

## Request for Tall Cedar Foundation MD Assistance Guidelines

### Tier One

This document is provided to offer general guidelines for providing financial assistance to those afflicted with Muscular Dystrophy or other neuromuscular diseases.

This is a tier one application where you can request up to five thousand dollars (\$5,000.00 USD) for financial assistance of a Muscular Dystrophy or Neuromuscular related expense as explained within.

For the purpose of this process, an applicant is defined as either the person afflicted or his/her legal guardian.

If an applicant requires financial assistance, a Request for Tall Cedar Foundation Financial Assistance application must be completed. The applicant should be assisted in completing the application by their local Constituent Forest MD chairman or any forest member.

The application must be completed in its entirety to be considered.

If the applicant is requesting assistance due to medical expenses the applicant must provide original copies of all invoices and explanation of benefits received from any medical insurance provider reflecting what has been paid and what is still due and owing. The un-reimbursed amount would be considered an eligible medical expense.

The statement of need should be as complete and detailed as necessary to allow the reader to understand the circumstances surrounding the request for funds. If necessary, the statement of need may be typed on a separate page that would then be attached to the application.

The key is there must be need and that need must be documented. Every application is to be judged on its own merits. You should also recognize that not all family structures are the same. The traditional nuclear family now comprises less than 50% of all families. We have domestic partnerships, alternative living arrangements, more adult children living with their parents and their own children, unmarried coupling in shared living arrangement, etc. In short, each local constituent forest should know the local need better than anyone else.

Every application for funds must be signed by the applicant, the committee members, and the officers where appropriate. Request for Financial Assistance applications should be treated as confidential documents and should not be discussed in public venues.

Where there is a large or extraordinary medical expense, identify what steps have been taken to establish a payment program or workout agreement with a provider.

Any payments will be made directly to the vendor. The family WILL NOT received any monies directly.

#### **Items that may not be considered or paid for using these funds:**

Recreational expenses – this includes vacations, recreational travel, tickets for sporting events, concerts and related type activities, and rental vehicles; with the exception of official MD therapies.

Exclusions also include club memberships and associated fees and restitution arising from any civil or criminal proceeding including court ordered payment, arbitration, or settlement conferences.

NOTE: This is not an inclusive list and other activities may be added if deemed necessary by the Tall Cedar Foundation board of directors.

# Request for Tall Cedar Foundation MD Financial Assistance Tier One Application

Requestor Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Relation to Recipient \_\_\_\_\_

Amount being requested (not to exceed \$5,000 USD): \$ \_\_\_\_\_

Recipient Name \_\_\_\_\_ Age \_\_\_\_\_

Recipient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Applicants Statement of Need (continue on reverse side if needed) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will your Health Insurance Cover any of the expenses? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, amount covered \$ \_\_\_\_\_

Name of Vender item/equipment will be purchased from \_\_\_\_\_

Vendor Address: \_\_\_\_\_

Vender Phone Number: \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Recommending Forest Name \_\_\_\_\_ No. \_\_\_\_\_

Name of Forest MD Chairman \_\_\_\_\_ Phone No. \_\_\_\_\_

REGION NO. DIST. NO. FOREST NO.

TALL CEDAR FOUNDATION AUTHORIZATION AND CONSENT FOR RELEASE AND REVIEW OF ANY AND ALL FINANCIAL AND MEDICAL RECORDS RELATED TO THIS APPLICATION.

The applicant hereby authorizes and consents to the release and review of (his) (her) Financial and Medical records by the Tall Cedar Foundation, for the purpose of determining eligibility for benefits from the Muscular Dystrophy Fund. The Tall Cedar Foundation is required to protect the confidentiality of information. All Officers are required to comply with our policies. All information provided on this application, is true to the best of my knowledge.

APPLICANTS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ACTION: Tall Cedar Foundation Awards Committee

We the undersigned members of the committee have investigated the application and find that statements listed on this application (are) (are not) in order. The committee at a meeting on \_\_\_\_\_ recommend that Relief be (granted) (denied) in the total amount of \$ \_\_\_\_\_

Payable: S Lump Sum \_\_\_\_\_ Direct to Vendors (bills) \_\_\_\_\_

SIGNATURE \_\_\_\_\_ COMMITTEE CHAIRMAN - PRINT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ COMMITTEE MEMBER - PRINT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ COMMITTEE MEMBER - PRINT NAME \_\_\_\_\_

ACTION: TALL CEDAR FOUNDATION BOARD OF DIRECTORS

The Foundation Board at a meeting held on \_\_\_\_\_ (approved) (modified) (disapproved) the committee's recommendation and ordered S \_\_\_\_\_ be (Paid) (Filed).

SIGNATURE \_\_\_\_\_ CHAIRMAN - PRINT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ SECRETARY - PRINT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_ TREASURER - PRINT NAME \_\_\_\_\_

Amount approved to date this year \$ \_\_\_\_\_

Review application to be certain that all instructions have been followed and all sections of the form have been fully completed.