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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: _____

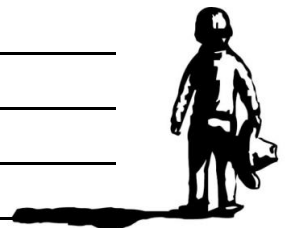
AVERAGE MONTHLY TAKE-HOME PAY: _____ HOW LONG AT THIS JOB? _____

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

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MAIL: PO Box 31333, Billings, MT 59107

For questions, call 671-5209

