Horizon Emergency Grant Application

Lupus Foundation of Minnesota
2626 E. 82nd Street, Suite135
Bloomington, MN 55425

952-746-5151 – Office
952-746-5155 – Fax

We serve those affected by lupus, raise awareness and fund research in an ongoing effort to improve the lives of others.

Dear Horizon Emergency Grant Applicant,

The Lupus Foundation of Minnesota understands that with ever changing complications and symptoms, those touched by lupus experience a wide range of obstacles that can create financial emergencies.

As a result, the Lupus Foundation offers the Horizon Emergency Grant (HEG) program to assist financially independent lupus patients who are temporarily experiencing a financial crisis.

The maximum grant amount awarded is $300.00 with all payments being distributed to the vendor. Approval is not guaranteed, however through the application process, Client Services will work with you on locating available community resources.

This application packet will provide you with all eligibility information and documents necessary for application. Please complete all forms in their entirety and please ensure that we are provided with your contact information. Missing information will delay processing. Once the paperwork is received, a Client Services representative will contact you to arrange an appointment to review your application.

Sincerely,

Client Services
Lupus Foundation of Minnesota

Eligibility Explanation Form

Below is a detailed explanation of the eligibility requirements for the Horizon Emergency Grant (HEG). After reviewing this page you feel that you meet criteria for consideration, please complete the application in its entirety and return to Client Services.

Section 1 - Application Requirements

1- All applicants must be a resident of Minnesota, Western Wisconsin, North Dakota or South Dakota to be considered for the HEG.

2- Applicants must have a confirmed lupus diagnosis. LFM will request verification from the
treating physician.

3- All applicants must have applied for assistance from their local county agency for this Matter and provide supporting documentation. (example: Emergency Assistance)

4- If you are a returning HEG applicant, your request will not be considered if it has been less than 24 calendar months since you have received the HEG.

5- You understand that an appointment will be scheduled with a client service representative to review your application, documents and available resources.

Section 2 - Reasons for Application Request

Note: There is no guarantee that a grant will be awarded. All other resources will be researched prior to evaluation of the HEG grant.

The following are appropriate requests for consideration:

- **Late Bills**
- **Late or missed rent / mortgage payment**
- **Medical expenses not covered by insurance**

The following are unacceptable requests and you will not be considered for the HEG grant:

- Court Fines
- Traffic Tickets
- Bail
- Any request for financial assistance that is related to illegal activity
- Travel and/or hotel accommodations
- Attorney Fees
- Any fees related to child custody issues
- School expenses

Horizon Emergency Grant
Eligibility Check-List

Section 1 – Application Requirements

1. Do you reside in: □ **MN** □ **ND** □ **SD** □**W. WI** □ **no**

2. Have you been diagnosed with lupus? □ **yes – year _________** □ **no**

3. Have you applied for financial help within your county of residence for this matter?

   □ **yes** □ **no, Why: _______________________________________**

4. Has it been at least 24 calendar months since you have received the HEG grant?

   □ **yes, month & year received ____________** □ **no** □ **first time applicant**

5. I have read the application requirements and understand that an appointment will be scheduled with a client services representative to review the application, submitted documents and community resources prior to consideration for the HEG grant. □ **yes** □ **no**

6- I understand that the HEG will not be used to pay for court fines, bail, traffic tickets, or any reason related to illegal activity, travel & hotel accommodations, attorney fees, child custody issues or school expenses. □ **yes** □ **no**

IF YOU HAVE CHECKED *NO* TO ANY OF THE ABOVE QUESTIONS, PLEASE REVIEW REQUIREMENTS

Section 2 – Reason for Application Request

Check the box that most closely represents your need: Supporting documents must be included in application.

□ Late Bills
□ Late or missed rent / mortgage payment
□ Medical expenses not covered by insurance

Please initial to acknowledge you have read and understand the following statements.

_____ I understand that an appointment will be arranged with a Client Service representative to review the application.

____ I understand that approval of the HEG grant is not a guarantee and all other resources will be reviewed and exhausted before consideration.

_____ Payments go directly to the vendor/provider, no exceptions

Explanation of Need

Please describe in writing the reason for the grant request including circumstances creating the need and the amount requested.

H.E.G.
Personal Information

Date: ___ / ___ /_______

Name: ____

Address: ____

State: _____________________ Zip: ______________

Home # (____) __________________ Cell# (____)___________________________

Other # (_____) ___________________ E-Mail: __________________________________

Date of Birth: ___________________________________

Gender: ___________________ Race/Ethnic Background: _____________________

Diagnosis Date: _____________________ Type: ☐ SLE ☐ Discoid ☐ Neo-Natal ☐ Other

How did you learn about the H.E.G. Program? ___________________________

Physician Information: ***Required for Verification Form***

Name of Physician: ____

Specialty *(Internist, Rheumatologist, Dermatologist, etc)*:_______________________________

Address: ____

Phone: (___) ________________ Fax :(____) ______________

Income Source

Name of Employer or Type of County/Government assistance: _______________________

County Financial Worker Name: _________________________________

Financial Worker Phone: _____________ Fax:(____) ______________

My signature certifies that to the best of my knowledge, I meet the eligibility requirements for the Horizon Emergency Grant and that all information submitted is true and accurate.

Print Name: ____

Signature ____

Date ____ /_____ /_________

Income and Budget Information

Household

Dependents in family (including applicant): **Adults:____** **Children:___**

☐ **Rent** ☐ **Own** ☐ **Other: ___________________________**

Monthly Income

Copies will be required for verification from all sources

Employment ☐ Full time ☐ Part time $___________
Spouse's earnings ☐ Full time ☐ Part time $___________
Other Income *(describe)* ________________________ $___________
Other Income *(describe)* ________________________ $___________
Other Income *(describe)* ________________________ $___________

Examples of other income: *support payments/alimony, unemployment, public assistance, VA benefits, etc.*

TOTAL MONTHLY INCOME → $___________

Monthly Expenses

Rent/Mortgage $___________
Home Phone $___________
Cell Phone $___________
Electric $___________
Gas $___________
Utilities *(water/sewage, trash/recycling)* $___________
Food $___________
Medicine $___________
1st Car Payment $___________
2nd Car Payment $___________
Car Insurance $___________
Child care $___________
Credit card payments $___________
Other debt $___________
Entertainment $___________
Other Expense *(describe)* ___________________ $___________
Other Expense *(describe)* ___________________ $___________
Other Expense *(describe)* ___________________ $___________
Other Expense *(describe)* ___________________ $___________

TOTAL MONTHLY EXPENSES→ $___________

H.E.G.
Provider Information

Approved grants are paid directly to the agency or provider, no exceptions. Please provide all requested information

Remember to attach appropriate documentation from each vendor

1. Name of Agency/Provider: ____

   Amount: $ ____________ Account/Reference#: ______________________________

   Phone :(___) ____________ Fax: (___) ____________ email: __________________

   Address: ____

   Assistance for ____

2. Name of Agency/Provider: ____

   Amount: $ ____________ Account/Reference#: ______________________________

   Phone :(___) ____________ Fax: (___) ____________ email: __________________

   Address: ____

   Assistance for ____

3. Name of Agency/Provider: ____

   Amount: $ ____________ Account/Reference#: ______________________________

   Phone :(___) ____________ Fax: (___) ____________ email: __________________

   Address: ____

   Assistance for ____

Revised 12/09

Lupus Foundation of Minnesota
Authorization for Release of Information

I hereby authorize health care professionals, social service workers, organizations or institutions to release to the Lupus Foundation of Minnesota documents, records or other information pertaining to the undersigned.

I further authorize the Client Services Team of the Lupus Foundation of Minnesota to disclose to the aforementioned professionals, organizations, and institutions any information which is material to my case, and I hereby specifically release the Foundation and the Board from any liability in connection with such disclosures.

I understand that my records are protected under State and Federal laws and may not be disclosed without my written consent, unless the law so provides. I also understand that I may revoke this consent at any time, but that such revocation may adversely affect the course of any proceedings requiring the information requested. I further understand that upon fulfillment of the above stated purpose this consent will automatically expire.

A photo static copy of this authorization has the same force and effect as the original.

____________________________________ ________________

Client Signature **Date**

____________________________________ ________________

Lupus Foundation Representative Signature **Date**

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