CHASE HAWKS MEMORIAL ASSOCIATION, INC.

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APPLICATION

THE **CHASE HAWKS MEMORIAL ASSOCIATION, INC**. IS A MONTANA NON-PROFIT ORGANIZATION FORMED TO PROVIDE SUPPORT TO **FAMILIES IN CRISIS SITUATIONS.**

THE MORE INFORMATION YOU PROVIDE TO HELP OUR REVIEW BOARD CONSIDER AND PRIORATIZE YOUR REQUEST, THE SOONER WE CAN REACH AN INFORMED DECISION AS TO HOW WE CAN BEST SERVE YOU. PLEASE HELP US BY PROVIDING THE FOLLOWING INFORMATION:

I AM MAKING APPLICATION FOR:

NAME: _____

ADDRESS: _____ **HOME PHONE:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

E-MAIL: _____ **MOBILE PHONE:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #** _____

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

APPLICANT'S EMPLOYER (Last or current): _____ **PHONE:** _____
PARENT'S EMPLOYER IF APPLICABLE

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

IF NOT EMPLOYED, PLEASE EXPLAIN WHY: _____

_____

SPOUSE/LIVE-IN EMPLOYER (Last or current): _____ **PHONE:** _____
PARENT'S EMPLOYER IF APPLICABLE

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

IF NOT EMPLOYED, PLEASE EXPLAIN WHY: _____

_____

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

AGES: _____

ARE ANY OF THE ADULTS LIVING IN YOUR HOME NOT WORKING? Why? _____

_____

IF YOU ARE NOT APPLYING FOR YOURSELF, WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

IS THIS YOUR FIRST TIME APPLYING TO CHMA? **Yes** _____ **No** _____

BRIEFLY DESCRIBE CRISIS SITUATION FOR WHICH THIS APPLICATION IS MADE:

IF THIS IS YOUR SECOND OR MORE APPLICATION, PLEASE EXPLAIN PRIOR SITUATION(S):

IF MEDICALLY RELATED, DO YOU HAVE MEDICAL INSURANCE? **YES** _____ **NO** _____

WHAT PERCENTAGE IS YOUR CO-PAY? _____ **IS IT CAPPED?** _____ **AT:** _____

HAVE YOU MET YOUR DEDUCTIBLE? **YES** ____ **NO** ____

WHAT ASSISTANCE ARE YOU RECEIVING FROM OTHER AGENCIES OR ORGANIZATIONS? (PLEASE INCLUDE AMOUNTS)

HAVE YOU BEEN TURNED DOWN BY ANY OTHER AGENCIES OR ORGANIZATIONS? IF SO, WHICH ONES?

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/Disability		___Approved	_____Monthly Payment Received

___CHILD SUPPORT ___RECEIVE $_____/mo ___PAY $_____ /mo

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

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

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 AVAILABLE CREDIT (CREDIT CARD, CREDIT LINE, ETC.) PLEASE EXPLAIN.

WHAT SPECIFICALLY DO YOU WISH CHMA TO HELP WITH?

IF YOU ARE REQUESTING FINANCIAL HELP, HOW MUCH DO YOU FEEL YOU NEED?

IF YOU ARE ASKING THAT BILLS BE PAID, HAVE YOU PROVIDED ADDRESSES AND INVOICE OR ACCOUNT NUMBERS OF THE CREDITORS?

HOW DID YOU HEAR ABOUT CHMA? _____

THE CHMA OFFICE IS RARELY STAFFED. PLEASE DO NOT COME BY OR CALL TO DISCUSS YOUR SITUATION OR TO CHECK THE STATUS OF YOUR APPLICATION; WE WILL NOTIFY YOU OF ANY NEED FOR MORE INFORMATION OR WHEN A DECISION HAS BEEN MADE BY THE COMMITTEE. INCLUDE THE BEST WAY TO CONTACT YOU ON THE APPLICATION.

IF YOUR SITUATION IS MEDICALLY RELATED, PLEASE INCLUDE A VERIFICATION LETTER FROM YOUR HEALTHCARE PROVIDER OR A CHMA REFERRAL FORM. REASONABLE VERIFICATION IS REQUIRED FOR ALL APPLICATIONS. THIS MAY BE FAXED, E-MAILED, OR MAILED DIRECTLY TO THE ASSOCIATION, BUT MUST BE REQUESTED OR PROVIDED BY YOU. APPLICATIONS ARE NOT CONSIDERED COMPLETE UNTIL THIS INFORMATION IS PROVIDED. IF VERIFICATION IS NOT PROVIDED WITHIN 30 DAYS OF APPLICATION WE ASSUME YOU HAVE FOUND OTHER RESOURCES. APPLICANT CERTIFIES THE INFORMATION PROVIDED TO BE CORRECT TO THE BEST OF THEIR KNOWLEDGE.

VERIFICATION INFO MUST BE RECEIVED BEFORE WE CONSIDER YOUR APPLICATION.
WE CANNOT ACT ON INCOMPLETE APPLICATIONS.

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED, UNPROCCESSED, 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.

APPLICANT NAME (Please Print): _____

APPLICANT SIGNATURE: _____

DATE: _____ **PHONE:** _____

CHASE HAWKS MEMORIAL ASSOCIATION, INC.
Return by Mail, or Fax to (406) 869-1719