APPLICATION FOR *LEND A HAND UP* BOOST FUNDING

To support a benefit and/or online fundraising campaign for a resident of Cass Co. (ND) or Clay Co. (MN) who is experiencing financial hardship due to a serious medical condition.

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

Resources are awarded to qualifying campaigns based on fundraising activities and current medical/financial challenges. Funding is prioritized for individual/families burdened by substantial hardship. Campaigns hosted to raise funds in memory of someone are generally not eligible for boost funding. Applications reviewed weekly.

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). Please do not publicize boost funding or use program logos until formal approval notice is given.

  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. Boost funding is calculated starting with the date the application is approved. 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 campaign and/or benefit is planned for an individual currently residing in Cass County, ND or Clay County, MN (1 yr or more) who has substantial expenses due to a life-threatening/incapacitating health issue.

□ If hosting a benefit or other community event to raise help for someone in medical crisis, the application must be submitted at least 30 days before the event. (Applications for online campaigns may be submitted any time).

□ 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 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 opportunities 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 (benefit fund statements) 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

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:	Name:
Email:	Email:
Phone:	Phone:
Address:	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, bank and signers info (may cross out personal I.D.)

Section 1D – Information about Fundraising Campaign Activities.

Online Giving Campaign Information	**(Optional) Benefit/Event Information***
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.)	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.
Campaign Name:	Day/Date of Event: Time:
Requested start date:	Name of Facility:
Key Contact:	Address:
How do you plan to promote your campaign: ___Facebook ___Twitter ___Email ___Blog ___Flyers ___Radio ___ TV ___Video ___Event ___Bulletin Other/Comments:	Fundraising activities: ___B-fast/lunch/dinner ___Bake/Craft Sale ___Raffle ___Silent/Online Auction ___Run/Walk/Bike ___ Music ___Golf/Bowling ___Other:

*A public benefit may be added to an approved 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. Please do not publicize until approval notice is given. 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 ___ Word of Mouth ___ Event ___ Internet ___ TV/Radio ___ Print/Media ___ 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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Part 2 – Information about Medical Hardship

To be completed by individual or parent/guardian who will receive proceeds from this campaign.

Section 2A – Recipient. Information about child or adult currently 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.

Name:	Age: Gender: ____Male ____Female
Street Address:	City, State, Zip:
Resident of: □ Cass Co ___ # yrs; or □ Clay Co ___ # yrs.	Cell: Home/Other:
Email:	Employer Name:
Names of other individuals living in the same household. If children, include their ages:	

Section 2B. Medical Hardship.

Diagnosis/Condition: _____	
Diagnosis Category: □ Cancer, □ Trauma, □ Preterm Birth/Defect, □ Nervous System, □ Transplant, □ Heart/Lung, □ Other	
Date/timeframe of original diagnosis:	Anticipated length of treatment:
Health Insurance: □ Private, □ Medical Assistance, □ None	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 a ***current balance*** and a ***self-paid total for the past 12 months*** from clinic/hospital/pharmacy. 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.

Expense Categories	***Out-of-Pocket Expenses Past 12 months-Current***	***Estimated Out-of-Pocket Upcoming 12 Months***
1. Medical Care: Provider, Lab, Radiology, Inpatient/Hospital		
2. Prescriptions/Medications/Equipment/Supplies		
3. Health Insurance – cost (if any) you pay to maintain coverage Your premium/liability expense per month x number of months		
4. Travel/Gas - based on .25 cents/mile x number of miles x number trips		
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 Facility: City:		
Total Out-of-Pocket Medical Expenses (add together lines 1-5)		
(Optional) Non-Medical Expenses increasing financial hardship due to medical condition, lost wages. (Ex; mortgage/rent, food, daycare, auto) Comment:		

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:

If signer is not the recipient, print signer's name and relationship to recipient:

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