

Three Rivers' Helping Hands Community Foundation

Application Guidelines

1. Funds shall be awarded to individuals, families and organizations in Three Rivers Electric Cooperative's service area **for essential needs such as health, safety and well-being of the community**. Families shall generally include all the individuals residing in a household whether or not they are related by blood or marriage. No more than one application shall be approved for one catastrophic event at one address. The Board of Trustees will make every attempt to distribute funds fairly to each county within the service area.
2. All applicants must submit copies of bids, estimates, bills, and/or paid receipts for which funding is being requested. The annual maximum amount an individual may receive is \$2,500; however, amounts awarded for dental assistance will generally be limited to \$1,000 per individual or \$2,000 per family and amounts awarded for hearing aids will generally be limited to \$1,500 per individual unless there are extenuating circumstances for either dental or hearing assistance. The annual maximum amount for a family shall be limited to \$2,500 per individual up to \$5,000 per family, and the annual maximum amount organizations may receive is \$10,000. Amounts awarded to organizations will generally be around \$5,000 unless the project or program warrants the maximum of \$10,000.

Once a decision is made by the Board of Trustees either approving or denying an application, the applicant must wait a period of 12 months from the date of review before applying for assistance again from the Foundation. No more than one application should be filed for one incident or illness, regardless of duration. Individuals and families shall generally be limited to three awards during their lifetime.

3. When funds are awarded to individuals and families, checks will be generally made payable to the individual or family applicant and another entity which will be the ultimate recipient of the funds (i.e. individual and hospital/merchant), so as to prevent the funds from being used for any unapproved purpose. Checks may be written payable to the individual or family applicant to reimburse for paid expenses if copies of paid receipts are submitted with the application for funding.
4. In accordance with the intended purpose of the Foundation, funds may **not** be used for the following activities and purposes:
 - a. Athletic team sponsorship, advertising;
 - b. General home repair (porches, sidewalks, heating and cooling systems, windows and doors);
 - c. Home reconstruction expenses following fires, floods, tornados and other natural and man-made catastrophic events;
 - d. Direct payment of normal daily living expenses, such as household rent, utility bills (electric, gas, fuel oil, and telephone) except that temporary expenses shall be allowable following the destruction of the applicants home;
 - e. Political purposes, campaigns and causes;
 - f. Automobile repair and purchase;
 - g. Transportation expenses to enable relatives other than parents or caregiver to accompany the sick to travel, or to enable sick persons to travel, other than to receive medical care;
 - h. Purchase of consumer credit counseling services for persons with debt management problems;
 - i. Funeral expenses (generally not approved but may be considered if there are extenuating circumstances);
 - j. Donations to the United Way or other agencies which have the primary goal of collecting and distributing funds to other organizations. However, the intent is not to prevent awarding trust funds to organizations which receive funding from these or other sources, if such organizations operate in accordance with the purposes of Three Rivers' Helping Hands Community Foundation;
 - k. Applications from tax supported entities shall be considered for extraordinary expenses only and shall not be considered for normal administrative expenses such as office equipment or supplies.

**AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION
INCLUDING PSYCHIATRIC/PSYCHOLOGICAL/MENTAL HEALTH**

Patient Name: _____	Birthdate: _____
Address: _____	SS#: _____
Dates of treatment to release: <input type="checkbox"/> All <input type="checkbox"/> Specific Dates: _____	

I AUTHORIZE _____ TO RELEASE THE FOLLOWING SPECIFIC INFORMATION TO THREE RIVERS' HELPING HANDS COMMUNITY FOUNDATION, P.O. Box 918, Linn, Missouri 65051 :

Detailed Medical Billing Records as well as Insurance Coverage and Payment Information

This information is to be released for the purpose of application for awards from our charitable foundation.

Medical records (including psychiatric, psychological and mental health records) frequently contain confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of such information will be harmful to the patient, release of such information may be withheld..

I understand that the records released may contain alcohol and drug treatment, AIDS/HIV or mental health information. I understand this communication will reveal my presence as a patient in a treatment facility.

This release demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 & 164 and Federal Regulations 42 CFR Part 2 and all federal regulations and interpretive guidelines promulgated thereunder. **The recipient of this information may not disclose this information unless another authorization is obtained from me or unless such disclosure is required or permitted by law (42 CFR Part 2).** I understand once the requested information is disclosed, the HIPAA Privacy Regulations may no longer protect it should the recipient re-disclose it.

I authorize the above named person/organization and/or members of their staff, to furnish the above information, including photostatic or faxed copies of my medical records to the above named organization or to its agents. I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above-stated purpose, this consent will automatically expire:

90 days 180 days one year other _____ from the date signed.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Three Rivers' Helping Hands Community Foundation

Change for Life

1324 E. Main, PO Box 918. Linn, MO 65051
573-644-9000 or 1-800-892-2251

For Office Use Only

Application for Individual and/or Family

Incomplete applications will automatically be denied assistance.

To be complete, all 4 pages of this application must be submitted with your personal statement attached.
If not applicable, mark as n/a. Please type or print clearly with dark ink.

REQUEST

- Amount of Request: _____
- Date of Application: _____
- Please attach your personal statement to:
1) tell how the funds will be used, and
2) explain the circumstances that have prompted your need of assistance.
- Please attach appropriate bids/estimates/bills directly relating to your request.

PERSONAL INFORMATION

- Name of Applicant: _____
Last First Middle
- Address: _____
Street or P.O. Box

City State Zip Code County
- Do you OWN or RENT your home? Own Rent _____
Date of Birth
- Home/Cell Phone: _____ Work Phone: _____
- Email Address: _____
- List names of other members of household, including children (If children, give age.): _____

PERSONAL REFERENCES

- Please give three references from persons other than relatives. (References may not be given by a director or employee of Three Rivers Electric Cooperative or Three Rivers' Helping Hands Community Foundation.)
- 1. Name: _____ Phone: _____
Address: _____
Occupation: _____ Relationship to Applicant: _____
- 2. Name: _____ Phone: _____
Address: _____
Occupation: _____ Relationship to Applicant: _____
- 3. Name: _____ Phone: _____
Address: _____
Occupation: _____ Relationship to Applicant: _____

EMPLOYMENT INFORMATION

- Is applicant currently employed? Yes No
- If not, ***PLEASE EXPLAIN WHY:*** _____
- Gross MONTHLY earnings (include all employed members of the household): _____
- Employment History of Applicant
 - Employer #1 _____ Supervisor _____
 - Address _____ Phone _____
 - Dates of Employment _____ Salary/Wage _____
 - Employer #2 _____ Supervisor _____
 - Address _____ Phone _____
 - Dates of Employment _____ Salary/Wage _____
- Employment History of Others in Household - Name _____
 - Employer #1 _____ Supervisor _____
 - Address _____ Phone _____
 - Dates of Employment _____ Salary/Wage _____
 - Employer #2 _____ Supervisor _____
 - Address _____ Phone _____
 - Dates of Employment _____ Salary/Wage _____

OTHER ASSISTANCE

- List other social service agencies (MOCA, HDC, etc.) you have contacted (include name of person contacted):

- Is individual or family receiving any other form of assistance or aid (donations, insurance, etc.)? Yes No
- If yes, please list: _____

Incomplete applications will automatically be denied assistance.
(If not applicable, mark as n/a.)

Financial Statement

Date of this Statement _____

MONTHLY INCOME

Monthly Income (include income of all household members)		
	Wages	\$ _____
	Bonus/Tips/Commission	\$ _____
	Social Security Benefits	\$ _____
	Welfare	\$ _____
	Food Stamps	\$ _____
	Alimony	\$ _____
	Child Support	\$ _____
	Other _____	\$ _____
	TOTAL MONTHLY INCOME:	\$ _____

MONTHLY EXPENSES

Monthly Expenses (include expenses of all household members)		
	<input type="checkbox"/> Mortgage Loan Payment or <input type="checkbox"/> Rent payment	\$ _____
	Grocery Estimate	\$ _____
Utilities:	Electricity	\$ _____
	Gas	\$ _____
	Telephone/Cell	\$ _____
	Water/Sewer	\$ _____
	Internet	\$ _____
	Cable/Satellite TV/Streaming Services (Netflix, Hulu, etc.).....	\$ _____
	Other _____	\$ _____
Transportation:	Vehicle Payments	\$ _____
	Gasoline	\$ _____
Insurance:	Home/Rental Insurance	\$ _____
	Medical Insurance.....	\$ _____
	Life Insurance.....	\$ _____
	Auto Insurance	\$ _____
Other:	Medical	\$ _____
	Credit Card Payments	\$ _____
	Student Loan Payments	\$ _____
	Other Loan Payments (not house or auto)	\$ _____
	TOTAL MONTHLY EXPENSES:	\$ _____

NET MONTHLY INCOME (total income minus total expenses)	\$ _____
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*Incomplete applications will automatically be denied assistance.
(If not applicable, mark as n/a.)*

ASSETS

Assets (include assets of all household members - attach list if necessary)

Cash on Hand/Savings Account \$ _____

Checking Account Balance \$ _____

Property (home, mobile home, land, etc.)

Property #1 _____ Market Value \$ _____

Property #2 _____ Market Value \$ _____

Property #3 _____ Market Value \$ _____

Other Assets (vehicles, boats, livestock, equipment, etc.)

#1 _____ Cash Value \$ _____

#2 _____ Cash Value \$ _____

#3 _____ Cash Value \$ _____

#4 _____ Cash Value \$ _____

TOTAL ASSETS: \$ _____

LIABILITIES

Liabilities (include liabilities of all household members - attach list if necessary)

Credit Card Balance

Name of Credit Card _____ \$ _____

Name of Credit Card _____ \$ _____

Name of Credit Card _____ \$ _____

Student Loan Balance

Loan #1 \$ _____

Loan #2 \$ _____

Other Loans (autos, ATV, boats, unsecured, etc.)

Loan #1 _____ \$ _____

Loan #2 _____ \$ _____

Other Debt (taxes, bills, miscellaneous, etc.)

Debt #1 _____ \$ _____

Debt #2 _____ \$ _____

Debt #3 _____ \$ _____

TOTAL LIABILITIES: \$ _____

The information contained in this statement is for the purpose of obtaining funding from Three Rivers' Helping Hands Community Foundation on behalf of the undersigned. Each undersigned understands that the information provided herein is used to determine grant funding, and each undersigned represents and warrants that the information provided is true and complete and that Three Rivers' Helping Hands Community Foundation may consider this statement as continuing to be true and correct until a written notice of a change is provided. Three Rivers' Helping Hands Community Foundation is authorized to make all inquires they deem necessary to verify the accuracy of the statement made herein.

Please check box at right if you do NOT want the information contained in this application to be shared with other agencies that may help meet your needs.

Signature of Applicant

Date

Signature of Spouse/Co-Applicant

Date