CHARITABLE FUNDS APPLICATION

The Healing Hand Foundation Charitable Funds Award is a supplemental fund supplied by Healing Hand Foundation. Completed applications are reviewed by a SEARHC designated staff member.

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

- Applicant has completed the entire application in full, including the "Information Worksheet" on Page 2.
- Applicant/Patient is enrolled as a SEARHC Beneficiary or a veteran and resides in a SEARHC Community. The following communities are not serviced by SEARHC: Yakutat, Ketchikan, and Metlakatla.
- Applicant has an unmet need not funded by any other source such as Medicare, Medicaid, VA, private insurance, Denali KidCare.
- Applicant has not received an award within the past year and understands this is for a current need (not past unpaid bills).
- Applicant understands he/she will have a financial responsibility (not to exceed 20%) for durable medical equipment and pharmaceuticals that must be met before award is processed and that any payments will be made directly to the provider and not the applicant.

COMPLETE THE FOLLOWING, PLEASE PRINT:

Applicant's Full Legal Name: _____ **Date of Birth:** _____ **Date:** _____
(As shown on legal ID)

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

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

Email: _____ **Male/Female:**_____

Patient's Name: _____ **Date of Birth:** _____**Relationship to Applicant:** _____
(If different from applicant) **Male/Female:**_____

CHOOSE ONE:

_____TRAVEL _____DURABLE MEDICAL EQUIPMENT (DME) _____PHARMACEUTICALS

Please indicate type of DME below:

_____**Eye glasses** _____**Dentures** _____**Crowns/Partials** _____**Other:**_____

Have you applied for or are you eligible for (please circle all that apply):

Medicare	Medicaid	Private Insurance	Denali KidCare
HRSA Sliding Fee Scale	VA	Vocational Rehabilitation	Tribal Assistance Programs

Other (please state) _____

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. **Applications will not automatically be paid; applications must be approved and any patient obligation met before payments will be made by SEARHC. Funds can be used for escort travel, durable medical equipment and pharmaceuticals only**.

___Yes, I am willing to have the Healing Hand Foundation (HHF) contact me to talk about my experience of applying for/receiving funds. SEARHC may release only my name, address, and phone number to HHF so they may contact me directly. Note: This information is helpful in fundraising. If preferred you may call HHF at 907-364-4402.

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

Applicant/Patient Signature_____ **Date** _____

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CHARITABLE FUNDS INFORMATION WORKSHEET

Please Print
Name of Applicant: _____ **Location:** _____

Application Received by: _____ **Date:** _____

Reason for funding request; be specific; please use another sheet of paper if you need more space on which to make your case. Please include back-up information to justify request. ***If requesting travel assistance, please be sure to indicate preferred travel dates and flights. Be sure to attach invoice and/or treatment plan, with total cost, with your application for DME or pharmaceutical requests.***

_____

_____

_____

_____

_____

For Travel Requests: Preferred Travel Dates & Flights:

_____

_____

SEARHC USE ONLY BELOW THIS LINE

Initials: _____ Date application received: _____

____Approved ____Declined (If declined, reason for not funding request):_____

_____

Amount approved: _____

Date payment made to vendor or sent to Finance for processing: _____

Additional Notes:

_____

_____

_____

_____

PLEASE MAIL OR EMAILTHIS FORM TO:

SEARHC c/o ELMC HHF Patient Experience, 3100 Channel Drive, Suite 300, Juneau, AK 99801

Fax: 907-966-8416

hhfapps@searhc.org