Foundation Source

APPLICATION FOR MEDICAL EMERGENCY AND DISTRESS GRANTS

Overview

The attached form was developed by Foundation Source to provide a mechanism to provide medical emergency and distress relief to those suffering from a terminal condition or life-threatening illness, while remaining in compliance with IRS regulations. Although we have tried to streamline the process, we want to underscore that it is important that the form be filled out carefully and with forethought. It is recommended that the foundation's board formally adopt its medical emergency assistance grant program and memorialize the board action (e.g., with minutes). The grant program should benefit victims of current and future medical emergencies. This form represents our interpretation of applicable IRS rules and guidance, and should not be construed as legal advice.

A foundation's decision about how its funds will be distributed must be based on an objective evaluation of the victim's needs at the time the grant is made. According to IRS Publication 3833, a private foundation providing emergency assistance must make a specific assessment that a grant recipient of aid is financially or otherwise in need. Accordingly, the grant amount will vary depending on the applicant's level of need. If a grant is made outside of the U.S., the foundation must take into account the local cost of living and currency values in determining the appropriate grant amount. Individuals do not have to be totally destitute to be eligible to receive emergency assistance; they may merely need relief from the distress of extreme illness.

The IRS requires that a granting foundation record, among other things, the grant recipient's need for assistance at the time of the grant; the objective criteria applied to assess need; the process by which grant recipients were selected; and the name, address, and amount distributed to each grant recipient. The IRS requires a granting foundation to make its annual return open to public inspection and disclose a grant recipient's identity and address, the grant amount, and a description of the grant purpose. However, the IRS does not require the foundation to track how the grant recipient spent the funds. In fact, there are no restrictions on the grant recipient's use of grant funds.

Foundation Source's Application for Medical Emergency Assistance & Distress Grants has been designed to meet the IRS's record-keeping and needs assessment requirements:

Sections 1 – 4 provide the opportunity for the applicant to detail the circumstances that gave rise to the need for medical emergency assistance or distress relief, so that an objective assessment can be made by the foundation's board.

Section 5 requires a referral from the physician or health care provider treating the applicant and/or a member of the applicant's household.

Section 6 to be completed by the foundation, describes the factors that influenced the board's decision to provide medical emergency assistance or distress relief to a particular applicant or household over another. In addition, this section is meant to document how the foundation's board became aware of the applicant's need for assistance.

Section 7 establishes that no family or business relationship exists between the foundation's insiders and the person or household seeking medical emergency assistance or distress relief.

Charitable Class

Finally, the IRS requires that grant recipients be selected from an open-ended group of individuals known as a "broad charitable class." This group must be large enough to ensure that the number of members comprising the class is not fixed. For this reason, the foundation should develop a means to identify persons in need of assistance beyond the board's immediate sphere of social contacts. This may be accomplished by obtaining referrals from clergy, local charities, community organizations and social workers, reading newspaper and magazine articles, and establishing other channels.

Application for Medical Emergency Assistance and Distress Relief

Purpose	Grant of up to $6,500 in any 12-month period for individuals and families who require assistance due to medical emergencies in connection with terminal conditions or life-threatening illnesses.
Eligibility requirements	Individuals and families in need of relief from the physical and mental trauma caused by a life-threatening illness. This includes persons in need of short-term counseling because of stress experienced as a result of a medical emergency or extreme illness.
How to apply	**Sections 1 - 4** should be filled out by the applicant. **Section 5** should be completed by a health care provider who is familiar with the applicant's needs. See that section for details. The completed form should be returned to the person who gave it to you. **Sections 6 - 7** should be completed by the foundation.

Section 1 – General Applicant Information

Last Name: _____ First Name: _____ Middle Initial: _____

Home Address: _____ Apartment No. _____

City: _____ State: _____ Zip: _____ Phone: _____

Section 2 – Information About the Applicant's Household

List the full name, date of birth, relationship, and the last four digits of the social security number of each person living in your household, including yourself, as reported on your tax return. Attach additional sheet(s) if necessary.

1	**Your full name** (first, middle, last):	Date of Birth	Last 4 Digits of S.S.#
		____ / ____ / _____	
2	**Full name of the 2nd person in your household** (first, middle, last):	Date of Birth	Last 4 Digits of S.S.#
		____ / ____ / _____	
	Relationship to you:		
3	**Full name of the 3rd person in your household** (first, middle, last):	Date of Birth	Last 4 Digits of S.S.#
		____ / ____ / _____	
	Relationship to you:		
4	**Full name of the 4th person in your household** (first, middle, last):	Date of Birth	Last 4 Digits of S.S.#
		____ / ____ / _____	
	Relationship to you:		
5	**Full name of the 5th person in your household** (first, middle, last):	Date of Birth	Last 4 Digits of S.S.#
		____ / ____ / _____	
	Relationship to you:		
6	**Full name of the 6th person in your household** (first, middle, last):	Date of Birth	Last 4 Digits of S.S.#
		____ / ____ / _____	
	Relationship to you:		

Section 3 – Information About the Medical Emergency or Nature of the Illness

Name of Applicant: _____

Approximate Date of Medical Emergency or Diagnosis of Illness _____

Briefly describe the nature of the illness or medical emergency and the circumstances supporting your request for assistance:

_____

_____

_____

_____

_____

_____

_____

_____

Section 4 – Applicant's Declaration

I certify that I meet the above described eligibility requirements for medical emergency assistance or relief from distress due to serious illness and that all the information I have provided to qualify for such assistance or relief is complete, correct, and true to the best of my knowledge. I further certify that the foundation making this gift (the Foundation) has not required me to use the proceeds of this gift for travel, study, or similar purposes. I understand that I may be denied assistance if any of the above is false, and that I may be required to repay any assistance that I receive based on false or incomplete information.

Upon request, I agree to provide the Foundation or its Administrator with evidence of the information I have given on this application. I understand that this application becomes the property of the Foundation when submitted.

I understand that the Foundation's annual return is open to public inspection and that, if I receive a grant, the Foundation will be required by federal tax law to disclose on its annual return my identity and address, the grant amount, and a description of the grant purpose. I understand that, if I receive a grant, the Foundation will report on its annual return the address I provided above unless I provide an alternate address below to be used in place of my home address.

Alternate Address: _____

Street Address, City, State, Zip

SIGN HERE > _____ **DATE >** _____

Stop here – you have completed your part of this application.

Please make certain that Section 5 is completed by your treating physician or health care provider. This application will be rejected if the required referral is not completed and signed.

Return this completed application to the person who gave it to you.

Section 5 – Health Care Provider Referral Form

This referral form must be completed and signed by the physician or health care provider treating the applicant and/or a member of the applicant's household. Please return this completed form to the patient.

Patient's name _____

Health care provider's name _____

Area of specialty & title _____

Facility's name (if applicable) _____

Address _____

City, state and zip _____

Phone _____

How long have you been treating the patient? _____ Date of last examination _____

How many contacts have you had with the patient in the last six months? _____

Describe the patient's significant medical problems:

_____

_____

_____

Describe treatment and response:

_____

_____

_____

Additional comments:

_____

_____

I affirm that all the information I have given above to assist the named applicant in qualifying for medical emergency assistance is complete, correct, and true to the best of my knowledge.

SIGN HERE > _____ **DATE >** _____

Health Care Provider's Signature

To Be Completed by Foundation

Section 6 – Situation Analysis

Name of Applicant: _____

How did the foundation become aware of this applicant's need for emergency medical assistance or distress relief?

Applicants for medical emergency assistance must be referred by a person or organization not affiliated with the granting foundation. Please check all boxes that apply:

☐ Clergy ☐ Counselor ☐ Employer ☐ Health Care Professional

☐ News/Media ☐ Nonprofit ☐ Psychologist ☐ Social Worker

☐ Other _____

Name of referral source _____

If referral source is an individual, please provide the following contact information:

Address _____

City _____ State _____ ZIP _____

Phone No. _____

Please indicate the factors that influenced the foundation to provide emergency medical assistance or distress relief to this particular applicant and/or household based on the applicant's description of need and input provided by the above referral source(s):

Please check all that apply:

☐ This applicant has no "safety net," such as nearby family or friends, who can offer assistance.

☐ This applicant is amongst those most adversely affected by this emergency.

☐ This applicant is one of the most economically disadvantaged persons affected by this medical emergency and lacks the basic resources necessary to cope with the resulting hardships.

☐ This applicant has a large number of dependents.

☐ This applicant (or a member of the household) is gravely ill and requires medical attention.

☐ This applicant (or a member of the household) is physically disabled or handicapped.

☐ This applicant (or a member of the household) is emotionally traumatized/psychologically fragile.

☐ This applicant (or a member of the household) is of advanced age.

☐ Other: _____

_____

_____

_____

_____

Section 7 – Foundation Approval

Name of Applicant: _____

Please indicate below the amount of assistance the foundation would like to approve up to the $6,500 maximum.

Total Grant Approved: $ _____

Once the applicant's eligibility for assistance has been confirmed, the initial grant will be processed and, at your option, the grant check will either be mailed directly to the applicant's home address, sent to you for delivery to the applicant, or sent to a third party for delivery to the applicant.

DELIVERY OPTIONS:

☐ **Send check to applicant's home address.**

☐ **Send check to me.**

☐ **Send check to the third party indicated below to deliver to the applicant.**

Entity Name: _____

Contact Name: _____ Title: _____

Address: _____

Phone Number: _____ Email: _____

By signing below, I certify that I am authorized to sign this application on behalf of the below named foundation (the Foundation) and that I have reviewed this application and determined that the applicant has met the eligibility requirements for this grant. I declare that no substantial contributor to the Foundation, nor any of the Foundation's officers, directors, and/or trustees and members of their respective families or households, will benefit, either directly or indirectly, from the making of this gift. I further declare that the Foundation has not required the applicant to use the proceeds of this gift for travel, study, or similar purposes. I also declare that the proceeds of this gift will not be used to influence legislation or the outcome of any specific public election or to finance voter registration drives. Moreover, I declare that the proceeds of this gift will not be used to satisfy the charitable pledge or obligation of any "disqualified person" with respect to the Foundation, as that term is defined in Section 4946 of the Internal Revenue Code. Additionally, I declare that the grant amount was determined based upon an assessment of the information provided by the applicant, such amount is no more than is necessary to meet the applicant's needs and, if the grant was made to an applicant outside of the U.S., the Foundation has taken into account the local cost of living and currency values in determining the appropriate grant amount.

Finally, whether I have instructed Foundation Source above to send the grant check to me or to a third party for delivery to the applicant, I understand that the Foundation, for tax reporting purposes, relies upon the check's delivery to the applicant by no later than the last day of the Foundation's tax year in which the check is received by me or the third party. In either case, I understand that Foundation Source will have no liability whatsoever in the event that such delivery is not made on a timely basis.

Name of Foundation _____

Please Print

Name of Authorized Person _____

Please Print

SIGN HERE > _____ **DATE >** _____

Please email this completed application to your Private Client Advisor. If you have any questions about how to fill out this application, please call Foundation Source at 800-839-1754 or contact your Private Client Advisor.

Foundation Source

ABOUT FOUNDATION SOURCE

www.foundationsource.com

Foundation Source is the nation's largest provider of management solutions for private foundations. We empower people and companies to create a better world with their philanthropy through a configurable suite of administrative, compliance, and advisory services complemented by purpose-built foundation management technology and private foundation experts.

We work in concert with financial advisors, legal and accounting professionals, consultants and family offices, as well as directly with individuals, families and corporations to bring philanthropic visions to life. With over two decades of service, Foundation Source supports approximately 2,000 family, corporate and professionally staffed foundations of all sizes and has enabled more than $7 billion in charitable grants.

Have a question? Call 800.839.0054 or
send us an email at info@foundationsource.com.