Love for Louisville Old National Bank Survivors Fund
3 things to do before you start your Category B or C application

1. Decide how you want to be paid

A. There is absolutely no restriction on where the funds go or how they are used. You can be paid by check or Zelle. Our preferred method of payment is Zelle, which will directly deposit funds into your account and does not require us to have your account information. If you use Zelle, ask your bank if they place any limit on incoming Zelle transfers.
B. However, if you receive public benefits, please see the section below to consider the impact. We **recommend** that you work with a certified financial planner so the money can do whatever you want it to do.

2. Consider your Public Benefits

Do you receive any of the following public benefits?

- Public Assistance/Cash Assistance/TANF
- SNAP/Food Stamps
- Medicaid/MAGI
- SSI/Disability
- SSD/Disability
- Veterans Benefits
- Rental Assistance/Shelter
- Section 8 Housing
- Public Housing/BMHA/HUD/rapid rehousing/SPOA
- Medicare/Medicare Part D

If you answer "yes" to any of the above, when the government learns about the gift you receive, it could possibly impact your ability to continue to receive these public benefits. Receiving public benefits will not have any impact whatsoever on the size of the gift that you receive from the fund. We also want to ensure that any gift you receive from the fund does not jeopardize your public benefits. If you receive public benefits, you will be directed to speak with an attorney who will look at your specific situation and benefits and offer you legal advice on what you can do to protect your public benefits.

The attorney may advise you that the gift you receive will have no impact on your benefits. Or the attorney may recommend the creation of a "special needs trust" so your gift does not disqualify you from any of your public benefits. It is always **your choice** how to proceed, but we want you to make an informed choice as to what option is best for you, so you do not have any unexpected consequences. If we are paying to a trust or a minor custodial account, we must issue that individual payment by check.

3. Complete your other required documents

A. **If you were injured and are applying under Category B or C**, you will need to complete the HIPAA authorization which authorizes your medical provider to validate your treatment with us. This release only authorizes the release of information related to medical treatment and hospitalization; it is not in any way related to medical expenses.

B. **Have a photo of the front and back of a government-issued photo identification.**

Authorization for Release of Protected Health Information

Authorization for Use and Disclosure of Protected Health Information
Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PLEASE NOTE THAT THIS FORM MUST BE CO-SIGNED BY A WITNESS

This form gives your healthcare providers written authorization to release certain health information, as designated below, to the persons named in section 2.

CLAIMANT Information																	
First Name										**MI**		**Last Name**					
Date of Birth												**Last 4 digits of SSN**					
		/			/												

1. I hereby authorize all medical service sources and health care providers to disclose the limited protected health information (''PHI'') described below to the Fund Administrators and their agents of the Love for Louisville Old National Bank Survivors Fund, National Compassion Fund for the purpose of consideration for obtaining a financial gift from the Love for Louisville Old National Bank Survivors Fund.

2. I hereby authorize the release of my PHI, as designated below, from my healthcare providers to the specific entities listed in (5) below, to be used solely by the Love for Louisville Old National Bank Survivors Fund authorized representatives.

3. **I authorize only the release of my protected health information confirming my treatment for injuries arising from the shootings on April 10, 2023, and the dates of my treatment / hospitalization.**

4. I do not authorize the release of Behavioral and Mental Health Service Information, referrals and treatment for alcohol and substance use disorder, Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

5. The following specific entities may receive disclosures of protected health information about me:

   Fund Administrator
   c/o National Compassion Fund
   1450 Duke St Alexandria, VA 22314
   ONB@NationalCompassion.org

   Or its agent:
   Venable, LLP

6. This authorization of the release of my PHI covers the period: from April 10, 2023, to August 15, 2023.

7. This authorization shall be in force and in effect until October 1, 2023, at which time this authorization expires.

8. I understand that this authorization is voluntary and that I have the right to revoke this authorization, in writing, at any time by notifying the Fund Administrator at the address shown above, or by contacting my health care providers individually. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand information released pursuant to this authorization may no longer be protected by HIPAA privacy regulations and may be subject to re-disclosure by the recipient.

9. I understand treatment, payment, enrollment or eligibility for benefits by my healthcare providers is not conditioned on whether I sign this authorization.

Signature of patient: _____ Date: _____
(If patient either is under legal age of has a guardian appointed by the court, this authorization must be signed by the patient's parent or guardian.)

Signature of Parent/Guardian: _____ Date: _____

Printed Name of Parent/Guardian: _____

Relationship to Patient: _____

Si necesita ayuda para llenar este formulario, por favor envíe un mensaje electrónico a ONB@NationalCompassion.org