

## **Frequently Asked Questions**

### **1. What needs to be included with my application?**

There are four pieces to your application. The application page, financial information, release of information and the physician's statement of medical necessity. Each form needs to be completed by the appropriate person and returned to NDAD. If you are requesting a piece of equipment or modifications to your home, two independent bids need to accompany the application. A copy of your most recent federal income tax return, along with any schedules or attachments needs to be included with your application.

It is vital to fill out the application completely as NDAD staff may note other types of services that could potentially qualify for assistance. Staff may also know of other referral sources for the request.

### **2. How long does it take to process my application?**

Once the *completed* application is received, it takes approximately 3-5 days for a response. If there are follow-up questions or missing information, it may take several days longer. NDAD cannot process an application without all necessary forms and information.

### **3. What types of services does NDAD provide?**

If you qualify and the request is within NDAD guidelines, NDAD provides direct financial assistance for personal attendant care expenses, prescription medications, out of town medical travel, home accessibility and durable medical equipment needs. NDAD offers information, advocacy and referral services. NDAD sponsors wheelchair athletics, including the Wallbangers wheelchair basketball team and the annual Escape to the Lake event that gives individuals with physical disabilities the opportunity to waterski.

### **4. What is a client contribution?**

Based on your income, you may have a client contribution to meet before you qualify for services. A client contribution is a dollar amount that you must show NDAD that you have paid towards out of pocket medical expenses within one year of your application date. Examples of medical expenses that you can count are hospital and clinic payments, pharmacy payments, travel expenses for medical appointments out of town, medical equipment purchases, etc. Insurance premiums and nursing home fees do not count towards this amount. NDAD will require proof of payments in the form of canceled checks, copies of clinic, pharmacy or hospital payments, and receipts of payment of other medically related expenses.

**5. Who is eligible for services?**

Anyone with a health challenge is eligible to apply. However, you must qualify with NDAD before you are approved. NDAD is a “last resort” agency, meaning that all other avenues must be exhausted before NDAD may consider your request. In other words, if you are eligible for Medicaid, Medicare, have private insurance or other options, we will request that you have denials from these places before NDAD considers your request. NDAD encourages anyone to apply. NDAD has information and referral for many individual requests.

**6. What if my request is denied?**

Unfortunately, NDAD cannot grant every request. Funds are limited and/or requests are outside NDAD guidelines for assistance. However, NDAD staff will do their best to find an appropriate referral.

**7. How can I get in touch with you?**

NDAD has offices in Grand Forks (main office), Fargo, Minot, Bismarck and Williston. Please contact our Grand Forks office for detailed information. (1-800-532-NDAD) or visit our website at [www.ndad.org](http://www.ndad.org).

**8. What is NDAD Community Fundraising?**

It is a fundraiser put on by friends and family of a person(s) with a disability for which NDAD acts as custodian of the funds raised. These funds can be used to help the person with urgent needs and expenses. The funds may also be used beyond the scope of NDAD’s guidelines, such as helping with doctor, clinic or hospital bills and/or used to pay pre-existing bills. The benefits for using NDAD include:

- NDAD is a 501 (c)(3) charitable organization. Any funds donated to NDAD will qualify for a charitable donation and be deductible for donors who itemize.
- NDAD is an established, reputable organization, which makes individuals more likely to donate.
- NDAD provides marketing and consulting expertise to help community volunteers with fundraising ideas. NDAD personnel will create and/or copy posters, letters or any other advertising items necessary for fundraisers.
- NDAD tracks the funds raised and expenses paid. The client, family member or representative can bring in the donation and NDAD will provide the necessary accounting functions.
- Approved bills are submitted to NDAD and will be paid with donated funds. This can be a great relief to individuals in dealing with an overwhelming situation. It is also convenient for clients if they are at medical facilities for long periods of time.

- NDAD offers this service free of charge. One hundred percent of funds raised will be spent on client needs.

**9. Will NDAD pay for outstanding medical bills or equipment purchases?**

**NDAD will not pay for any prior existing bills. This includes hospital and clinic bills, durable medical equipment, dental bills, etc. Anything that is purchased prior to approval through NDAD is considered outside NDAD guidelines. Additionally, NDAD will not pay for hospital, clinic or dental bills at any time unless the individual has participated in a community fundraiser with NDAD and these items were listed on the fund drive agreement.**



**NDAD**  
helping others to help themselves

2660 South Columbia RD  
Grand Forks, ND 58201  
(701) 775-5577  
1-800-532-NDAD

# APPLICATION FOR ASSISTANCE

Date \_\_\_\_\_

## APPLICANT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle Month Day Year

Address \_\_\_\_\_ County \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employed By \_\_\_\_\_ Work Phone \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employed By \_\_\_\_\_ Work Phone \_\_\_\_\_

State the Nature of Applicant's Disability: \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Pharmacy \_\_\_\_\_ Phone Number \_\_\_\_\_

Describe the type of assistance you are requesting and give a cost estimate, if known. If more than one item is requested, please prioritize: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION (if applicable)

Father \_\_\_\_\_ Employed By \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ (Reside in Applicant's Home?) \_\_\_ Yes \_\_\_ No

Mother \_\_\_\_\_ Employed By \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ (Reside in Applicant's Home?) \_\_\_ Yes \_\_\_ No

List all Dependent Children or others living in applicant's home:

Name	Birthdate	Disabled?	Name	Birthdate	Disabled?
1. _____			4. _____		
2. _____			5. _____		
3. _____			6. _____		

Check the Agencies & Financial Programs listed below that the Applicant has contacted. List the status of applications using **A**(applied) **D**(denied) **R**(receiving) **NA**(not applicable).

- |                             |  |                          |
|-----------------------------|--|--------------------------|
| _____ Community Action      | _____ Temporary Assistance                       | _____ Veterans Benefits  |
| _____ Medicare              | _____ for Needy Families                         | _____ Home Health Income |
| _____ Family Subsidy        | _____ State Children's Health                    | _____ Housing Assistance |
| _____ Medical Assistance    | _____ Insurance Program                          | _____ Food Stamps        |
| _____ Homemaker Services    | _____ Vocational Rehabilitation                  | _____ Pension            |
| _____ Indian Health Service | _____ Fuel Assistance                            | _____ Other              |
| _____ Legal Assistance      | _____ Mental Health Case Management              |                          |
| _____ General Assistance    | _____ Developmental Disabilities Case Management |                          |

**PLEASE COMPLETE REVERSE SIDE**

List Agencies you have applied to for this request.

1. \_\_\_\_\_ Decision \_\_\_\_\_ Reason \_\_\_\_\_ Phone \_\_\_\_\_  
2. \_\_\_\_\_ Decision \_\_\_\_\_ Reason \_\_\_\_\_ Phone \_\_\_\_\_

**If you have received denials from these Agencies, we will need a copy of the denial letter.**

If Applicant is a Veteran, did he/she actively serve during war time? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is there a pending/final lawsuit as a result of Applicant's Disability? \_\_\_\_\_ Yes \_\_\_\_\_ No

Was the Disability work-related? \_\_\_\_\_ Yes \_\_\_\_\_ No Have you filed for Worker's Compensation? \_\_\_\_\_ Yes \_\_\_\_\_ No

Status of Claim (Pending, Approved or Denied) \_\_\_\_\_

Is any person in the household other than the Applicant receiving Social Security Benefits? \_\_\_\_\_ Yes \_\_\_\_\_ No

Name \_\_\_\_\_ Type of Benefit \_\_\_\_\_

Name \_\_\_\_\_ Type of Benefit \_\_\_\_\_

Are you receiving Medicare \_\_\_\_\_ Yes \_\_\_\_\_ No Part A, B or Both \_\_\_\_\_

If Applicant is receiving Medical Assistance (Medicaid):

Case Worker's Name \_\_\_\_\_ Recipient Liability \$ \_\_\_\_\_

If you were denied Medical Assistance, what was the reason for denial? \_\_\_\_\_

Is the Applicant covered under Health Insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No Type of Policy \_\_\_\_\_

Company \_\_\_\_\_

Do you have any other Insurance Policies? \_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, please state the company \_\_\_\_\_

Did any Agency/Person refer you to NDAD? \_\_\_\_\_ Yes \_\_\_\_\_ No Agency/Person \_\_\_\_\_

May we contact \_\_\_\_\_ Yes \_\_\_\_\_ No Phone \_\_\_\_\_

If your request is of high cost or you need assistance on a long term basis, would you like information on NDAD sponsoring a community fund raiser? \_\_\_\_\_ Yes \_\_\_\_\_ No

The North Dakota Association for the Disabled, Inc. \_\_\_\_\_ may \_\_\_\_\_ may not use applicant's name, photograph, or information concerning medical condition in publicizing its assistance efforts.

## IMPORTANT INFORMATION

In addition to the above information, we request a complete signed copy of the Applicant's most recent Federal Tax Return, including any schedules. If the Applicant is a minor, is living in the parent or guardian's home or is being supported by the parent or guardian, we request a complete signed copy of the income tax return from the parent or guardian. If both the Applicant and the parent/guardian filed a return, please send a complete signed copy of both. If neither were required to file a return, please inform us.

Have there been any fundraising events in your behalf? If so, please enter donation total and expenditures.

In order to be considered for assistance you will also need to send a doctor's diagnosis and recommendation for any equipment or services you are requesting.

**Your application cannot be processed without tax information and doctor's recommendation.**

Applicant must be a United States Citizen.

I hereby declare that the information given on this application is true to the best of my knowledge. I give NDAD my permission to verify.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



**NDAD** 2660 South Columbia RD  
Grand Forks, ND 58201  
*helping others to help themselves* (701) 775-5577

**FINANCIAL INFORMATION**

Please remit the following information along with a COMPLETE SIGNED COPY OF YOUR MOST RECENT TAX RETURN.

**FAMILY INCOME**

<b>WHO MAKES INCOME</b>	<b>FROM WHERE</b>	<b>MONTHLY INCOME</b>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

(Income Sources including but not limited to: Employers, Social Security, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), TANF, Retirement Payments, Pensions, Unemployment Benefits, Workman’s Compensation, Food Stamps, Housing & Heating Supplements, Daycare/ Caregiver Supplements, Dividends from Investments, Lawsuit Settlement Payments, Other Family Benefits and Income from Others Living in Your Home.)

**FAMILY ASSETS**

<b>NAME OF BANK:</b> _____	<b>ACCOUNTS HELD</b> _____	<b>BALANCE (AS OF THIS DATE)</b> _____
	_____	_____
	_____	_____
	_____	_____

**INVESTMENTS (TOTAL VALUE AS OF TODAY):**

<b>CD</b> \$ _____	<b>MUTUAL FUNDS</b> \$ _____
<b>BONDS</b> \$ _____	<b>STOCKS</b> \$ _____
<b>TRUSTS</b> \$ _____	<b>OTHER</b> \$ _____

**RETIREMENT ACCOUNTS:**

<b>NAME ON ACCOUNT</b> _____	<b>BALANCE (AS OF TODAY)</b> \$ _____
_____	\$ _____
_____	\$ _____

**OTHER ACCOUNTS:**

<b>NAME ON ACCOUNT</b> _____	<b>BALANCE (AS OF TODAY)</b> \$ _____
_____	\$ _____
_____	\$ _____

**OTHER ASSETS**

**ESTIMATED TRUE VALUE**

RENTAL PROPERTY \$ _____	CAR \$ _____
LAND \$ _____	OTHER \$ _____
SECOND HOME \$ _____	
BUSINESS \$ _____	

**PLEASE COMPLETE REVERSE SIDE**

**FAMILY DEBT**

**BALANCE OF LOAN AS OF THIS DATE**

SECOND HOME LOAN BALANCE \$ \_\_\_\_\_

LAND DEBT \$ \_\_\_\_\_

BUSINESS DEBT \$ \_\_\_\_\_

RENTAL PROPERTY DEBT \$ \_\_\_\_\_

OTHER DEBT \$ \_\_\_\_\_ EXPLAIN \_\_\_\_\_

\$ \_\_\_\_\_ EXPLAIN \_\_\_\_\_

\$ \_\_\_\_\_ EXPLAIN \_\_\_\_\_

**Is there anything else you would like to tell us about your medical needs?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I CERTIFY THAT ALL INFORMATION LISTED HERE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THE INFORMATION GIVEN IS TO BE USED TO DETERMINE MY ELIGIBILITY TO RECEIVE SERVICES FROM NDAD. I HEREBY GRANT MY PERMISSION TO NDAD TO INVESTIGATE THE INFORMATION HEREIN.**

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



**NDAD**

*helping others to help themselves*

**2660 SOUTH COLUMBIA RD**

**GRAND FORKS, ND 58201**

**PHONE: (701)775-5577**

**FAX: (701)795-6630**

**PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY**

This form is for the purpose of defining a client's need to receive assistance from NDAD. **This form must be filled out by a medical professional and signed by your physician.** Please fill out this form as completely as possible. The information you provide will assist NDAD in determining the medical necessity of a client's request. Please mail to above address or fax it to the above number when completed. If you contact us, we will fax this to your physician for you.

PATIENT'S NAME	D.O.B	PHONE
ADDRESS	CITY	STATE ZIP CODE

TO BE COMPLETED BY PHYSICIAN: Fill out all sections applicable. Indicate N/A if not applicable.

DIAGNOSIS/PROGNOSIS/ DURATION OF NEED:

MEDICATIONS/EQUIPMENT/OTHER PRESCRIBED(please include dosage, quantity & purpose):

MEDICAL TRAVEL REQUIRED:

NAME OF FACILITY: \_\_\_\_\_

DATE OF APPOINTMENT \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

REMARKS & COMMENTS AS TO NECESSITY OF CLIENT REQUEST:

PHYSICIAN'S SIGNATURE

DATE SIGNED

CLINIC OR HOSPITAL

TELEPHONE NO.



# AUTHORIZATION FOR RELEASE OF INFORMATION

**NDAD** 2660 South Columbia Rd  
Grand Forks, ND 58201

*helping others to help themselves*

## **SECTION 1**

INSTRUCTIONS: Please complete Section 1. Section 2 will be completed by NDAD as needed. Sign and date Section 3.

Name of Client (Last, First, Middle Initial)	Birthdate		
Street Address	City	State	Zip Code

## **SECTION 2**

### **CLIENT RELEASE AND SIGNATURE**

1. I Hereby Authorize: (Name and Address of Person / Agency)
2. To Release Information To: (Name and Address of Person / Agency to Receive Information)
3. The Following Information Is Requested: (Be Specific)
4. The Information Identified Above Will Be Used For Determining Eligibility for NDAD Services.
5. This release of information consent remains in effect until \_\_\_\_\_  
(Date)  
or \_\_\_\_\_  
(Specific Event Terminating Operation of the Release)

### **SECTION 3**

#### **CLIENT CONSENT:**

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality. A photography of this release is as effective as the original. This release of information is reciprocal. This means that information can be shared between the two parties mentioned above.

Signature of Client	Date
Signature of Parent / Guardian or Custodian (If Needed)	Date
Signature of Witness (If Needed)	Date