Montana District - LCMS

MERCY Fund

Purpose: A District grant program to Provide for un-reimbursed, uninsured, or underinsured healthcare and support of Montana District LCMS church workers and their immediate family members. Understanding that each individual case will be different and needs will vary, each Mercy Fund grant request will be handled on a one by one consideration with final grant authority coming from the Montana District – LCMS Board of Directors.

This grant is to be used to reimburse individual church workers and immediate family members for all uncovered Medical and Travel expenses.

Travel: Reimburse for fuel, taxi, airfare, shuttle and lodging to obtain necessary medical treatment. Reimbursement amount to be based on unmet need and substantiated with receipts.

Medical: Reimburse for all out of pocket medical expenses not covered by Health insurance or other sources (i.e., Health Savings Accounts, Cafeteria plans, other donations). Medical reimbursements would cover such items as co-pays, co-insurance costs, deductible limits, and out of pocket medication costs.

Administration: Funds for grants will be derived from Board directed grants and from individual restricted contributions from individuals and organizations. Individual and organizational donations made to the Montana District – LCMS Mercy Fund will be a charitable tax deductible to the donor. Any unused donations designated towards a specific individual or cause will maintained within the fund and used for other individuals as the need arises. Grants will be awarded based on properly completed and documented application. More than one grant may be awarded to the same individual or family as needed.

Application: (See attached Mercy Fund request form)

Each application is to be made in the form of a reimbursement request that will be paid tax free as a granted gift to the intended individual. Each requested amount is to be justified and supported with copies of receipts, health care payment records, and/or invoiced bills. Each request must be signed by the requestor or qualified family member or care provider.

The congregation of the intended grant recipient must also endorse the grant reimbursement request to attest that they have done everything they can do to support the church worker and/or family member.

Those individuals with chronic and long medical treatment needs can submit requests on a monthly basis for consideration.

The District office will review the application for completeness, request additional information in needed, and submit it to the District President for action and approval. The District President will summarize the request and submit it either in person or via e-mail to the District board of directors for approval. Once approved the grant request will be sent to the district treasurer for immediate payment.

Publicity: The District will publicize the formation of the Fund and solicit donations by way of letters, emails, district web site (www.mtdistlcms.org), and monthly Reflections newsletters. Amount of grants awarded and balance of available Mercy Funds will be included in monthly, quarterly, and annual financial reports. The amount of Mercy Fund grants awarded to any one individual or family will not be publicized without the individuals consent.

Funding: The amount of funding will depend solely on the benevolent donations by the district board and individuals. The amount of grants released will be limited to the balance of the fund at time of grant approval. The Montana District Board of Directors have the right to refuse any and all grant applications and dissolve the Mercy Fund as required at any time.

The MONTANA DISTRICT of the LUTHERAN CHURCH--MISSOURI SYNOD

MERCY FUND REQUEST FORM

Rev: Jan 2015

Mail Completed Form and attached Receipts to: The Montana District - LCMS, 759 Newman Lane, Ste. 2, Billings, MT 59101

Payable to: _____ Date: _____

Complete Mailing Address:

Trip To: _____ **From:** _____

Reason: _____

Travel:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	continue on blank paper if needed	
Dates:									**TOTAL**
Fuel									
Motel									
Meals									

Other Medical Expenses (Explain): **Attach Receipts for all claimed expenses**

TOTAL: $_____

_____

Signature and Date

Congregation Endorsement:

We the members of _____Lutheran Church are aware of the medical needs of the above applicant and have exhausted all available means to provide any additional support.

_____

Signature and Date of Church President