PO BOX 31333
BILLINGS, MT 59107

PHONE
(406) 671-5209
(800) 736-5312

CRISIS FAX
(406) 869-1719

CHASE HAWKS MEMORIAL ASSOCIATION

APPLICATION

CHASE HAWKS MEMORIAL ASSOCIATION IS A MONTANA NON-PROFIT ORGANIZATION THAT PROVIDES ASSISTANCE TO INDIVIDUALS AND FAMILIES IN **CRISIS SITUATIONS.**

PLEASE PROVIDE COMPLETE INFORMATION SO THE REVIEW COMMITTEE CAN CONSIDER AND PRIORITIZE YOUR REQUEST.

HEAD OF HOUSEHOLD NAME: _____ **D.O.B.:** _____

PHONE: _____ **E-MAIL:** _____ **SSN:** _____

STREET ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

WHAT IS THE BEST WAY TO CONTACT YOU? _____

MARITAL STATUS: ___Never Married ___Married ___Separated ___Divorced
___Widowed ___Common-Law ___Live-In Partner

EMPLOYER (Last or current): _____ **PHONE:** _____

AVERAGE MONTHLY TAKE-HOME PAY: _____ **HOW LONG AT THIS JOB?** _____

IF NOT EMPLOYED, PLEASE EXPLAIN WHY & HOW LONG: _____

_____

_____

SPOUSE/LIVE-IN NAME: _____

EMPLOYER (Last or current): _____ **PHONE:** _____

AVERAGE MONTHLY TAKE-HOME PAY: _____ **HOW LONG AT THIS JOB?** _____

IF NOT EMPLOYED, PLEASE EXPLAIN WHY & HOW LONG: _____

_____

_____

HOW MANY IN HOUSEHOLD? ADULTS: _____ **CHILDREN:** _____

AGES & RELATIONSHIPS: _____

DESCRIBE THE CIRCUMSTANCES OF THE CRISIS SITUATION FOR WHICH THIS APPLICATION IS MADE:

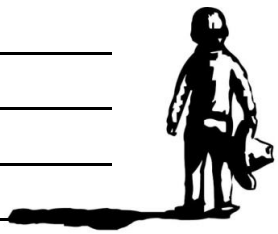
_____

_____

_____

_____

_____



IF THIS IS NOT YOUR FIRST APPLICATION TO CHMA, PLEASE EXPLAIN PRIOR SITUATION(S):

IF MEDICALLY RELATED, DO YOU HAVE MEDICAL INSURANCE? YES ___ NO ____

WHAT PERCENTAGE IS YOUR CO-PAY? _____ WHAT IS YOUR OUT OF POCKET MAXIMUM?: _____

HAVE YOU MET YOUR DEDUCTIBLE? YES ____ NO ____

YOUR FEDERAL PROGRAM STATUS:

Medicaid	**___Applied**	**___Approved**	**_____Monthly Payment Received**
Medicare	**___Applied**	**___Approved**	**_____Monthly Payment Received**
Social Security	**___Applied**	**___Approved**	**_____Monthly Payment Received**
SS Disability	**___Applied**	**___Approved**	**_____Monthly Payment Received**
Housing	**___Applied**	**___Approved**	**_____Monthly Payment Received**
TANF	**___Applied**	**___Approved**	**_____Monthly Payment Received**
Unemployment	**___Applied**	**___Approved**	**_____Monthly Payment Received Ends_____**
WIC	**___Applied**	**___Approved**	**_____Monthly Payment Received**
SNAP	**___Applied**	**___Approved**	**_____Monthly Payment Received**
W/Comp	**___Applied**	**___Approved**	**Monthly Payment Received**
Disability	**___Applied**	**___Approved**	**_____Monthly Payment Received**

HAVE YOU APPLIED FOR ASSISTANCE FROM ANY OTHER AGENCIES OR ORGANIZATIONS? IF SO, WHICH ONES? AND WHAT IS THE STATUS OF EACH APPLICATION (AMOUNT APPROVED, DENIED, PENDING)

CHILD SUPPORT ___ RECEIVE $_____/mo ___ PAY $_____ /mo

DO YOU OWN YOUR HOME? _____ESTIMATED EQUITY? _____MONTHLY PAYMENT? _____

DO YOU RENT? _____MONTHLY RENT? _____HOW LONG AT THIS ADDRESS _____

LANDLORD: _____ PHONE: _____

ADDRESS: _____

DO YOU HAVE FAMILY THAT CAN HELP YOU?

DO YOU HAVE RETIREMENT BENEFITS OR OTHER NON-CASH ASSETS?

DO YOU HAVE AVAILABLE CREDIT (CREDIT CARD, CREDIT LINE, ETC.)? PLEASE EXPLAIN:

PLEASE EXPLAIN WHAT IS NOT COVERED OR COMPENSATED BY THE ABOVE RESOURCES:

WHAT IS NEEDED TO FULLY RESOLVE THIS CRISIS SITUATION?

WHAT IS YOUR SPECIFIC REQUEST OF CHMA?

IF YOU ARE ASKING FOR ASSISTANCE WITH BILLS, HAVE YOU PROVIDED ADDRESSES AND INVOICE OR ACCOUNT NUMBERS OF THE CREDITORS?

HOW DID YOU HEAR ABOUT CHMA?

IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE ABOUT YOUR SITUATION?

APPLICATION CHECK LIST:

- ✓ APPLICATION IS COMPLETE: YOU CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF YOUR KNOWLEDGE
- ✓ REFERRAL FORM IS ATTACHED OR HAS/WILL BE SENT: REASONABLE VERIFICATION IS REQUIRED FOR ALL APPLICATIONS, IT MAY BE FAXED, EMAILED, OR MAILED, BUT **MUST BE REQUESTED BY YOU**.
- ✓ VERIFICATION OF NEED IS ATTACHED IF RELEVANT (HEALTH PROVIDER LETTER, BILLS, ETC…)

ADDITIONAL VERIFICATION MAY BE REQUESTED UPON RECEIPT OF YOUR APPLICATION. AFTER 30 DAYS, INCOMPLETE APPLICATIONS ARE CLOSED, AS WE ASSUME YOU HAVE FOUND OTHER SOURCES OF ASSISTANCE.

ALL INFORMATION MUST BE RECEIVED BEFORE WE CONSIDER YOUR APPLICATION, INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED, UNPROCESSED, TO BE COMPLETED AND SIGNED.

ALL INFORMATION IS VOLUNTARILY PROVIDED

YOU ARE HEREBY AUTHORIZING THE CHASE HAWKS ASSOCIATION TO VERIFY AND SHARE INFORMATION WITH OTHER SERVICES AND CHARITABLE ORGANIZATIONS. YOU ARE HEREBY AUTHORIZING YOUR REFERRAL AGENCY AND ANY OTHER AGENCIES YOU HAVE APPLIED TO FOR ASSISTANCE TO SHARE THAT INFORMATION WITH CHMA.

IF YOU ARE APPLYING ON BEHALF OF SOMEONE ELSE, WHAT IS YOUR RELATIONSHIP TO THAT PERSON?

APPLICANT NAME (Please Print): _____

APPLICANT SIGNATURE: _____

DATE: _____ **BEST PHONE TO REACH YOU AT:** _____

CHASE HAWKS MEMORIAL ASSOCIATION

AGENCY REFERRAL

REFERRING PROFESSIONAL _____ PHONE _____

AGENCY _____ EMAIL _____

ADDRESS - CITY - STATE - ZIP CODE _____

NAME OF APPLICANT _____

The CHMA Crisis Fund Grant Review Committee is comprised of community volunteers who evaluate and prioritize grant requests based on CHMA criteria. Grants are processed on a first come, first served basis within the constraints of the budget. CHMA grants are typically under $500; higher amounts will be considered in extenuating circumstances on a limited basis. Your input is invaluable in this process.

OUR APPLICATION INCLUDES PERMISSION TO VERIFY ANY INFORMATION PROVIDED. PLEASE COMPLETE THE CHECKLIST FOR SUPPORTIVE INFORMATION. IF YOU REQUIRE ADDITIONAL FORMS TO VERIFY APPLICATION DETAILS, PLEASE ASK THE APPLICANT TO COMPLETE THEM – WE WILL CALL TO VERIFY THIS REFERRAL.

- ✓ APPLICATION IS ATTACHED OR HAS BEEN SENT TO CHMA ____
- ✓ HEALTH PROVIDER VERIFICATION IS ATTACHED (if request is medically related) _____
- ✓ I HAVE VERIFIED THE DETAILS AND NEEDS DESCRIBED IN THE APPLICATION YES_____ NO_____
- ✓ WHAT OTHER AGENCIES HAVE YOU REFERRED THE APPLICANT TO FOR ASSISTANCE? _____

_____

- ✓ PRIORITY FOR FUNDS SHOULD BE _____ FIRST, AND THEN

_____

- ✓ IN YOUR OPINION, WHAT IS NEEDED TO FULLY RESOLVE THIS SITUATION?_____

_____

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

_____ , AT THIS NUMBER: _____

_____ _____

SIGNATURE OF REFERRING CARE PROVIDER DATE

MUST BE SIGNED BY THE PERSON COMPLETING THIS REFERRAL

CHASE HAWKS MEMORIAL ASSOCIATION
Return by
FAX: 406-869-1719
EMAIL: christa@chasehawks.com
MAIL: PO Box 31333, Billings, MT 59107
For questions, call 671-5209