

## REQUEST FOR ASSISTANCE

### INTRODUCTION

Louie's Kids is a national organization providing assistance to kids who are overweight or obese and whose family cannot meet the financial challenge.

The organization was established by the Yuhasz family to honor their father, Louis S. Yuhasz, Jr., who died in January 2001 from obesity-related complications.

Unfortunately, there is no magic wand that will make the weight disappear and good health return. And Louie's Kids can't do the hard work it takes to lose weight; the kids have to do that themselves. But we can provide kids some knowledge about what works for losing and controlling weight, and some tools to use to get the job done. All we ask in return is that kids and their families commit themselves to leading healthy, active lives.

### HOW WE CAN HELP

When you complete this Request for Assistance, we will assess the needs of the applicant and attempt to devise a plan of action. We'll likely enroll the applicant in an on-line and telephone counseling program. We may assign a volunteer mentor to the child to provide motivation and support throughout the process. Our assistance might include getting the child started with a gym or health club membership, or sessions with a dietician or nutrition counselor. If the child makes progress but needs more support, we can help with more intensive programs, like month-long summer camps.

### WHAT WE EXPECT OF THE KIDS

We expect that kids receiving assistance from Louie's Kids to fully participate and be open to change in their lives. Change in their weight won't come without changing the way they eat, so if they're picky eaters who won't touch anything but pizza, they're not going to succeed. Change in their weight won't happen without a lot of sweat, so if they're not willing to exercise, we can't help them. And if the kids think they can lose the weight in a few weeks, then go back to eating the way they were and not exercising, they are mistaken; controlling their weight needs to be a lifelong commitment.

### WHAT WE EXPECT OF THE PARENTS

The kids can't do this themselves. They are going to need the help of a parent every step of the way. It's the parent's role to make sure there are healthy foods for the kids to eat. It's the parent's role to help the kids set -- and meet goals. It's oftentimes the parent's role to play taxi-driver, making sure the kids get to the gym or to an appointment with a nutritionist. Most of all, it's the parent's role to provide the support and encouragement the kids will need to make a big change in their lives.

## WHAT WE NEED

First things first: let's get the paperwork done. Then we'll fix the combination of "fixes" that fits the needs of the kid. Here's what we need:

1. Completed Application including student and parent signatures. Fax to 800-457-7497.
2. Child's personal statement (about 200 words). How can we help you? How does your weight currently effect your life? Are you committed to doing what it takes to change things?
3. Parent or guardian's statement (about 200 words). How will your child benefit from these programs? Can you provide the support the child will need to be successful?
4. Two recommendations. You may ask teachers, adult relatives outside the immediate family, or other adult members of the community. These must be submitted with the application.
5. Confidential statement from the child's primary care physician, family practitioner, or pediatrician recommending the need for a weight loss program to improve the health and well being of the child applying for assistance, **along with verified height and weight. *The statement from the child's doctor should also detail ANY AND ALL medications being prescribed for the child. Your child's most current weight must be clearly written on the Doctor's confidential statement. Many Doctor's office scales do not exceed 350 lbs. The actual weight of your son/daughter is required and without this information the application will be considered incomplete.***
6. Copies of the parent(s)' tax return for the most recent year, to verify financial need.
7. A signed release under the Health Insurance Portability and Accountability Act. A release form follows the application page.

**REQUEST FOR ASSISTANCE**Child's Name: \_\_\_\_\_ Gender:  Male  Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent or Legal Guardian's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

 I have read and understood that these programs require complete participation and sometimes intense physical activity. I have read and understood that these programs provide a healthy diet designed by nutritionists who specialize in childhood obesity issues. I understand that my child will be expected to eat new, and healthy meals as part of these programs. I/We hereby release, waive, indemnify and hold Louis' Kids, Inc., and all of its officers, trustees, directors, employees, and agents (hereinafter jointly referred to as "indemnatee") harmless from any and all claims, causes of action, suits, liability, losses, or damages for any property damage, property loss or theft, personal injury, death or other loss arising from or relating to the acceptance and use of the services of the Louie's Kids, Inc. I understand that Louie's Kids, Inc. does not carry participant insurance and that I will be solely responsible for any medical, health or personal injury costs relating to my use of the services of the Louie's Kids, Inc. I have been encouraged to have a medical physical examination and purchase health insurance prior to any and all participation. I/We authorize Louie's Kids to take and utilize the name, voice, photographs and/or videotapes or audiotapes of the child during the Program, without any compensation to Parent or the Child. Parent understands and agrees that these photographs and tapes of Child's acts, poses, plays, faces, person, likeness and appearance of any and all kinds and/or recording of voices may be used in preparing promotional literature or publicity and tapes for Louie's Kids in any medium. Parent waives his or her and Child's rights of publicity in connection therewith.

Child's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only:

 Completed Application with Signatures  Child's Statement  Parent's Statement  
 Two Recommendations  Physician's statement  Copies of Parent(s)' W2 Form

Date Completed Application Package was Received: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF APPLICANT'S PROTECTED HEALTH INFORMATION**

(Valid Authorization Under 45 CFR Chapter 164)

**Statement of Intent:** It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits use, disclosure or release of my health information (or, sometimes herein, "protected medical information"). I am signing this Authorization because it is crucial that my health care providers readily use, release or disclose my protected medical information to, or as directed by, that person or those persons designated in this Authorization to allow them to discuss with, and obtain advice from, others or to facilitate decisions regarding my health care when I otherwise may not be able to do so without regard to whether any health care provider has certified in writing that I am incompetent for purposes of HIPAA:

**1. Appointment of Authorized Recipient**

I, ????, an individual, hereby appoint ???? as Authorized Recipient for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

**2. Grant of Authority**

Therefore, I authorize a health care provider (a "covered entity" as defined by HIPAA) to use, release and disclose my individually identifiable health information in accordance with and as authorized by 45 CFR Sec(s). 164.502(a)(1)(i) and (iv), 164.502(a)(2)(i), 164.524 and 164.528.

I specifically authorize:

- a. All covered persons and entities as defined in HIPAA, including but not limited to doctors (including but not limited to physicians, podiatrists, chiropractors, or osteopaths), psychiatrists, psychologists, dentists, therapists, nurses, hospitals, clinics, pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, medical insurance companies or any other health care providers or affiliates;
- b. to use, release and disclose any of my protected medical information, including but not limited to, reports and/or records concerning my medical and psychiatric history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization for access to, disclosure and release of ANY protected medical information by or to the persons named in this Authorization as if each person were me;
- c. to, or as requested by, the Authorized Recipient.

### **3. Termination**

This Authorization is not affected by, and shall not terminate by reason of, my subsequent disability or incapacity. This Authorization shall terminate on ??? or earlier upon my written revocation expressly referring to this Authorization and the date it is actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. Such revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it.

### **4. Re-disclosure**

By signing this Authorization, I acknowledge that the information used, disclosed or released pursuant to this Authorization may be subject to re-disclosure by the Authorized Recipient whose name is written in paragraph 1 of this Authorization and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require the Authorized Recipient to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this Authorization.

### **5. Instructions to the Authorized Recipient**

The Authorized Recipient shall have the right to bring a legal action in any applicable forum against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, the Authorized Recipient is authorized to sign any documents that the Authorized Recipient deems appropriate to obtain use, disclosure or release of the protected medical information.

### **6. Effect of Duplicate Originals or Copies**

If this Authorization has been executed in multiple counterparts, each counterpart original will have equal force and effect. The Authorized Recipient may make photocopies (photocopies shall include: facsimiles and digital or other reproductions, hereafter referred to collectively as "photocopy") of this Authorization and each photocopy will have the same force and effect as the original.

### **7. My Waiver and Release**

With regard to information disclosed pursuant to this Authorization, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation. In addition, I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from the use or disclosure of my protected medical information in reliance upon this Authorization and for any actions taken by the Authorized Recipient.

### **8. Severability**

I intend that this authorization conform to United States and ???(South Carolina?) law. In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

I understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization and that any revocation of this authorization must be in writing.

