ANP
HEALTH SOLUTIONS

JPP Management of Negaunee, LLC
d/b/a ANP Health Solution Services
Community Advocacy Fund

Financial Assistance Guidelines

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1. The Purpose of the Community Advocacy Fund

JPP Management of Negaunee, LLC d/b/a ANP Health Solution Services is committed to assisting eligible applicants in the communities we serve and extending financial assistance for health advocacy services to those in need as outlined in this policy. The ANP Health Solution Services Community Advocacy Fund ("the Fund") exists to provide short-term financial assistance to eligible clients who are experiencing financial hardship that directly impacts their health, safety, or ability to access essential services. The Fund aims to promote equity, stability, and well-being within the communities served by ANP Health Solution Services. **The Community Advocacy Fund is made possible through the generous support of community sponsors and partners. ANP Health Solution Services is committed to being a responsible and ethical steward of these funds to ensure they are used effectively to assist as many individuals and families as possible.**

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2. Eligible Uses of Funds

Financial assistance is granted ONLY for *health advocacy or dual advocacy with limited clinical services* provided by the staff at ANP Health Solution Services

Funds may **not** be used for illegal activities, non-essential luxury items, or expenses unrelated to health, safety, or basic living needs.

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3. Eligibility Criteria

Applicants must meet **all** the following criteria to be considered for assistance:

1. **Client Status**
   - Applicants must be a current or recent client of ANP Health Solution Services AND be in good financial standing with ANP Health Solution Services

2. **Demonstrated Financial Need**
   - Applicants must demonstrate financial hardship, such as loss of income, medical expenses, housing instability, or other extenuating circumstances.
   - Submission of all documentation required

3. **Purpose Alignment**
   - The requested assistance must align with the mission and allowable use of the Community Advocacy Fund.

4. **Length of Assistance**
   - The Fund is intended for short-term or emergency assistance. However, the Community Advocacy Fund financial committee has the authority to grant exceptions on a case-by-case basis.

5. **Residency or Service Area**
   - Applicants must reside in or receive services within the geographic area served by ANP Health Solution Services. Exceptions will be made for applicants that are unable to make their own decisions, and their appointed legal representative resides outside of the geographic area served by ANP Health Solution Services.

6. **Compliance and Honesty**
   - Applicant must provide accurate and truthful information. Misrepresentation may result in denial or future ineligibility.
   - Applicants must communicate to ANP Health Solution Services any change in their financial situation that occurs while receiving services that may affect their eligibility status. Failure to do so may void any amount of financial assistance provided by ANP Health Solution Services Community Advocacy Fund and disqualify applicants from future financial assistance.

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4. Application Process

- Clients must complete a Community Advocacy Fund application
- Applications may be submitted directly by the client or with assistance from an ANP Health Solution Services staff member or case manager.
- Required documentation must be submitted with the application or within a specified timeframe.
- Incomplete applications may be delayed or denied.

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5. Determination and Review Process

1. Designated Review Committee

- Applications are reviewed by the Community Advocacy Fund Committee ("the Committee"), consisting of designated ANP Health Solution Services staff and/or leadership.
- Committee members must disclose any conflicts of interest and recuse themselves when necessary.

2. Evaluation Criteria

The Committee evaluates applications based on:

- Severity and urgency of need
- Complexity of health condition(s)
- Alignment with Fund purpose and eligible uses
- Availability of funds
- Applicant's current financial situation
- Prior assistance received (if applicable)
- Applicants that are active military, Veterans, law enforcement, first responders (fire, EMS, etc.), and meet the other eligibility criteria will automatically receive a minimum of $500 in assistance. Must show proof.

- Applicants with a gross Family Income at or below 250% of the current Federal Poverty Level are eligible for full financial assistance.
- Applicants whose gross Family Income is greater than 250% but less than or equal to 400% of the current Federal Poverty Level are eligible for partial financial assistance to apply toward ANP Health Solution Services and the applicant is responsible for the remaining fees. Payment plans are available.

3. Funding

- Our goal is to assist as many eligible applicants as possible to maximize the impact of our sponsor-supported resources. Therefore,
- Award amounts are determined based on individual applicant needs, urgency, and level of financial hardship based on the Federal Poverty Levels
- Eligible applicants may receive free or discounted health advocacy and liaison services provided by ANP Health Solution Services
- **Not all approved applicants will receive the same amount of financial assistance.**

4. Decision-Making

- Decisions are made by majority vote or consensus, as determined by Committee policy.
- The Committee will determine the dollar amount awarded to each applicant based on the Evaluation Criteria listed above.
- Applicants will be notified by phone and mail of the decision within a reasonable timeframe, typically within 14 business days, depending on urgency and volume of requests.

5. Receiving Services

- A **Community Advocacy Fund Financial Assistance Agreement** will be enclosed with an approval letter that must be signed and returned within 10 days to start receiving services and to avoid forfeiture of approved assistance. Failure to respond within 14 days from the date of the letter will result in forfeiture of funds. ANP Health Solution Services will make a diligent effort to contact the approved applicant by phone to avoid forfeiture.

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6. Distribution of Funds

- Clients will be required to sign an itemized attestation form that they did receive the services noted on the form by ANP Health Solution Services at the rate specified in the Payment Terms of the Financial Agreement. The form will include the dollar amount granted and line items of services received and the remaining balance of funds.
- Approved funds will be disbursed directly to ANP Health Solution Services when services have been rendered to the client by the staff at ANP Health Solution Services and the client's signature of attestation has been received by ANP Health Solution Services and submitted to the Committee and approved by the Committee for payment.
- Payments made by clients prior to application for Financial Assistance will be reviewed to determine if a refund should be processed.
- All disbursements are subject to internal financial controls and recordkeeping requirements.

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7. Transparency and Accountability

- ANP Health Solution Services is committed to transparency and accountability to both clients and community sponsors.

- Financial activity related to the Community Advocacy Fund will be tracked and documented.
- **Bank statements and financial summaries will be shared regularly on the ANP Health Solution Services website**, in accordance with privacy and compliance requirements.
- Sponsor contributions will be respected by ANP Health Solution Services and the Community Advocacy Fund financial committee and stewarded responsibly to ensure ethical use and sustained community impact.

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8. Appeals and Exceptions

- Decisions of the Committee are final.
- In rare or extraordinary circumstances, the Committee may make exceptions to these guidelines at its discretion, provided the decision aligns with the mission and legal requirements of ANP Health Solution Services.

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9. Confidentiality

- All client information and application materials are handled confidentially and used solely for the purpose of determining eligibility and administering the Fund.

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10. Policy Review and Amendments

- These guidelines may be reviewed and updated periodically by ANP Health Solution Services to ensure compliance with legal, ethical, and organizational standards.

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11. How to Apply

Applicants can apply by:

- downloading the financial assistance application on ANP Health Solution Services websites and mailing it to:
- Print or fill out electronic application on website and submit documents to:
    - Email:
    - Home Address:
- Call/email ANP Health Solution Services to request a copy of the application to print or in electronic format.

ANP
HEALTH SOLUTIONS
Advanced Nursing Professional

FINANCIAL ASSISTANCE APPLICATION

Instructions: Complete application and attach copies of all necessary documentation.

(complete fields below)

Applicant Name (First Middle Last)
Birth Date (mm-dd-yyyy)

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance

APPLICANT INFORMATION

Applicant Name (First Middle Last)			Birth Date (mm-dd-yyyy)
Address	City	State	Zip Code
Responsible Party Completing the application (if not the Applicant)		Relationship to the Applicant	
Household Annual Income (as reported on income tax filing)	Household size (applicant, spouse, and dependents as reported on income tax filing)		
Phone ☐	Medical Insurance Name and Policy Number		
Employment Status ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Unemployed ☐ Student ☐ Retired	Employer Name		
Employment Length	Unemployed Date/Length (mm-dd-yyyy)	Are you claimed on another tax return ☐ Yes ☐ No (If "Yes" provide tax return.)	

DEPENDENTS/FAMILY INFORMATION (if more than 6, use separate page)

All adult family members' income must be disclosed. Sources of income include, for example:

* Wages * Unemployment * Self-employment * Worker's compensation * Disability * SSI
* Child/spousal support * Work study programs (students) * Pension * Retirement account distributions
* Other (please explain_____)

Full Name (First Middle Last)	**Birth Date** (mm-dd-yyyy)	**Relationship**	**If 18 years and older:** Total gross monthly income (before taxes)
1.			
2.			
3.			
4.			
5.			
6.			

FINANCIAL ASSISTANCE APPLICATION (continued) **(**complete fields below)

Applicant Name (First Middle Last)
Birth Date (mm-dd-yyyy)

SPOUSE INFORMATION

Marital Status	
Name	Birth Date (mm-dd-yyyy)
Employment Status ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Unemployed ☐ Student ☐ Retired	Employer Name
Employment Length	Unemployed Date/Length (mm-dd-yyyy)

INCOME INFORMATION

REMEMBER: *You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. <u>All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written, signed statement describing your income. Please provide proof for every identified source of income. Examples of proof of income include:</u>

- A "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation

<u>Monthly Household Expenses:</u>

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (child support, loans, medications, other)

ASSET INFORMATION

This information may be used if your income is above 101% of the Federal Poverty Guideline

Current checking account balance $_____ Current savings account balance $_____	Does your family have these other assets? **<u>Please check all that apply:</u>** ☐ Stocks ☐ Bonds ☐ 401K ☐ Health Savings Account(s) ☐ Trust(s) ☐ Property (excluding primary residence) ☐ Own a business

FINANCIAL ASSISTANCE APPLICATION (continued) (complete fields below)

Applicant Name (First Middle Last)
Birth Date (mm-dd-yyyy)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

APPLICANT AGREEMENT

I certify that all information listed is true and correct to the best of my knowledge. I understand that information is to be used to ascertain my ability to pay for services provided by JPP Management of Negaunee, LLC d/b/a ANP Health Solution Services or an affiliated entity and I give permission to JPP Management of Negaunee, LLC d/b/a ANP Health Solution Services and all affiliated staff, members, and all others involved in determining eligibility to share the information as necessary to consider my financial assistance request. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided. I hereby grant permission to JPP Management of Negaunee, LLC d/b/a ANP Health Solution Services, all affiliates and representatives or agents to investigate the information contained herein.

Certification Signatures

Applicant or Responsible Party Signature	Date (mm-dd-yyyy)
Applicant or Responsible Party Printed Name (First Middle Last)	

CHECKLIST

NOTE: You only need to submit documentation that is applicable. The more documentation submitted will help with the determination process of granting financial assistance.

☐ W-2 withholding statement
☐ Current pay stubs (last 3 months)
☐ Last year's income tax return, including schedules if applicable
☐ Written, signed statements from employers or others
☐ Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
☐ Approval/denial of eligibility for unemployment compensation.
☐ Mortgage Statement or Rental Agreement
☐ Investment Portfolio Statement
☐ Worker's Compensation
☐ Disability/SSI
☐ Pension
☐ Social Security
☐ Child Support (Friend of the Court)
☐ Unemployment