WWW.NCHEROES.ORG
POST OFFICE BOX 652 | PINEVILLE, NC 28134
FAX 980-225-0395 | INFO@NCHEROES.ORG

Application for Hardship Grant

Tips for Applicants

Things You Can Do To Help Your Chance of Getting a Grant:

1. Provide **ALL** requested information **with** your application, including forms, copies of bills, and photos. Incomplete information may lead to denial of application.
2. Provide email and phone numbers and be available to answer questions.
3. You will help your chances for approval if you provide as much detail as possible regarding your military service and your specific financial hardship.

Instructions & Eligibility Checklist

Checklist Part 1 – Am I Eligible? – *My North Carolina Connection*

To qualify for a grant from the North Carolina Heroes" Fund, you must have a North Carolina connection.

I have a North Carolina Connection. (Please check the boxes which apply to you)

- ☐ I am a veteran and North Carolina native
- ☐ I am a veteran and my current permanent residency is in North Carolina
- ☐ I am associated with a North Carolina Guard or Reserve unit.
- ☐ I am Active Duty stationed in North Carolina

*If none of these North Carolina connections apply, **STOP NOW**, you unfortunately do not qualify for a grant*

Checklist Part 2 – Am I Eligible? – *My Financial Hardship*

To qualify for a grant, which is an average of $2,500, your financial hardship must be related to your military service.

My financial hardship is connected to my service. (Please check the boxes which apply to you)

- ☐ I suffered an injury during a recent deployment which impacted my financial situation
- ☐ VA Disability payments have not yet began.
- ☐ I have a disability, but I am still waiting for a rating to be service-connected.
- ☐ My family had an unusual financial strain while I was deployed
- ☐ My financial hardship is directly related to my military service, but not one of the categories above. I will provide extensive detail in the Financial Hardship section of the application.

*If your financial hardship is not directly connected to your military service, **STOP NOW**, you unfortunately do not qualify for a grant*

Checklist Part 3 – Information & Documents you will need as part of this application process

*Please take a few moments to gather **all** of the following **before** submitting your application*

- ☐ Proof of service (DD214 or similar)
- ☐ Medical Records* (if hardship is medical related)
- ☐ Documentation supporting combat related injury
- ☐ Income Statement/Pay stubs
- ☐ Copies of All Current Monthly Bills
- ☐ Recent Photographs
- ☐ HIPPA Waiver Form*
- ☐ Completed Application

** Medical records are not required, but are helpful in evaluation application if hardship is due to injury*

REQUIRED INFORMATION

Please type or write legibly for all provided information. Please do not leave any requested information blank.

PERSONAL INFORMATION

Contact Information

Name			
Age			
Current Address			
Hometown/Base (If different than above)			
Email			
Home Phone		**Cell Phone**	
Alternate Contact			

Describe Your Family & Marital Situation

Marital Status	☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated	**Number of children Living with you, or for which you are financially responsible**	☐ 1 ☐ 3 ☐ 2 ☐ 4 or more

Your Veterans Administration Contacts

VA Case Managers can be very helpful in the application process. They get to know your story and can help us understand your financial hardship.

Do you have a VA Case Manager with whom you currently work?	☐ Yes ☐ No ☐ I have had a Case Manager in past but have not seen recently	**Does your Case Manager and our Committee have your permission to discuss the specifics of your situation?**	☐ Yes ☐ No ☐ Not Applicable

Name of VA Case Manager		
VA Case Manager Contact Information	**Phone Number**	
	Email	

Military Service Information

We Honor Your Military Service. Tell Us About It:

Current or Last Military Rank and Status			
Service Branch		**Discharge Date** ***(if applicable)***	
Years of Military Service		**Current / Most Recent Unit & Location**	
Location(s) and Date(s) of Overseas Service			
Primary Specialty / Role			
Describe Your Discharge Conditions	☐ Honorable ☐ Dishonorable ☐ General ☐ Not Discharged – Still Serving If your discharge was under General or Dishonorable conditions, it may negatively impact your eligibility. You should provide with your application a description of any unusual circumstances related to your discharge.		
Name of Current or Most Recent Commanding Officer or NCO			
Contact Information for Commanding Officer or NCO:			

Financial Hardship Information

What Caused Your Service-Related Financial Hardship

What Caused Your Financial Hardship? Describe For Us: • If you were injured, how and where did it occur? • Where there expenses associated with injury? • What financial difficulties occurred due to service? • Was your hardship related to your discharge from military & transition to civilian life? Please provide as many details as possible. If more room is needed, please feel free to continue explanation on another page.			
Describe Hardship Need – How much are you requesting to help your situation? We limit our help to $1500 or less. With what bills / debt / expenses are you requesting assistance?			
Do You have a service-connected injury / disability?	☐ Yes ☐ No	**If you have a disability, what is your rating?**	**%**
Have you been diagnosed with PTSD?	☐ Yes ☐ No	**If you have PTSD, what is your GAF score?**	

Financial Disclosure Information

What is Your (Include Your Spouse's) Monthly Income

Current Monthly Income From Current Job (after taxes) or Unemployment Income	$
Monthly Veterans Benefits / Retirement Income	$
Spouse's Monthly Income	$
Monthly Disability Payments	$
TOTAL MONTHLY INCOME	**$**

List ALL Your Monthly Expenses

Monthly Payments / Expenses	Total Average Monthly Payment	Are Your Behind?
Car Payment	$	☐ Yes ☐ No
Mortgage or Rent	$	☐ Yes ☐ No
Car Insurance	$	☐ Yes ☐ No
Water	$	☐ Yes ☐ No
Power / Electric	$	☐ Yes ☐ No
Phone	$	☐ Yes ☐ No
Other:	$	☐ Yes ☐ No
Other:	$	☐ Yes ☐ No
Other:	$	☐ Yes ☐ No
TOTAL MONTHLY EXPENSES	**$**	*If your expenses are more than your income, we may ask about your budget*
Describe any financial assistance you have received from your base or unit		
Describe any financial assistance you have received service related support agencies such as Army Community Service, Navy Fund, Army Emergency or a similar agency?		

Summary Page	
How would a North Carolina Heroes' Fund grant change your life?	

Please check all of the following boxes to indicate you agree with all of the following statements:

☐ I certify that all of the information provided is accurate to the best of my knowledge.

☐ I understand that this application will not be considered unless all requested information is provided and can be easily verified.

☐ I understand and agree that the North Carolina Heroes' Fund may display a personal profile on its website so that potential donors can understand examples of our recipients.

☐ I understand that the North Carolina Heroes' Fund is under no obligation whatsoever to provide financial support regardless of whether my application falls within its guidelines. I agree to hold the North Carolina Heroes' Fund harmless pertaining to all issues concerning my application.

Signature:	
Printed Name:	
Date:	

Please include <u>all</u> with the application:

- Proof of service (DD214 or similar)
- Copies of <u>All</u> Current Monthly Bills
- Medical Records* (if hardship is medical related)
- Recent Photographs
- Documentation supporting combat related injury
- HIPPA Release Form

Mail, Email of Fax forms to:
info@NCHeroes.org
North Carolina Heroes' Fund, Inc.
P.O. Box 652
Pineville, North Carolina 28134
Fax 980-225-0395

Supporting Our Neighbors Who Defend Our Freedom

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
UNDER FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
(HIPPA)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by federal privacy regulations, including HIPAA. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Patient Name:_____ **ID/SS #:** _____

Patient Address: _____ **Date of Birth:** _____/____/____
(Street/City/State/Zip)

Persons/organizations providing the information: _____
(Medical Provider Name/VA Hospital or Clinic)

Persons/organizations receiving the information: (Send to)

North Carolina Heroes' Fund
PO Box 652, Pineville, NC 28134
Fax: 980-225-0395
Email: info@NCHeroes.org

Specific description of information, covering health care from to_____**:**
(Start Date) (End Date)

Complete health records and bills (prescription bills, history and physical, discharge summary, operative reports, consultation reports, radiology and imaging reports), excluding all images (x-rays, photographs, etc.)

Other (please specify) _____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire six months after date of signing this form. **Initials:** _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and that, if I do revoke this authorization, this will not have any effect on any action the providing organization takes before receiving the revocation. **Initials:**_____
3. I understand that I have the right to refuse to sign this Authorization. **Initials:**
4. I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law. **Initials:** _____
5. I understand the data release may include material protected by law including Mental Health, Drugs and Alcohol, HIV/AIDS and other communicable diseases and Genetic Testing. **Initials:**_____

I have read and understand the information in this Authorization.

X_____ **Date:** _____
Signature of patient or designated representative
(Form MUST be completed before signing).

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION