



## PFIC Financial Assistance Program

The PFIC Financial Assistance Program is designed to help offset costs that may occur due to the burden of illness that PFIC can place on a family's daily life.

The cost of being a patient with a chronic illness can be consuming, even more so for a rare chronic illness. The need for financial assistance is essential to allow families to overcome these burdens.

Examples of Expenses that can be covered:

- Home: Rent/mortgage or Utilities (ex. electric, water, etc.)
- Vehicle: Car payments or car insurance
- Medical: Medical expenses not covered by insurance (including genetic testing, vitamin supplementation and travel expenses related to doctor's appointments))
- Education: Tuition payment, books, tutor payments, etc.

The Financial Assistance Program will accept applications from any person who is currently receiving treatment for PFIC, as well as any parent, guardian or caregiver of a child who is currently receiving treatment for PFIC. Additionally, applications will be accepted from a dependent of a person who is currently receiving treatment for PFIC. The amount of financial assistance granted will depend on severity of need and available funds at time of application. Awards will not exceed \$1000 USD.

The PFIC Network will accept applications throughout the year. Applications can be submitted at any time, but will be evaluated on a monthly basis. Applicants will be notified of application status- "approved" or "reapply"- by the 15<sup>th</sup> of the month following the application submission. (For example: an application received in March will hear of status by April 15). Please note, due to partnership constraints and compliance with country specific regulations, an application that is submitted from outside of the United States may take up to an additional 60 days before approval of funds.

To apply for financial assistance, the applicant must have:

- A completed Financial Assistance Program Application
- A confirmed PFIC diagnosis, confirmed by physician or casework on hospital/clinic letterhead; or Medical Eligibility form completed by a physician  
*(\*\*May substitute this requirement by providing public social media page or*



*CaringBridge page sharing information about PFIC diagnosis and/or journey at the decision and discretion of the PFIC Network Executive Director\*\*)*

- A signed Waiver (See Program “Terms and Conditions”)
- An explanation of specific financial need

Additional information regarding application process:

- A detailed description of need is highly recommended, as it will be used to determine level of need among applicants.
- You may apply as many times as needed throughout the year. However, a family will be awarded assistance a maximum of one (1) time per calendar year.
- The PFIC Network will ONLY make payments to third party service providers, not directly to the applicant. (For example: A request is made for assistance for an electric bill. If approved, PFIC will make payment directly to the electric company).
- For International Applicants, for tax compliance and legal reasons, funds cannot be awarded from PFIC Network directly and will instead be awarded to a partner organization or a PFIC Network affiliate who has a contract in place to release the funds.
- The third-party bill(s) MUST be provided, if approved, before any assistance will be granted .
- Assistance cannot be used for emergency services, including utility cut-off notices.
- Final approval of financial assistance is determined on a case-by-case basis by the PFIC Network Board of Directors.

**PFIC Financial Assistance Application Form**  
**If you need assistance in filling out this form, please contact us**  
**Please email completed form to [emily@pfic.org](mailto:emily@pfic.org)**

**Patient Information**

Patient's name: \_\_\_\_\_

Age: \_\_\_\_\_

Parent/Guardian (if patient is a minor): \_\_\_\_\_

**Applicant Information (if different than patient):**

Applicant name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**Physician Information (Provider for PFIC treatment)**

Hospital/clinic where treated: \_\_\_\_\_

Physician name: \_\_\_\_\_

Physician phone number: \_\_\_\_\_

**Applicant Address**

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip or Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_

Applicant Phone Number: \_\_\_\_\_

Applicant Email: \_\_\_\_\_



