# Healing Hand Foundation Charitable Funds Application

The Healing Hand Foundation Charitable Funds Award is a supplemental fund supplied by Healing Hand Foundation. Completed applications are reviewed on a case-by-case basis by a designated fund manager.

Applicants who meet the following criteria are eligible for consideration of an award pending availability of resources:

- Applicant has completed application in full, including "Client Information Worksheet" (to justify the request.)
- Applicant/Patient is enrolled as a Southeast Alaska Regional Health Consortium (SEARHC) Beneficiary.
- Applicant has an unmet need not funded by other grant organizations such as Medicare, Medicaid, VA, private insurance, Denali KidCare.
- Applicant understands this is for a current need (not for past bills unpaid) and is given once a year.

**COMPLETE THE FOLLOWING, PLEASE PRINT:**

**Applicant's Name:** _____ **Date of Birth:** _ _ _ _ _ _ _ **Date:** _ _ _ _ _ _
Full Name (including middle name) on picture I.D.

**Mailing Address:**_____ **City:**_____ **State:** **Zip:**_____

**Home Phone#:**_____ **Work Phone#:**_____ **Cell#:**_____

**Patient's Name:**_____ **Date of Birth:**___ **Relationship to Patient:**_____

**Email:** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

**STATE YOUR UNMET NEED, PLEASE BE SPECIFIC:**

TRAVEL DURABLE MEDICAL EQUIPMENT PHARMACEUTICALS

---

**Please circle at least one you have applied for (and are eligible to receive)**

Medicare Medicaid Private Insurance Denali KidCare
HRSA Sliding Fee Scale VA Vocational Rehabilitation Tribal Programs (STA, Ray Paddock,
Other (please state)_____ General Assistance, etc.)

Are you a US Veteran? __Yes __No

**SEARHC will not automatically pay a bill; applications must be approved in advance by a designated fund manager before payments will be made by the SEARHC accounting department. Funds can be used for escort travel, durable medical equipment and pharmaceuticals only.**

_Yes, I am willing to have Healing Hand Foundation (HHF) contact me to talk about my experience of applying for/receiving funds from this award. SEARHC may release only my name, address, and phone number to HHF so they may contact me directly. (Note: This information is very helpful in fundraising. If preferred, you can call HHF at (907) 364-4402. Where applicable, HHF will call you back to save you the long distance phone charges).

_No, I would rather not be contacted by Healing Hand Foundation at this time, but thank you.

**CERTIFICATION AUTHORITY & RELEASE OF INFORMATION:** I certify the accuracy of this application and authorize the appropriate SEARHC staff access to any information, including medical statements and/or medical records, to verify the information provided on this application. All information will be kept confidential.

**Applicant's/Patient's Signature**_____ **Date**_____

**PLEASE MAIL (OR FAX) THIS FORM TO:**

C/0 SEARHC MT. EDGECUMBE HOSPITAL, Social Services, 222 TONGASS DRIVE, SITKA, ALASKA 99835 FAX (907) 966-8698

Healing Hand FOUNDATION

# CHARITABLE FUNDS CLIENT INFORMATION WORKSHEET

PLEASE REFER TO "GUIDELINE TO COMPLETING INFORMATION WORKSHEET')

**Name of Applicant:**_____ **Location:**_____ **Date:**_____

**Application Received by:** _____

Reason for funding request; be specific; please use another sheet of paper if you need more space on which to make your case:

State your recommendation and please include back up information to justify your request. Also please state which vendor we should forward payment to and include an invoice.

**SPACE BELOW RESERVED FOR SEARHC OFFICE USE**

Steering Committee Member Approval _____ Date _____

Second Signature, Steering Committee Member _____ Date _____
(for funds approved $101-$750)

Signature of VP (for funds over $750) _____ Date _____

Amount:_____

__ Approved Declined

Reason for not funding request:

Initials: Date:_ _

PLEASE MAIL THIS FORM TO: **HEALING HAND FOUNDATION**
C/0 SEARHC MT.EDGECUMBE HOSPITAL, 222 TONGASS DRIVE, SITKA, ALASKA 99835