

CHASE HAWKS MEMORIAL ASSOCIATION, INC

AGENCY REFERRAL

HEALTH PROVIDER / CASE WORKER / CASE MANAGER

PHONE

AGENCY / HOSPITAL / CLINIC / PRACTICE

ADDRESS - CITY - STATE - ZIP CODE

NAME OF APPLICANT / PATIENT

The Grant Review Board is in frequent contact and meets at least monthly to review and prioritize requests. They award grants in aid based on their assessment of the appropriate amount and priority on a first come, first served basis. Individual grants are normally capped at Three Hundred Dollars per request and emphasis is on non -medical expenses. They will always consider exceptions and extenuating circumstances. Your input is invaluable in this process.

OUR APPLICATION INCLUDES PER MISSION TO VERIFY ANY INFORMATION PROVIDED. PLEASE COMPLETE: CHECKLIST FOR SUPPORTIVE INFORMATION

- ✓ APPLICATION IS ATTACHED OR HAS BEEN SENT TO CHMA _____
- ✓ HEALTH PROVIDER VERIFICATION IS ATTACHED _____
- ✓ MY OFFICE HAS VERIFIED THE DETAILS AND NEEDS DESCRIBED IN THE APPLICATION YES _____ NO _____
- ✓ I WILL CONTACT THESE ORGANIZATIONS ALSO _____

- ✓ OUR ASSESSMENT INDICATES THAT \$ _____ WILL BE NEEDED TO FUND THIS REQUEST.
- ✓ PRIORITY FOR FUNDS SHOULD BE _____ FIRST, AND THEN _____

- ✓ PAYMENT SHOULD BE MADE TO: APPLICANT _____ SERVICE PROVIDER _____ OTHER _____
- ✓ HOW LONG HAVE YOU KNOWN APPLICANT? _____
- ✓ THE BEST TIME FOR ME TO DISCUSS THIS REFERRAL IS: _____
_____, AT THIS NUMBER: _____

SIGNATURE OF REFERRING CARE PROVIDER

DATE

MUST BE SIGNED BY THE PERSON COMPLETING THIS REFERRAL

FAX BACK TO: 406-869-1719 e-mail: crisis@chasehawks.com
MAIL BACK TO: PO Box 31333, Billings, MT 59107

