Application for the Direct Financial Assistance Program
- Information & Instructions -

The Direct Financial Assistance Program funds specific disability/medical items and services for people with mental and physical disabilities and chronic health conditions. Individuals must apply and qualify per NDAD guidelines to receive assistance.

As a charity, NDAD is a last resort funding source, meaning, all other financial options must be exhausted before NDAD will consider your request. If you are eligible for Medicaid, Medicaid Expansion, Medicare, patient assistance programs, private health insurance, or other entities, you must try these entities first.

Eligibility Guidelines

- You have a disability or chronic medical condition
- You are a United States citizen OR a permanent, legal resident of the United States
- You are a North Dakota resident OR a resident of an adjacent state living in a border town (MN – East Grand Forks, Moorhead, and Breckenridge only; SD – Lemmon only)
- Your request is a covered item or service
- Your request is not covered by another funding source
- You meet the client contribution*

  *Based on your income, you may have a client contribution to meet. A client contribution is a dollar amount that you must show NDAD that you paid towards out-of-pocket household medical expenses to qualify. If this applies to you, an NDAD Client Services Representative will contact you.

Covered Items & Services (some restrictions apply)

- Adaptive recreational activities
- Durable medical equipment
- Home modification
- Medical supplies
- Out of town medical travel expenses
- Paratransit fees (does not include city bus)
- Personal attendant care/respite care expenses
- Prescription medications
- Vehicle accessibility

Noncovered Items & Services (including but not limited to)

- Clinic and hospital bills
- Dental and vision expenses
- Emergency assistance
- Health insurance premiums
- Medicaid Cost Share (Recipient Liability)
- Medical items & services acquired before applying to NDAD
- Non-disability or non-medical items
- Reimbursement of medical bills

How to Apply

1. Complete Sections 1 – 6 of the application forms

   Please note: by providing your email you give permission for NDAD to send you correspondence about your application and emails about NDAD services. Your email will not be shared with third parties. Sharing your email is optional and will not have any impact on qualifying for services.

2. Complete Sections A, B, & C of the Multi-Agency Authorization to Disclose Information form.
3. Include a copy of your current health insurance card(s) – front and back.
4. Include two price quotes from two different durable medical equipment retailers for requests of medical equipment, home modification, and vehicle accessibility.
5. Include appointment schedule for out of town medical travel requests.
6. Include a copy of your green card (if you are a permanent, legal resident of the U.S.).

SUBMIT ALL FORMS, PROOF OF HOUSEHOLD INCOME, & APPLICABLE DOCUMENTS TO THE OFFICE ON THE APPLICATION.

Once NDAD receives your complete application, processing will be begin. If requested information is missing, processing your application will be delayed.

You will be notified if your request is approved or denied. Payment of item/service is sent directly to the vendor.

NDAD cannot grant every request. Funds are limited or request is outside NDAD guidelines. If your request is denied, NDAD staff will do their best to find an appropriate referral. NDAD has information and referral sources for many individual requests.

If your request is of high cost or you need assistance long term, NDAD would like to help you with a community fundraiser. **A generous match is provided!**

NDAD Community Fundraisers are 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.

This service offers benefits in several ways. NDAD is a 501(c)(3) charitable organization, meaning funds donated to NDAD may be deductible for donors who itemize on their taxes.

Donations directly to an individual may cause that person to lose eligibility for various public assistance programs that are based on income. With NDAD as fund custodian, eligibility for public programs should be protected.

NDAD also helps to provide marketing and consulting expertise for fundraisers, which may include creation and copying of posters and letters and sharing information on social media.

The community fundraiser service is offered free of charge by NDAD. All funds raised are spent on the client's needs.

If you have questions, please contact the Client Services Representative at the office on the application.

4642 Amber Valley Parkway S, Fargo ND 58104
Phone: 701-281-8215 | Fax: 701-281-8216
fargo@ndad.org

DIRECT FINANCIAL ASSISTANCE APPLICATION

SECTION 1 – APPLICANT'S INFORMATION				
Name (Last, First):			DOB:	Gender:
Permanent Street Address:			Apt.	City:
State:	Zip:	County:	Home Phone:	
Email:			Cell Phone:	

Complete this section if applicant is a minor.

Mom's Name:	*DOB:*	*Phone:*
Address:		
Dad's Name:	*DOB:*	*Phone:*
Address:		

Race: ☐ White ☐ Black/African American ☐ American Indian/African Native ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Other	Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Are you a U.S. citizen? ☐ Yes ☐ **No** **If No, a copy of your green card is <u>required</u> proving permanent, legal residency of the U.S.**	
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed	
Name of Spouse/Partner:	DOB: Phone:

Describe your disability/medical condition:		
Have you had an organ transplant? ☐ Yes ☐ No	Applied to NDAD before? ☐ Yes ☐ No	
What are you requesting from NDAD? ☐ adaptive recreational activities ☐ durable medical equipment ☐ home modification ☐ medical supplies ☐ out of town medical travel - gas card ☐ out of town medical travel - hotel ☐ paratransit ☐ personal attendant care ☐ prescription medications ☐ respite care ☐ vehicle accessibility Explain request (if needed):		
Name of local physician for request:		Phone:
Physician's clinic/hospital:		City:
Pharmacy:		Phone:

List other agencies you have applied to for this request and submit denial notifications.

Name:	*Decision:*	*Reason:*	*Phone:*
Name:	*Decision:*	*Reason:*	*Phone:*

Are you a veteran? ☐ Yes ☐ No	Do you receive veteran's benefits? ☐ Yes ☐ No ☐ NA
Is your disability/medical condition work related? ☐ Yes ☐ No What is the status of your Workforce Safety Insurance claim? ☐ Approved ☐ Denied ☐ Pending ☐ NA	

How did you hear about NDAD? ☐ word of mouth ☐ agency ☐ brochure/advertisement ☐ event ☐ social media ☐ search engine, i.e., Google ☐ other:
May we contact your referral source? ☐ **Yes** ☐ No **If Yes, include the person's contact information on the Multi-Agency Authorization to Disclose Information form.**
Has any fundraising been done on your behalf? ☐ Yes ☐ No If yes, what is the balance? $
Do you give permission for NDAD to utilize your name, photo, and medical information in publicizing its assistance efforts? ☐ Yes ☐ No

What type of health insurance do you have? **Provide front & back copy of your insurance card(s).**

☐ Medicaid ~ What is your Cost Share (Recipient Liability) $ Please contact your county human service zone for the dollar amount.	☐ Medicaid Expansion
If denied Medicaid, why? ☐ over income limit ☐ other, explain:	
☐ VA/Military ☐ Private Insurance-what company?	☐ None
☐ Medicare ~ ☐ Part A ☐ Part B ☐ Part D ☐ Part C/Medicare Advantage ☐ Extra Help	

SECTION 2 – HOUSEHOLD MEMBERS

Do you live alone? ☐ Yes ☐ **No** **If No, complete this section. List dependent children and all other persons living with you including those not related to you. Do not include yourself.**

Name of Household Member	DOB	Relationship to Applicant	Has a disability?	Does person receive Social Security benefits? If yes, what type?

SECTION 3 – HOUSEHOLD MEMBER'S INCOME

Name of Person Making Income	Income Source	Gross Monthly Income (before deductions)
		$
		$
		$
		$
		$
		$

SECTION 4 – PROOF OF HOUSEHOLD INCOME

DO YOU FILE FEDERAL INCOME TAX RETURNS? #1 ☐ YES #2 ☐ NO

#1 Submit a **complete copy of your most recent federal income tax return with schedules and attachments.** Submit spouse's return if you file separately.

#2 Submit **official documents from Income Sources you listed in Section 3.** NDAD will accept Form SSA-1099 or award letters for Social Security Benefits, W-2/Year-End-Paystub/1099 for Employee Wages, Form 1099-R for Retirement/Pension, Form 1099-DIV for Investment Dividends, Form 1099-G for Unemployment Compensation, or other documentation of payments from Workforce Safety Insurance, Short-Term/Long-Term Disability, Temporary Assistance for Needy Families (TANF), Child Support, Alimony, Lawsuit Settlements, Bureau of Indian Affairs, Veterans Affairs, Childcare Supplements, other Household Benefits and Income. No bank statements accepted.

SECTION 5 – HOUSEHOLD ASSETS

Do you have checking accounts? ☐ Yes ☐ No If yes, what are the balances? $

Do you have savings accounts? ☐ Yes ☐ No If yes, what are the balances? $

Do you own investments (401K, IRA, Stocks, Bonds, Mutual Funds, Trusts, Life Insurance, Other)?
☐ Yes ☐ No If yes, what is the total balance for all investments? $

Do you own land (not including your primary residence)? ☐ Yes ☐ No
If yes, what is the taxable land value? $ County location(s):

SECTION 6

Signature of Applicant:	Date:
Signature of Parent/Guardian:	Date:

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fargo@ndad.org

MULTI-AGENCY AUTHORIZATION TO DISCLOSE INFORMATION

Instructions: Complete Sections A and B. Sign & Date Section C.

Section A

Name (Last, First)			DOB	
Street Address	Apt.	City	State	Zip Code

Section B – NDAD requires specific information to process your application. Provide your physician, pharmacy, social worker, family member, referral source, or other entities that you authorize sharing this information with NDAD. Check the boxes for materials to be disclosed.

Physician/Facility_____
Street Address _____
City _____ State ____ Zip _____
Phone _____ Email _____

To disclose/exchange information between dates:
_____/_____/_____ to _____/_____/_____

☐ Verification of Treatments/Services
☐ Medical Diagnosis
☐ Prescribed Medications/Supplies/Equipment
☐ Financial Information for NDAD Application
☐ Other _____

Pharmacy _____
Street Address _____
City _____ State ____ Zip _____
Phone _____ Email _____

To disclose/exchange information between dates:
_____/_____/_____ to _____/_____/_____

☐ Verification of Treatments/Services
☐ Medical Diagnosis
☐ Prescribed Medications/Supplies/Equipment
☐ Financial Information for NDAD Application
☐ `Other_____

Person or Agency_____
Street Address _____
City _____ State ____ Zip _____
Phone _____ Email _____

To disclose/exchange information between dates:
_____/_____/_____ to _____/_____/_____

☐ Verification of Treatments/Services
☐ Medical Diagnosis
☐ Prescribed Medications/Supplies/Equipment
☐ Financial Information for NDAD Application
☐ Other _____

Person or Agency_____
Street Address _____
City _____ State ____ Zip _____
Phone _____ Email _____

To disclose/exchange information between dates:
_____/_____/_____ to _____/_____/_____

☐ Verification of Treatments/Services
☐ Medical Diagnosis
☐ Prescribed Medications/Supplies/Equipment
☐ Financial Information for NDAD Application
☐ Other _____

Section C

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 *(sign in ink)*		Date
Signature of Parent/Guardian/Custodian/Power of Attorney *(if needed) (sign in ink)*		Date
Signature of Witness *(if needed) (sign in ink)*	Relationship	Date

Have you:

- ✓ Filled out the application for assistance completely?
- ✓ Signed and dated your application for assistance?
- ✓ Filled out Sections A and B, signed and dated Section C of the Multi-Agency Authorization to Disclose Information form?
- ✓ Included a complete, signed copy of your most recent federal tax return, including schedules and attachments?
- ✓ If taxes aren't filed, include verification of your household income. This may include copies of social security yearly benefit statements (form SSA-1099) or monthly award letters, W-2's/year-end pay stubs/1099's for wages, unemployment compensation benefits, or other income documents. (Refer to Section 4 of the application).