- INFORMATION & INSTRUCTION SHEET -
DIRECT FINANCIAL ASSISTANCE APPLICATION

NDAD is a charitable organization with programs for people with disabilities and health challenges. The Direct Financial Assistance Program funds disability/medical items and services. As a charity, NDAD is a last resort funding source, meaning, all other financial options must be exhausted before NDAD will consider your request. Individuals must apply and qualify per NDAD guidelines to receive assistance.

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
- ✓ 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
- ✓ Home modification
- ✓ Medical equipment
- ✓ Medical supplies
- ✓ Out of town medical travel expenses
- ✓ Paratransit fees
- ✓ 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 Recipient Liability
- ✓ Non-disability or non-medical items
- ✓ Pre-existing bills (bills acquired before applying to NDAD)

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 emails about equipment, newsletters, and other updates. 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, and C of the Multi-Agency Authorization to Disclose Information form
3. If requesting medical equipment, medical supplies, home modification, or vehicle accessibility, please include two price quotes from two different durable medical equipment retailers

4. If requesting out of town medical travel expenses, please include appointment schedule from the medical facility
5. If you are eligible for Medicaid, Medicaid Expansion, Medicare, patient assistance programs, private health insurance, or other options, include denials from these entities.
6. Include a copy of your green card (if you are a permanent, legal resident of the U.S.)

Submit all forms, household income verification, and applicable documents to the office on the application.

Once NDAD receives your complete application, it takes approximately 5-7 business days for processing. If requested information is missing, processing your application may take longer.

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.

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.

The 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.

1012 S 12th St Suite A, Bismarck ND 58504
Phone: 701-751-0739 | Fax: 701-751-0860
bismarck@ndad.org

NDAD
helping others to help themselves

DIRECT FINANCIAL ASSISTANCE APPLICATION

SECTION 1 – APPLICANT'S INFORMATION				
Name:			DOB:	Gender:
Street Address:			Apt:	City:
State:	Zip:	County:		Home Phone:
Cell Phone:		Email:		

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, are you a permanent, legal resident of the U.S.? ☐ Yes ☐ No ☐ NA If yes, include a copy of your green card.
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed	
Name of Spouse/Partner:	DOB: Phone:

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

List other agencies you have applied to for this request.

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:		
Who referred you to NDAD?		May we contact? ☐ Yes ☐ No
Name:	Phone:	Email:
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? Mark all that apply.

☐ Medicaid What is your Recipient Liability? $ /month		☐ Medicaid Expansion
Medicaid Case Worker:	Phone:	
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.

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

SECTION 3 – HOUSEHOLD INCOME

Name of Person Making Income	Income Source	Gross Monthly Income
		$
		$
		$
		$
		$
		$

SECTION 4 – HOUSEHOLD INCOME DOCUMENTS REQUIRED

DO YOU FILE FEDERAL INCOME TAX RETURNS? ☐ YES ☐ NO

If you mark **YES,** NDAD requires a **complete copy of your most recent federal income tax return with schedules and attachments.** Include spouse's complete return if you file separately.

If you mark **NO**, NDAD requires **recent documents from Income Sources listed in Section 3.** NDAD will accept Form SSA-1099 for Social Security Benefits or Social Security award letters, 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 a checking account? ☐ Yes ☐ No If yes, what is the balance? $
Do you have a savings account? ☐ Yes ☐ No If yes, what is the balance? $
Do you own investments (401K, IRA, Stocks, Bonds, Mutual Funds, Trusts, Life Insurance, Other)? ☐ Yes ☐ No If yes, what is the balance? $
Do you own land (not including your primary residence)? ☐ Yes ☐ No If yes, what is the land value? $ County location:

SECTION 6

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

1012 S 12th St Suite A, Bismarck ND 58504
Phone: 701-751-0739 | Fax: 701-751-0860
bismarck@ndad.org

MULTI-AGENCY AUTHORIZATION TO DISCLOSE INFORMATION

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

Section A

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

Section B

NDAD requires specific information to process your application. Provide your physician, pharmacy, case worker, family member, and other entities that you authorize sharing this information with NDAD. Check boxes for materials to be disclosed.

Facility/Physician _____
Street Address _____
City _____ State ____ Zip _____

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

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

Pharmacy _____
Street Address _____
City _____ State ____ Zip _____

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

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

Agency/Person _____
Street Address _____
City _____ State ____ Zip _____

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

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

Agency/Person _____
Street Address _____
City _____ State ____ Zip _____

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

☐ Verification of Treatments/Services
☐ Medical Diagnosis
☐ Prescription Medications
☐ 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	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 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).