

Funding Application

Please carefully read our **funding guidelines** prior to application. They are located at: www.hhf-ak.org/applications-and-forms
Applications will only be reviewed if they are submitted for a financially unmet medical need. The applicant must have had the specific need denied or considered ineligible for assistance through programs such as Medicare, Medicaid, Denali KidCare, private insurance, or other similar programs. The applicant's household income must be below 200% of the federal poverty limits (which can be found in our funding guidelines).

If you are applying on behalf of someone else or are seeking travel assistance for a family member or escort, please first enter the contact information for the patient receiving medical care under "Patient/Recipient", and then select "applying for someone else". Please then enter the contact information for the person filling out the application or the family member/escort who is seeking travel assistance.

Patient Contact Information

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Community: Angoon Skagway Klukwan Haines Gustavus Pelican Hoonah Juneau
 Sitka Kake Petersburg Craig Klawock Hydaburg Kasaan Wrangell

Mailing Address: _____ City: _____ Zip: _____

Primary Phone: _____ Primary Phone: _____ Email: _____

Applying for someone else? Yes No

If applying for someone else, or are seeking travel assistance to travel alongside a patient, please provide the following contact information

Your Name _____ Your Relationship to the Patient: _____

Your Phone: _____ Your Email: _____ Your Date of Birth: ____/____/____

Type of Request:

Travel Request

Non-Travel Request

- | | |
|--|--|
| <input type="checkbox"/> Eyeglasses | <input type="checkbox"/> Pharmaceuticals/Supplements |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Orthodontics |
| <input type="checkbox"/> Crowns/Partials | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Other Durable medical Equipment (DME) | |
| <input type="checkbox"/> Other _____ | |

For non-travel unfunded medical needs **more than \$300**, the Healing Hand Foundation will cover 80% of the unfunded medical need, up to a \$600 annual maximum per patient per year.

For needs **less than \$300**, the patient funding responsibility will be \$0;
for needs **more than \$300**, the patient portion will be 20% of the total need, unless the HHF's \$600 annual cap has been met.

Please record the total cost of the unfunded goods or services **TOTAL FUNDING NEED** _____

and the **PATIENT FUNDING RESPONSIBILITY** _____

Please be sure to attach an invoice and/or treatment plan, showing total cost and any amount paid to date, with your application.

Reason for Assistance: Please let us know why the funding is needed. Include any background information to justify the request.

Certification Authority and Release Information:

By signing below, you certify the accuracy of this application and authorize the appropriate SEARHC staff access to any information, including medical statements and/or medical records. This process is completed in order to verify the information provided on this application. All information will be kept confidential.

You understand that applications will not automatically be paid; applications must be approved and any patient obligation met before payments will be made.

You are attesting that, for this unmet funding need, you have applied for and been denied or deemed ineligible for all of the following: Medicare, Medicaid, Denali KidCare, HRSA Sliding Fee Scale, Veterans Administration benefits (VA), Vocational Rehabilitation, Tribal Assistance Programs, or private insurance.

You understand that funds can only be used for the specific purpose they are being provided for.

Please sign below to show that you have reviewed, understand, and agree to the Certification Authority & Release of Information as stated above.

Signature: _____ Date: _____/_____/_____

Signature is required to process application

Permission to be Contacted: Yes No

Please check the above box if you are willing to have the Healing Hands Foundation (HHF) contact you about your experience of applying for/receiving funds from this award. SEARHC may release only your name, address, and phone number to HHF so they may contact you directly. Note: This information is helpful in fundraising so that we can assist as many people as possible.