Frequently Asked Questions

1. **What needs to be included with my application?**
   There are two pieces to your application - the Application page and the Release of Information. Each form needs to be completed 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 applicaton?**
   Once the *completed* application and necessary documents are 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 and vehicle accessibility and durable medical equipment needs. NDAD offers information, advocacy and referral services. NDAD sponsors wheelchair athletics, including recreational basketball 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 and Williston. Please contact our Grand Forks office for detailed information. (1-800-532-NDAD) or visit our website at www.ndad.org. Contact the nearest office to your location for assistance:
   Grand Forks: 701-775-5577
   Fargo: 701-281-8215
   Minot: 701-838-8414
   Williston: 701-774-0741

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 S. Columbia Rd
Grand Forks, ND 58201
phone: (701) 775-5577
toll free: (800) 532-NDAD
fax: (877) 795-6630

APPLICATION FOR ASSISTANCE

Date_____

APPLICANT INFORMATION

Name_____Birthdate_____
Last First M.I. Month Day Year

Address_____County_____ Home Phone_____

City_____State_____Zip_____ Cell Phone_____ Work Phone_____

Gender_____ | Ethnicity (optional): ☐ African American ☐ Caucasion ☐ Hispanic ☐ Indian
☐ Middle Eastern ☐ Multi-Racial ☐ Native American ☐ Pacific Asian or Asian

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

Spouse's Name_____ Birthdate_____Cell Phone_____

Email _____

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

What is the applicant's disability?_____

What assistance is being requested?_____

Name of Physician for this request_____ Phone Number _____

Name of Physician's Clinic_____ Phone Number _____

Name of Pharmacy_____ Phone Number _____

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 or Both _____

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?_____

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)

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

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

FINANCIAL INFORMATION

Please remit the following information along with a
COMPLETE SIGNED COPY OF YOUR MOST RECENT FEDERAL TAX RETURN.
(If you are not required to file federal income taxes, please note this. Provide a social security yearly benefit statement, year-end pay stub or W-2, unemployment benefit statement or other form of income documentation).

FAMILY INCOME

WHO MAKES INCOME	INCOME SOURCE	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, 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

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AUTHORIZATION FOR RELEASE OF INFORMATION

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. This release of information consent remains in effect until _____(Date)

or_____
(Specific event terminating operation of the release)

SECTION 3

CLIENT CONSENT:

The information identified above will be used for determining eligibility for NDAD Services.
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