Angel Fund

As of July 1, 2017 we will only be accepting electronic applications submitted through our online system.

https://hhfgrants.smapply.io/prog/angel_fund/

Use this form only if you have been preapproved to do so.

Contact the Humboldt Health Foundation at ulhf@hafoundation.org or (707) 442-2417 with any questions.

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HUMBOLDT HEALTH FOUNDATION

Angel Fund

Guidelines

What is the Angel Fund?

The Angel Fund provides small grants to individuals in Humboldt County for medical or health related needs. Humboldt Health Foundation (HHF) created the Angel Fund in 1997 and provides ongoing funding for these grants. HHF's mission is to improve the health and wellbeing of the residents and communities of Humboldt County.

Who can apply?

- Applications must be made through a qualified sponsor (the Angel), such as a recognized social service agency, school counselor or medical provider.
- This sponsor takes on the responsibility of administering the grant if the application is approved.
- Funds are not provided directly to the person in need of assistance, with the exception of medical travel grants.
- Checks cannot be made payable to the 'Angel' or his/her organization/business.

What are the Grant Requirements?

- The Angel Fund is designed to provide assistance with medical and healthcare related needs for residents of Humboldt County.
- Funds are granted on a **one time basis per person per 365 day period.**
- Items that are of a recurrent nature are generally not funded.
- Funding will not be provided for items that have other identifiable sources of funding, either from insurance, government organizations or other charitable organizations.
- The fund serves the needs of both children and adults.
- The fund cannot pay for expenses already incurred.
- Decisions to grant funds are contingent upon funding criteria and the availability of funds at the time of review.
- Occasionally the committee will ask for additional information before making a decision.
- Grants in excess of $500 are seldom approved, and most grants fall within the range of $50-$250.
- There is a **two week turn-around time required** for application review and check processing.
- The Angel Fund Committee meets every Tuesday, with the exception of holidays.
- **All applications must be complete and submitted by 12:00 p.m. on Friday to be considered by the committee on Tuesday.** Grant should be submitted using our online portal at hhfgrants.smapply.io

Who to contact:

- Get in touch first with your doctor's office, social worker, or other entity who will act as your "Angel".
- Questions about how to apply call the Grants Department at the Humboldt Health Foundation office at (707) 442-2417 or email ulhf@hafoundation.org.
- Questions about an application that has already been submitted? Contact the Angel for status update.

Medical /Dental Travel Grant Requirements

The purpose of a Medical/ Dental Travel Grant is to assist individuals that have no choice but to leave our area to seek medical care. Whenever possible we hope that local medical resources have been fully researched before patients are sent on long trips that can be expensive and exhausting.

To apply for Medical Travel funding through the Angel Fund, we require the following information in addition to the completed Angel Fund request form:

- Written verification of the patient's appointment
- Date of travel
- Name of physician and facility the client is traveling to
- Purpose of appointment
- Explanation of the diagnosis
- Whether a local specialist was considered
- Whether the person is also receiving travel funds from other organizations

The Angel Fund does not pay costs for travel that has already occurred. The appointment must be upcoming.

Please note:

- Once a request is approved by our committee it typically takes about a week for the check to be prepared.
- Please submit requests at least two weeks in advance of the patient's travel date to ensure funding is available before he/she has to leave the area.
- **The maximum we give to help with travel is $200.**
- While we understand that this amount does not cover the client's total costs, the Foundation is able to assist over 300 local families with medical travel per year by maintaining this amount.

Regularly Funded (List is not prioritized):

- Medically related examinations, procedures and equipment *(when not covered through insurance)*
- Eyeglasses / Vision Services ($130.00 maximum) *(requires a copy of the prescription if exam has already been completed, and only secondary after insurance priority)*
- Medically related travel ($200.00 maximum) *(requires verification of appointment)*
- Items to improve accessibility/independence for disabled or elderly individuals
- Orthopedic needs ($180 maximum)
- Compression stockings
- Local Bus Tickets (for transportation to medical appointments)
- Wheelchair accessibility items
- Prescriptions *(emergency, short-term)*
- Physical Therapy and/or Equipment
- Minor home repairs *(if related to a medical, safety, accessibility or independence need)*
- Psychological Counseling Evaluation, only on an emergency basis and with a long term management plan

The following items are <u>not</u> generally funded:

- Adult Dental Care
- Dentures
- Hearing Aids
- Lift Chair
- Acupuncture/Massage
- Care Providers
- Weight Loss Programs
- CPAP Machines
- Counseling (long term)
- Aerochamber
- Burial/Cremation Costs
- Tattoo Removal
- iPad/iPod
- Cell Phone
- Vision Therapy
- Rent/Deposits/Utility Bills
- Car Payments/Vehicle Maintenance
- Birth Certificates
- Green Cards
- Driver's License
- Driver Ed Class
- Waste Removal
- Smoke Alarms
- Wood for Stove
- Baby Items
- Child Care
- Parenting Classes
- Woodstove Barriers/Fireplace Gates
- Summer Camps
- Dog Training

Angel Fund

Incomplete applications will not be accepted.

Recommendation for funds on behalf of an individual. Last name of person in need will remain confidential.

Please review guidelines, make sure application is completely filled out and attach additional pages if necessary. ***2 page document***

Requested by (Angel's Name):		Date:	
Job Title:			
Agency:			
Agency Mailing Address:		City, State, Zip:	
Email: *Preferred communication*			
Phone /Ext:			

CLIENT INFORMATION:

Full name:		Age:	
Family Monthly Income:		# of People in Household:	
City & State of Residence:		Race / Ethnicity:	
Insurance type:			

MEDCIAL/DENTAL TRAVEL: ☐N/A

Please note, Angel Fund will only provide financial assistance for **upcoming** trips, and will not pay for expenses already incurred. Please submit this application a **minimum of two weeks** before appointment.
What is the diagnosis/medical issue the patient is being seen for? (Be specific.)
Name of the Humboldt County doctor who is referring out of the area? (Not health center.)
What local treatment options were sought prior to patient being referred out of the area?
Reason the patient is being referred out of the area? (Reason local option did not work.)
Medical office and location of upcoming appointment:

Date of appointment:	

☐**Confirmation of appointment MUST be included for consideration of Angel Fund Grant, please attach to application. Check box to verify appointment confirmation is included. SEE PAGE 2**

ASSISTIVE AIDS: ☐N/A

You must include a detailed quote from the business where items will be purchased.
Description of items needed:
What is the medical reason the assistive aids are needed?
Will this be permanent or temporary? (Please check.) ☐ Permanent ☐ Temporary
Please list other programs client has tried to access for assistance with this matter.
Why didn't those resources meet the needs of your client / patient?

ALL OTHER REQUESTS: ☐N/A

What is the client's medical diagnosis?
What type of assistance are you seeking from Angel Fund?
Explain why this is medically necessary:
Please list other programs client has tried to access for assistance with this matter.
Why didn't those programs meet the needs of your client?
☐ **If requesting glasses, a prescription must be included. Check box to verify that prescription has been included.**

Amount Requested:		**If approved, checks should be made payable to (name, address, and zip code):**
		Please check: ☐Deliver by mail ☐ Pick up at Humboldt Area Foundation

Checks cannot be made payable to requesting party. Only travel grants can be made payable to the person in need. All other checks will be made to the business where items will be purchased. *Person's first and last name will be referenced on the check stub.*

Requests must be received by ***12:00 p.m. on Friday*** for Committee consideration on Tuesday.

Forward Requests to:

Attn: Angel Fund
Humboldt Health Foundation
363 Indianola Road
Bayside, CA 95524

ulhf@hafoundation.org
(707) 442-2417 phone
(707) 442-2382 fax

Please do not write below this line. For office use only

Approved Date: _____ Amount: _____ Check to: _____

Profile: _____Grant: _____ Other notes: _____