APPLICATION FOR ASSISTANCE
INSTRUCTION SHEET

INFORMATION AND INSTRUCTIONS

Please read before filling out the application.

What types of services does NDAD provide?
If you qualify and the request is within NDAD guidelines, NDAD provides direct financial assistance for prescription medications, durable medical equipment and supplies, out-of-town medical travel expenses, personal attendant care expenses, home and vehicle accessibility, dial-a-ride/paratransit fees, and adaptive recreational activities. NDAD also provides information and referral services.

Who is eligible for services?
Anyone with a disability/medical condition and is a permanent resident of ND (or bordering community in a surrounding state) 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, or have private insurance or other options, we will need denials from these entities before NDAD considers your request. NDAD encourages anyone to apply. NDAD has information and referral for many individual requests.

How do I apply for assistance?
There are two pieces to your application - Application (side 1 and 2) and Release of Information. Each form needs to be completed and returned to NDAD. 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. Please note: by providing your email address you are giving NDAD permission to add you to our mailing list. Sharing your email is optional and will not have any impact on qualifying for services.

What needs to be included with my application?
Along with the Application and Release of Information, NDAD requires documentation of household income. A complete, signed copy of your most recent federal income tax return, along with schedules or attachments, needs to be included with your application. If you are not required to file a federal income tax return, then provide a social security yearly benefit statement, year-end pay stub or W-2, unemployment benefit statement, or other form of household income documentation. No bank statements, please.

NDAD uses a multi-agency Release of Information to obtain specific information from your physician, pharmacist, case worker, family member, etc. regarding your medical care/other needs. To complete the Release of Information, please fill in names and addresses of those persons and agencies you authorize to exchange your medical/other information and sign and date the release.

If you are requesting a piece of equipment, please provide two independent bids along with the application. If you are requesting out-of- town medical travel, include verification of appointment and lodging reservation.

How long does the application process take?
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 longer. NDAD cannot process an application without all necessary forms and information.

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 household medical expenses within one year of your application date. Examples of medical expenses that you may count are hospital and clinic payments, pharmacy payments, vision expenses, dental expenses, travel expenses for medical appointments out of town, medical equipment purchases, etc. Insurance premiums, nursing home fees, and over-the-counter items do not count towards this amount. NDAD will require proof of payments that the items were paid for in the form of itemized printouts or receipts. Please contact your hospital/clinic, pharmacy, optometrist, dentist, etc. to obtain these documents. If you have medical travel expenses, include verification of the appointment days and times from the medical facilities. No hand written or self-prepared receipts, please.

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.

What is NDAD Community Fundraising?
It is a fundraiser put on by friends and family of a person(s) with a disability/health challenge 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. 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 staff will create and/or copy posters, letters or 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.

Will NDAD pay for pre-existing 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.

How can I get in touch with you?
NDAD has offices in Grand Forks (1-800-532-6323), Fargo (1-888-363-6323),
Minot (1-888-999-6323), and Williston (1-877-777-6323)
For more detailed information, visit our website at www.ndad.org.

NDAD
helping others to help themselves

2660 S. Columbia Rd
Grand Forks, ND 58201
phone: (701) 775-5577
toll free: (800) 532-NDAD
fax: (701) 795-6630

APPLICATION FOR ASSISTANCE

Date_____

- APPLICANT INFORMATION -

Name_____ Birthdate_____
Last First M.I. Month Day Year

Address_____ Apt._____

City_____ State_____ Zip _____ Home Phone _____

Gender_____ Email_____ Cell Phone _____

RACE: ☐ Caucasian ☐ Black ☐ American Indian ☐ Other ☐ Hawaiian/Pacific Islander ☐ Asian	Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name_____ Birthdate_____Cell Phone _____

Are you a United States Citizen? ☐ Yes ☐ No Are you a Permanent Resident? ☐ Yes ☐ No

What is the applicant's disability/medical condition?_____

What assistance is being requested? _____

Name of Local Physician for this request_____ Phone # _____

Name of Physician's Clinic_____ Phone # _____

Name of Pharmacy_____ Phone # _____

List agencies you have applied to for this request.

1._____Decision _____Reason_____ Phone_____

2._____Decision _____Reason_____ Phone_____

Are you a Veteran? ☐ 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_____

Are you receiving Medicare? ☐ Yes ☐ No Part A, B, D, or N/A _____

Are you receiving Medicaid? ☐ Yes ☐ No

Medicaid Case Worker's Name_____ Recipient Liability $_____

If you were denied Medicaid, what was the reason for denial?_____

Are you covered under Health Insurance? ☐ Yes ☐ No Company_____

Did any Agency/Person refer you to NDAD? ☐ Yes ☐ No Agency/Person_____

May we contact? ☐ Yes ☐ No | Phone _____

How did you hear about NDAD?_____

Has any fundraising been done on your behalf? If yes, when?_____ What is the balance? _____

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

NDAD ☐ may ☐ may not use applicant's name, photograph, or information concerning medical condition in publicizing its assistance efforts.

PLEASE COMPLETE REVERSE SIDE

PARENT/GUARDIAN INFORMATION (if applicant is a minor)

Father_____Birthdate_____Phone_____

Address_____(If other than applicant's)

Mother_____Birthdate_____Phone_____

Address_____(If other than applicant's)

HOUSEHOLD MEMBERS (List all dependent children, and ALL OTHER PERSONS living in your home, including those not related to you).

NAME	DATE OF BIRTH	DISABLED?	RELATIONSHIP TO APPLICANT
1			
2			
3			
4			
5			
6			

- FINANCIAL INFORMATION -

Along with the application, we require verification of household income. Please include all income for all members of the household.

Do you file federal income tax returns?

☐ **Yes** - Please submit a COMPLETE SIGNED COPY OF YOUR MOST RECENT FEDERAL TAX RETURN, INCLUDING ALL SCHEDULES AND ATTACHMENTS

☐ **No** - If you are not required to file federal income taxes, please submit a social security yearly benefit statement, year-end pay stub or W-2, unemployment benefit statement, or other form of income documentation

HOUSEHOLD INCOME

WHO MAKES INCOME	INCOME SOURCE	GROSS MONTHLY INCOME
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

(Income Sources including but not limited to: Employers, Self-Employment, Social Security, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), TANF, Retirement Payments, Pensions, Unemployment Benefits, Workman's Compensation, Daycare/Caregiver Supplements, Dividends from Investments, Child Support, Lawsuit Settlement Payments, Other Family Benefits and Income from Others Living in Your Home).

- FAMILY ASSETS -	
Checking Balance: $	Savings Balance: $
Total value of investments in CDs, bonds, trusts, mutual funds, stocks, IRA, 401K, other: $	
Land Value (not including your primary residence): $	

_____ _____ _____

Signature Parent/Guardian Date

NDAD
helping others to help themselves

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Grand Forks, ND 58201
phone: (701) 775-5577
toll free: (800) 532-NDAD
fax: (701) 795-6630

MULTI-AGENCY AUTHORIZATION TO DISCLOSE INFORMATION

INSTRUCTIONS: Please complete Section 1 & Section 2. Sign and date Section 3.

- SECTION 1 -

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

- SECTION 2 -

NDAD requires specific information to process your application for assistance. The information will be released to NDAD. Please fill out the agencies/persons and check the appropriate box(es) to authorize the exchange of information with clinics, hospitals, pharmacies, social services, family members, etc. Check all boxes that apply.

Name of Agency/Person_________________________
Street Address ______________________________
City________________State______ Zip__________

To disclose & exchange the following information between the dates of:____________to____________

- ☐ Verification of Treatments/Services
- ☐ Medical Diagnosis
- ☐ Prescription Medications
- ☐ Financial Information for NDAD Application
- ☐ Other______________________________
- ☐ Other______________________________

Name of Agency/Person_________________________
Street Address ______________________________
City________________State______ Zip__________

To disclose & exchange the following information between the dates of:____________to____________

- ☐ Verification of Treatments/Services
- ☐ Medical Diagnosis
- ☐ Prescription Medications
- ☐ Financial Information for NDAD Application
- ☐ Other______________________________
- ☐ Other______________________________

Name of Agency/Person_________________________
Street Address ______________________________
City________________State______ Zip__________

To disclose & exchange the following information between the dates of:____________to____________

- ☐ Verification of Treatments/Services
- ☐ Medical Diagnosis
- ☐ Prescription Medications
- ☐ Financial Information for NDAD Application
- ☐ Other______________________________
- ☐ Other______________________________

Name of Agency/Person_________________________
Street Address ______________________________
City________________State______ Zip__________

To disclose & exchange the following information between the dates of:____________to____________

- ☐ Verification of Treatments/Services
- ☐ Medical Diagnosis
- ☐ Prescription Medications
- ☐ Financial Information for NDAD Application
- ☐ Other______________________________
- ☐ Other______________________________

- SECTION 3 -

The information identified above will be used for determining my eligibility for NDAD services. Signing this authorization is voluntary. I have the right to revoke this authorization at any time by writing to the agency. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. I understand that my eligibility for services will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied services in some circumstances if I do not sign this consent. My information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by privacy laws. A photograph of this release is as effective as the original. This authorization is reciprocal, meaning my information can be shared between the parties mentioned above in any form or medium, including oral, written, or electronic means.

This authorization lasts for **one year** after the date signed unless a different expiration date is specified here:________________________

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

Have you:

- ✓ **Filled out the application for assistance completely?**
- ✓ **Signed and dated your application for assistance?**
- ✓ **Filled out Sections 1 and 2 and signed and dated Section 3 on the Release of Information?**
- ✓ **Included a complete, signed copy of your most recent federal tax return, including all schedules and attachments?**
- ✓ **If taxes aren't filed, please include verification of your total household income.** This may include copies of social security award letters, social security yearly benefit statements, year-end pay stubs or W-2's, unemployment benefit statements or other forms of income documentation