Instructions

Brief description of the Fund: Columbia Health makes available on an as-needed basis up to $750 to students who are unable to afford or, for other compelling reasons (e.g., related to concerns about confidentiality), choose not to avail themselves of benefits available to them through their health insurance. These funds are available exclusively to Full Time and Part Time students currently enrolled in degree-seeking programs in a Columbia School on the Morningside Campus who have paid the Health and Related Services fee. This policy does not apply to student enrolled at Columbia University Medical Center schools and programs, Barnard College, or to the Affiliates (Teachers College, Union Theological Seminary and Jewish Theological Seminary). These funds are intended exclusively to help defray expenses for specific urgent, time-sensitive and necessary healthcare-related services and treatments, examples of which include, but are not limited to, Elective Termination of Pregnancy, Emergency Care, Outpatient Substance Abuse Treatment, and Attentional Disorders and Learning Disabilities. This fund is not intended to defray expenses related to premium, deductibles, co-pays and co-insurance; nor will it be used to defray expenses associated with failure to access health insurance benefits appropriately (e.g., failing to request a specialist referral in a timely fashion).

Submission: Applications may be submitted to the Administrative Coordinator to the Associate Vice President, Columbia Health, 102 Wallach Hall, MC4201, 1116 Amsterdam Avenue, New York, New York 10027 or by fax to the same office at (212) 854-3654.

Application Review: Applications will be reviewed on a rolling basis by the Special Healthcare Needs Fund Committee and all decisions are final. Students will be informed of the Committee's decision as soon as possible and, in most circumstances, within three (3) business days following submission of their application.

All applications will be maintained in strict confidence in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Application

Please return this form to the Administrative Coordinator to the Associate Vice President, Columbia Health, 102 Wallach Hall, MC4201, 1116 Amsterdam Avenue, New York, New York 10027 or by fax to (212) 854-3654.

Applicant Name:	**Submission Date:**

UNI:	**Date of Birth: (for identification purposes only)**	**Health Insurance Plan:**

School:	**Program and Anticipated Degree:**

Cell Phone Number:	**University Email Address:**

Local Address: (for identification purposes only)

Brief Description of Need (Description must include a. specific name of healthcare-related service for which funds are being requested; b. date service will be obtained; c. name and address of healthcare professional where services will be obtained; d. reason(s) funds are being requested):

Applicant Signature_____ **Date**_____

FOR OFFICE USE ONLY
Date Received: _____ **Approved**____ **Denied**____
Date Notification Sent:_____ **Committee Member Initials**_____