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 may be 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.

Go to **ndad.org** for more information.

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

1808 20th Ave SE, Minot ND 58701
Phone: 701-838-8414 | Fax: 701-838-8425
minot@ndad.org

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helping others to help themselves

DIRECT FINANCIAL ASSISTANCE APPLICATION

SECTION 1 – APPLICANT'S INFORMATION (person needing assistance)

Last Name: _____ First Name: _____

DOB: _____ Gender: _____ Email: _____

Permanent Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: _____

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

Spouse/Partner Name: _____ DOB: _____ Phone: _____

Describe your disability/medical condition: _____

Have you applied to NDAD before? ☐ Yes ☐ No

Are you a U.S. Citizen? ☐ Yes ☐ No If no, a copy of your green card is required.

Complete this section if applicant is a minor or has a legal guardian.

Parent/Guardian Last & First Name: _____
DOB: _____ *Phone:* _____
Address: _____ *Relationship:*_____

Parent/Guardian Last & First Name: _____
DOB: _____ *Phone:* _____
Address: _____ *Relationship:*_____

What type of financial assistance are you requesting from NDAD? ☐ prescription medications
☐ medical supplies ☐ durable medical equipment ☐ respite or personal attendant care
☐ paratransit ☐ home modification ☐ vehicle accessibility ☐ adaptive recreational activities
☐ out-of-town medical travel (gas card) ☐ out-of-town medical travel (hotel)

Explain request: _____

Name of local physician for request(s): _____ Phone: _____
Physician's clinic/hospital: _____ City: _____
Pharmacy: _____ 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 Is there a claim? ☐ Yes ☐ No

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/agency contact details 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 $ _____

SECTION 2: INSURANCE INFORMATION

What type of health insurance do you have? **Provide front and back copy of your insurance card(s).**
☐ Medicaid (cost share? $_____) ☐ Medicaid Expansion
☐ Private Insurance – what company? _____ ☐ VA/Military
☐ Medicare (☐ Part A ☐ Part B ☐ Part C ☐ Part D ☐ Extra Help) ☐ None

SECTION 3 – HOUSEHOLD MEMBERS

Do you live alone? ☐ Yes ☐ No
List dependent children and all other persons living with you including persons not related to you.

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

SECTION 4 – PROOF OF HOUSEHOLD INCOME

Proof of household income is required to process your application!

If you are legally required to file federal income tax returns, **submit a complete copy of your most recent federal income tax return with schedules and attachments. Submit spouse's return if you file separately.**

If you are not legally required to file federal income tax returns, **submit official documents from any/all income sources. 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.

Please fill out the following:

Name of Income Earner	Income Source	Gross Monthly Income (before deductions)
		$
		$
		$
		$
		$

SECTION 5 – HOUSEHOLD ASSETS

Do you have checking account(s)? ☐ Yes ☐ No If yes, what are the total balances? $ _____

Do you have savings account(s)? ☐ Yes ☐ No If yes, what are the total balances? $ _____

Do you own investments such as 401K, IRA, Stocks, Bonds, Mutual Funds, Trusts, Life Insurance? ☐ Yes ☐ No
If yes, what is the total balance of the investments? $ _____

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

Demographics:

Race: ☐ White ☐ Black/African American ☐ American Indian/African Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

I certify that the information provided is true and complete to the best of my knowledge. I understand that providing false or misleading information may result in denial of assistance.

SECTION 6 – SIGNATURE

Signature of applicant: _____ Date: _____

Signature of parent/guardian: _____ 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 **(located on next page)**?
- ✓ 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).

⚠ ATTENTION
This application continues on the next page.

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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 to share 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