighting no coverage, a denial letter from your insurance company, or an Explanation of Benefits that shows no benefits are available.
- 3. **Proof of payment** (for reimbursement to the parent/guardian).
  - 1. Accepted proof of payment: receipt, provider invoice showing payment, front and back of *cashed* check, bank or credit card statement.

There are two payment options:

- 1. Reimbursement to the parent/guardian via check or Zelle.
- 2. Payment to the provider directly via check.
  - a. If we have not sent a provider payment before, we will need a copy of their W-9 to get them set up in our system.

Create Payment Request					
Reference the image and table bel	ow when creating a new payment request.				
Add Payment Request					
Who Do We Need to Send Payment To? *	Start Date Medical Service, Item or End Date Medical Service, Item or				
1 Select	Procedure Received or Purchased *     Procedure Received or Purchased *				
Enter Reimbursement Amount *					
Select the Approved Grant Service you are	Additional Information				
For the second s					
<b>•</b>					
Provider Invoice/Bill *	Explanation of Benefits (EOB) or Proof of Non-Coverage				
Click to select Name					
file(s)	Click to select				
Selected	6 file(s)				
Files:	Selected				
Upload	Files:				
	Lipland				
	opioau				
I attest that I am the parent or legal gua	ardian listed in the application and that these charges are, to the best of my knowledge, within the grant				
Signature *					
10 Submit Payment Request					
1 – Who Do We Need to Send	Select "Provider" or "Parent/Guardian" from the drop-down list.				
Payment To?	Note: If you select "Parent/Guardian," additional fields show up for additional required information				
2 – Start & End Dates of Medical	Select the calendar icon or enter the <b>date of service</b> in MM/DD/YYYY				
Service, Item or Procedure	format. If requesting payment for a single date of service, enter that date				
3 – Reimbursement Amount	Enter the dollar amount of the payment request.				
	Note: Payment amount must match on the invoice and the amount shown as "Patient Responsibility" on the EQB				
4 – Payment Method	Select "Check" or "Zelle" from the drop-down list.				
	(This box only shows when "Parent/Guardian" is selected for "Who Do We Need to Send Payment To?")				
5 – Zelle Payment Information	Enter the phone number or email address associated with your Zelle				
	account. Note: If your Zelle payment does not go through a check will automatically be				
	mailed to you instead.				
	(This box only shows when "Parent/Guardian" is selected for "Who Do We Need to Send Payment To?")				
6 – Approved Grant Service	Select the "magnifying glass" to select the approved grant service you				
7 Additional Information	are requesting payment for.				
	payment request. (E.g., the provider's mailing address, if different from				
	the invoice address.)				

8 – Provider Invoice/Bill	Upload a detailed invoice showing the child's name, date(s) of service, provider information, service rendered, and billed amount.
9 – Explanation of Benefits (EOB) or Proof of Non- Coverage	Upload an <b>Explanation of Benefits (EOB)</b> from your insurance that shows the details of how they have processed the charges for EACH requested date of service, including the patient responsibility amount. Note: Letters from providers are not accepted. If you choose to go to an out of network provider or a provider that does not accept insurance, you are responsible for submitting to your insurance for an EOB to be obtained. If you do not have coverage for the service, upload <b>proof of non-</b> <b>coverage</b> . Note: This is a document from your insurance company that confirms no hepefite will be paid out for a service or product. It could be a conv of your
	benefit summary's exclusions list highlighting no coverage, a denial letter from your insurance company, or an Explanation of Benefits that shows no benefits are available.
10 – Proof of Payment	<ul> <li>Upload a receipt, provider invoice showing payment, front and back of <i>cashed</i> check, or your bank or credit card statement.</li> <li>(This only shows when "Parent/Guardian" is selected for "Who Do We Need to Send Payment To?")</li> </ul>
11 – Parent/Legal Guardian Attestation and Signature	Read and acknowledge the parent/legal guardian attestation. Enter your name in the Signature text box. Note: Providers, social workers, or other proxies ARE NOT PERMITTED to submit payment requests.
12 – Submit Payment Request	Select "Submit Payment Request" to submit. Upon successful submission of the application, the following pop up will appear.
	Important Notes: Once submitted, a Grant Manager will review your request within three to five business days. You will then receive an email approving, denying, or requesting additional information for your payment request. After approval, your payment will be issued within 14 business days