

# Request for Fundraising Support

Online Donation Tools & Grant Request

Lend A Helping Hand offers online donation tools to improve fundraising efforts coordinated by volunteers, non-profit organizations, and/or employer groups that benefit individuals experiencing financial hardship due to a medical crisis.

If you are planning a fundraising effort and would like to apply for Lend A Helping Hand assistance:

1. Designate a lead volunteer to oversee fundraising activities and serve as the key contact.
2. Establish a benefit fund for donation management at a bank/credit union, with a volunteer(s) as title signer or coordinate a benefit fund through Lend A Helping Hand.
3. Complete this request form with information about the medical crisis and planned fundraising activities.
4. Obtain input and signatures of the lead volunteer.
5. Submit request to Lend A Helping Hand at P.O. Box 1080, Clarkston, MI 48347.

Note: Submit request as soon as possible to maximize available resources (for example; 3 weeks prior to scheduled event and/or before marketing efforts are underway.)

## Section 1 Lead Volunteer Information

**Lead Volunteer Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_  
**County:** \_\_\_\_\_ **Home Tele #:** \_\_\_\_\_ **Work/Cell #:** \_\_\_\_\_  
**Do you represent a business/org. sponsoring the effort?** \_\_\_ No \_\_\_ Yes/**Name:** \_\_\_\_\_  
Include name and contact information for at least 2 additional volunteers (or attach separate page of information):  
1. **Name:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
2. **Name:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

## Section 2 Benefit Fund Information

**Benefit Fund Name:** \_\_\_\_\_ **Bank/Credit Union:** \_\_\_\_\_  
**Bank/Credit Union Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_  
**Name of account title holder(s):** \_\_\_\_\_  
**Benefit fund start-up date:** \_\_\_\_\_ **Estimated end date of fund:** \_\_\_\_\_  
**Please attach a copy of the signature card or other documentation verifying the existence of the benefit fund.**

## Section 3 Fundraising Activities

**Place a check by planned fundraising activities. Include detail (as known) regarding date(s), location, timeframe, and other relevant information. If a flyer/appeal letter is already drafted, please attach.**

<input type="checkbox"/> Community event	<input type="checkbox"/> Mail/e-mail campaign	<input type="checkbox"/> Sale of baked goods, crafts, etc;
<input type="checkbox"/> Company/association event	<input type="checkbox"/> Run/walk/bike/bowling event	<input type="checkbox"/> Garage sale or car wash
<input type="checkbox"/> Church/faith-based event	<input type="checkbox"/> Raffle and/or auction	<input type="checkbox"/> Donated proceeds/% of items sold
<input type="checkbox"/> Neighborhood/family/friends event	<input type="checkbox"/> Online auction	<input type="checkbox"/> Other:

**Date(s):** \_\_\_\_\_ **Location(s):** \_\_\_\_\_

Additional information about fundraising effort/activities:

Include name(s) of any major sponsors and type/amount of support secured:

**Section 4 Lend A Helping Hand - Referral Source & Prior Assistance**

**How did you learn about Lend A Helping Hand? Check the referral source(s):**

- Friend/Family/Co-worker
- Church/Nonprofit Organization
- Employer/Business
- Broadcast Ad/Story (TV/radio)
- Internet Search
- Printed Ad
- Brochure
- Prior experience with program
- Other: \_\_\_\_\_

Please include name and/or location of referral source: \_\_\_\_\_

**Has the fund beneficiary (individual or family member) received prior help from Lend A Helping Hand?**

No  Yes, Amount \$ \_\_\_\_\_ Date: \_\_\_\_\_ Recipient/fund name: \_\_\_\_\_

**Section 5 Fund Beneficiary - Medical Crisis Information**

**Please provide information regarding the individual(s) experiencing a medical crisis (beneficiary).**

**Beneficiary Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** \_\_\_\_\_  
**Home Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_

**Parent/Spouse Name (as applicable):** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Beneficiary's medical diagnosis/condition:** \_\_\_\_\_

If there is more than one family member in medical crisis, please include this information:

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

**Summarize the medical crisis.** How has the medical illness/injury created financial hardship? Explain how the medical care, expenses, and any employment/income changes have impacted the individual/family. (May attach separate page)

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

**Out-of-pocket medical expenses for the individual/family**

Please list known and estimated out-of-pocket expenses as accurately as possible based on bills already received and/or paid, as well as anticipated out-of-pocket expenses for the following; medical bills, pharmacy/medical supplies, health coverage premiums, travel/lodging and other expenses related to medical care for up to a one year time period.

**Medical Expense Categories**

**Out of Pocket Expenses**  
(Amount the Individual/Family is liable for)

**Category 1 – Medical Care**

- A. Clinic, hospital, outpatient and home care charges including provider charges, diagnostic testing and treatment (lab, x-ray, dialysis, radiation, chemotherapy, PT/OT, and IV therapy) \$ \_\_\_\_\_
- B. Prescription medications/pharmacy \$ \_\_\_\_\_
- C. Other: \_\_\_\_\_ \$ \_\_\_\_\_

**Category 2 – Equipment & Supplies**

- A. Wheelchair, walking aides, assistive equipment for bath/toilet, hospital bed, vehicle handicap retrofitting, other: \_\_\_\_\_ \$ \_\_\_\_\_

**Category 3 – Dislocation Costs**

Reason for travel to out-of-area provider: \_\_\_\_\_

Name of medical facility: \_\_\_\_\_ City: \_\_\_\_\_

A. Travel Expenses. # Miles roundtrip: \_\_\_\_\_ # Trips: \_\_\_\_\_ \$ \_\_\_\_\_

B. Hotel/Lodging/Food. # Overnight stays: \_\_\_\_\_ # People: \_\_\_\_\_ \$ \_\_\_\_\_

C. Other: \_\_\_\_\_ \$ \_\_\_\_\_

**Category 4 – Health Coverage (Insurance Premium/Recipient Liability)**

A. Name of insurance carrier/coverage program: \_\_\_\_\_

Individual/family is responsible to pay: \$ \_\_\_\_\_ x \_\_\_\_\_ months to maintain coverage \$ \_\_\_\_\_

B. If no coverage, has the individual/family applied for Medicaid or other help? \_\_\_No \_\_\_Yes

Optional comment: \_\_\_\_\_

**Category 5 – Other Expenses**

A. Expense description: \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL AMOUNT OF OUT-OF-POCKET EXPENSES FOR INDIVIDUAL/FAMILY: \$ \_\_\_\_\_**

**How will contributions be used by the individual/family (fundraising beneficiary)?**

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

**Section 6 Signatures of Verification Benefit Fund Name: \_\_\_\_\_**

**A. Lead Volunteer Verification Statement**

By signing below, I acknowledge that information provided on this document is complete and accurate to the best of my knowledge. By submitting this application, I understand that the disclosed information will be reviewed by Lend A Helping Hand. I understand that grants and other forms of supportive services are not guaranteed and that I will be notified of the status of this request within 30 days following its receipt by Lend A Helping Hand.

▶ Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to beneficiary: \_\_\_\_\_

**B. Fund Beneficiary Verification Statement**

By signing below, I confirm that the non-covered expenses listed on this document are accurate and create financial hardship for me and/or family members who maintain responsibility for payment of these expenses. I certify that any funding received through Lend A Helping Hand shall be used for the sole purpose(s) designated on this document. I give authorization for Lend A Helping Hand to reproduce my photograph and share information included on this form for fundraising purposes.

▶ Beneficiary (or Parent) Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Print Name: \_\_\_\_\_

**C. Church/Nonprofit Organization Verification Statement**

**Name of Church/Nonprofit Organization:** \_\_\_\_\_ **County:** \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Explain how the church/nonprofit is affiliated with the volunteer(s) and/or beneficiary of the fundraising effort:

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

Include information regarding the type of support (if any) that the church/nonprofit is offering to improve the success of the fundraising effort (food, supplies, space, volunteers, marketing help, monetary funding, etc;):

Additional (optional) information regarding the affiliation noted above and/or this request:

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

By signing below, I acknowledge support for the fundraising effort outlined on this application on behalf of the church/nonprofit organization that I represent.

▶ Clergy/Nonprofit Director Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Forward completed **Volunteer Request for Fundraising Support** to:

**Lend A Helping Hand**  
**P.O. Box 1080**  
**Clarkston, MI 48347**

◇ Fax: (248) 394-1415    ◇ Email: Michelle@LendAHelpingHand.org    ◇ Office Telephone: (248) 394-1415

**Additional resources are available on the Lend A Helping Hand website:**  
**[www.lendahelpinghand.org](http://www.lendahelpinghand.org)**

**For DMF Lend A Hand use only**

\_\_\_ Approved for Grant \$ \_\_\_\_\_ Date notified: \_\_\_\_\_ Meeting scheduled: \_\_\_\_\_

Additional follow-up: \_\_\_\_\_ Survey sent: \_\_\_\_\_ Funds Distributed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_ Denied, Reason: \_\_\_\_\_ Notification Date: \_\_\_\_\_

Referral/Follow-up: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

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