LEND A HAND UP – Eligibility Guidelines for Boost Funding, Online Giving and Other Resources

Resources awarded to qualifying campaigns based on medical diagnosis, financial challenges and fundraising activities. Applications reviewed weekly. Funding is prioritized for individual/families burdened by substantial hardship.

Timelines & Award Criteria

Funding: Lend A Hand Up will award a $100 boost for every $500 raised, up to a $5,000 total boost per family. For Example: $500 raised becomes $600, $5,000 raised becomes $6,000 and $25,000 becomes $30,000. A boost cap of $1,000 per donor applies ($5,000 gift). Boost awards do not apply to amounts deposited into the benefit fund by recipient, household members or anyone that would financially gain from the fundraising campaign.

- **Online Campaign:** Applications for boost funding and other resources may be submitted at any time. If approved, Boost Funding is awarded based on online gifts made through lendahandup.org, effective upon approval date (90-day maximum campaign). Gifts raised through other sites or by cash/check are not eligible.

- **Benefit/Events:** Applications for boost funding and other resources must be submitted at least 30 days in advance of a scheduled benefit/community event. (Event must be open to the public). If approved, Boost Funding is awarded based on online gifts made through lendahandup.org, as well as cash and check gifts deposited into an established benefit fund. (Applicable upon formal approval date for a 90-day campaign.) Gifts raised on other online sites are not eligible for boost funding awards.

Note: A public benefit may be added to an online campaign as long as information is received/approved before the end of the 90 day online campaign and at least 30 days prior to benefit. Contact Lend A Hand Up.

**In follow-up to a 90-day campaign, recipient/families are not eligible for additional funding for at least 1 year.**

Eligibility Checklist

☐ An online fundraising campaign and/or benefit is planned to help an individual residing in Cass County, ND or Clay County, MN for 1+ yrs. who has substantial expenses due to a life-threatening or incapacitating health issue.

☐ If hosting a community benefit or other event open to the public for the primary purpose of raising help for an individual/family in medical crisis, there is time to submit an application at least 30 days before the event.

☐ A fundraising team of at least three people has been formed with a champion willing to; coordinate submission of an application to Lend A Hand UP, serve as a passionate leader and facilitate communication between recipient, volunteers and Lend A Hand UP staff. Champion should NOT live in the same household as recipient.

☐ Two community members (fundraising champion and another individual) are willing to endorse the campaign with an email, note or letter verifying how and why they plan to promote and/or support the campaign.

☐ A benefit fund with a checking account is established at a bank/credit union located in Cass or Clay County, with at least two title signers; one being the recipient/family and one being the fundraising champion (or other key volunteer who doesn’t live with recipient. See Section 1B.) All gifts raised through the campaign must be directed to this benefit fund. Learn more about setting up a benefit fund: [www.lendahandup.org](http://www.lendahandup.org) Host a fundraiser, Step 2.

If Lend A Hand Up support is approved:

☐ Volunteers must be willing to include Lend A Hand Up logo(s), website address and boost grant amounts on flyers, posts and promo items to build awareness of fundraising activities. (Logos will be shared upon approval).

☐ Recipient (or their parent/guardian) must confirm that they approve of fundraising activities and will privately share donation data as necessary to validate boost funding amounts.

Both parts of the application, along with two letters of endorsement and requested attachments, may be dropped off, emailed, mailed or faxed to the program office. If hosting a benefit, 30 days prior to event.

Lend A Hand Up, DMF Building, 4141 28 Ave S, Fargo, North Dakota 58104

◊ Tele: (701) 356-2661 ◊ Fax: (701) 271-0408 ◊ Email: jeanapeinovich@dakmed.org ◊ Learn more: [www.lendahandup.org](http://www.lendahandup.org)

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Did you know Lend A Hand Up has a fundraising “How to” Step by Step Guide? Check it out at lendahandup.org
LEND A HAND UP APPLICATION – APPLY FOR BOOST FUNDING

PART 1 – Information about Fundraising Campaign
To be completed by the Fundraising Champion. Please type or print!

Section 1A Fundraising Champion. Must be someone who does not live in the same household as the recipient
Name __________________________ Email (required) __________________________
Street Address __________________________ City, State, Zip __________________________
Resident of: □ Cass Co ___ # yrs; or □ Clay Co ___ # yrs. Cell __________________________ Home/Other __________________________
Name of Employer __________________________ Work Phone __________________________
How do you know the recipient? __________________________ How long have you known him/her? __________________________
☐ Attach/forward: copy of a driver’s license or other document verifying current residency of fundraising champion.
☐ Attach/forward: A letter/note/email from the fundraising champion listed above, as well as a separate letter/note/email from
one or both of the individuals listed in Section 1B summarizing how and why they will promote and support this fundraising
campaign. If representing a business, church, nonprofit, service club or other group, please include this information.

Section 1B – Please include Information for two community members willing to promote/support this fundraising campaign
Name __________________________ Email __________________________
Phone __________________________ Address __________________________
How do they know the recipient? __________________________ How do they know the recipient? __________________________

Section 1C Benefit Fund. Confirm that a benefit fund is established at a local bank/credit union with two authorized signers;
including the recipient (or a family member) and a volunteer listed in 1A or 1B who doesn’t live with the recipient.
Fund Name: __________________________ Type of Account: □ Checking (preferred) □ Savings __________________________
Bank Name: __________________________ Bank Address: __________________________
Signer 1 Name __________________________ If not Recipient, how are they related: __________________________
Signer 2 Name __________________________ How does this person know recipient: __________________________
☐ Attach/forward: copy of benefit fund signature card verifying fund name, signers and bank. May cross out personal ID #s.

Section 1D – Information about Fundraising Campaign Activities.

<table>
<thead>
<tr>
<th>Online Giving Campaign Information</th>
<th>(Optional) Benefit/Event Information*</th>
</tr>
</thead>
<tbody>
<tr>
<td>If approved, boost funding will be awarded based on online gifts made through lendahandup.org. (Gifts raised through other sites and cash/check gifts are not eligible for boost.)</td>
<td>If approved, boost funding will be awarded based on online gifts made through lendahandup.org as well as cash and check gifts deposited into the benefit fund at the bank.</td>
</tr>
<tr>
<td>Campaign Name __________________________</td>
<td>Day/Date of Event __________________________</td>
</tr>
<tr>
<td>Requested start date __________________________</td>
<td>Name of Facility __________________________</td>
</tr>
<tr>
<td>Key Contact __________________________</td>
<td>Time: __________________________</td>
</tr>
<tr>
<td>How do you plan to promote your campaign Facebook Twitter Email Blog Flyers __________________________</td>
<td>Fundraising activities B-fast/lunch/dinner Bake/Craft Sale Raffle __________________________</td>
</tr>
<tr>
<td>___Radio ___ TV ___Video ___Event ___Bulletin</td>
<td>___Silent/Online Auction ___Run/Walk/Bike ___Music</td>
</tr>
<tr>
<td>Other/Comments: __________________________</td>
<td>___Golf/Bowling ___Other: __________________________</td>
</tr>
</tbody>
</table>

* A public benefit may be added to an online campaign as long as information is received/approved before the end of the 90
day online campaign and at least 30 days prior to benefit. Contact the Lend A Hand Up office for more information.

Section 1E– Lend A Hand Up Referral Source
How did you learn about the Lend A Hand Up program? __________________________
Check your primary referral source(s):
___Prior experience ___Internet ___Brochure ___Newsletter ___Flyer ___TV ___Radio ___Event
___Newspaper/Magazine ___Friend/Family ___Bank ___Church/Nonprofit ___Medical Provider ___Other

Section 1F – Fundraising Champion Signature
Through my involvement, I understand that I may have access to medical and financial information, verbal and written, that I will treat
with utmost confidentiality and only discuss for the purpose of this application process and subsequent fundraising activities. If
funding is approved, I agree to; build awareness of program support, oversee communication between program staff, recipient and
volunteers and share documentation of fundraising results to validate funding. I extend assurance that all proceeds from this
fundraising effort will be deposited into the benefit fund established for this recipient to pay for medical and other expenses as noted
on this application. By signing below, I acknowledge that information in this application is accurate to the best of my knowledge.

Fundraising Champion Signature __________________________ Date: __________________________

In the unfortunate event of recipient death, generally, boost awards will be honored based on funds raised up to 7 days past date of death.

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Section 2A – Recipient. Share information about the child or adult experiencing life-threatening and/or incapacitating illness or injury that limits activities of daily living and has (or will) result in substantial out-of-pocket expenses of $5,000 or more.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age:</th>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City, State, Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resident of:</th>
<th>Cass Co ___ # yrs; or</th>
<th>Clay Co ___ # yrs.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email</th>
<th>Employer Name</th>
</tr>
</thead>
</table>

Names of other individuals living in the same household. If children, include their ages:

Section 2B. Medical Hardship.

Medical Diagnosis/Condition:

Date/timeframe of original diagnosis: 

Anticipated length of treatment: 

Health Insurance Carrier: 

Have you applied for Medicaid/Disability? Yes No

How have treatment and medical expenses created financial hardship. Summarize here or attach separate note.

Section 2C. Out of Pocket Expenses (NOT covered by insurance) related to medical care and treatment

Complete the table below identifying $5,000 or more of total billed and/or estimated out-of-pocket expenses related to medical care and/or rehabilitation for the individual named above. Only note amounts the individual/family is liable for such as medical bills and prescriptions not covered by insurance, monthly premium expenses, travel & lodging costs for out-of-area care (may include companion), etc.

NOTE: Billed and/or paid medical expenses may be determined by requesting report(s) from clinic/hospital/pharmacy. (Request a current balance and a self-paid total for the past 12 months.) Future out-of-pocket expenses may be estimated based on treatment plans, copays, deductibles, coinsurance, etc. Contact your insurance company and/or the business office of the clinic/hospital for assistance.

<table>
<thead>
<tr>
<th>Expense Categories</th>
<th>Out-of-Pocket Expenses Past 12 months-Current</th>
<th>Estimated Out-of-Pocket Upcoming 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Care: Provider, Lab, Radiology, Inpatient/Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Prescriptions/Medications/Equipment/Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Health Insurance – cost (if any) you pay to maintain coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your premium/liability expense per month x number of months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Travel/Gas - based on .25 cents/mile x number of miles x number trips</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Lodging/Food - If you receive medical care out-of-area, estimate costs based on $125/person or $200/family/companion x number of days there</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Out-of-Pocket Medical Expenses (add together lines 1-5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Optional) Non-Medical Expenses increasing financial hardship due to medical condition, lost wages. (Ex: mortgage/rent, food, daycare, auto)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Who is responsible for payment of listed out-of-pocket expenses?

Has this individual/family received prior funding from Lend A Hand/UP? No Yes, Date: 

Attach/forward copy of driver’s license or form verifying legal residency, name and age of recipient/parent/guardian

Attach/forward medical document: letter, report or treatment plan validating medical diagnosis/condition and provider

(Optional) Attach/forward report verifying total paid and/or billed for the past 12 months. Do NOT send multiple invoices.

Section 2D – Recipient Signature

I confirm information on this page to be accurate and verify that listed expenses create substantial financial hardship for myself and/or others responsible for payment. I give consent for Lend A Hand Up staff/committee to review information contained in this application for consideration of support. If approved, I give authorization for the use of my photo and information summarizing my medical crisis for fundraising purposes. I agree to privately share fundraising results to validate boost awards as outlined by the program’s eligibility guidelines and provide assurance that funding will be used to pay for expenses related to my medical care and rehabilitation.

Recipient Signature: Date: