

Medical Needs Foundation Application for Assistance

ALL INFORMATION PROVIDED IS HELD IN STRICT CONFIDENCE, AND IS ONLY TO BE USED TO ASSESS APPLICANT'S STATUS AS A POTENTIAL MNF RECIPIENT.

Instructions:

In order to be considered as a recipient for a grant, MNF requires that you complete this application in its entirety (including financial forms) and submit it along **with a copy of your families' last two income tax returns, a copy of a pay stub or other income statement indicating household income.** A copy of all outstanding medical bills should be included with the application, and should be summarized.

- 1. Applicant Name: _____
- 2. Birth Date / Age: _____
- 3. Address: _____

- 4. Guardian(s) (if not applicant) _____
Relationship: _____
- 5. Please list family members relying on support by your immediate family unit (other than applicant)

| Name | Relationship | Age |
|------|--------------|-----|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

- 6. Phone Number:
Daytime _____
Evening _____



7. Insurance Coverage: Carrier(s): _____

Plan Type (check all that apply):

- HMO
- Point of Service or PPO
- Indemnity
- Other

Monthly Premium Cost to You: _____

Co-Payments or Deductible: _____

Briefly, describe your insurance benefits:

Prescription Drug Coverage:

Any Plan Limits:

Policy Type (check all that apply):

- Group through employer
- Individual, purchased by self/family
- Government (Medicare/Medicaid)
- Other State Programs (list below)

10. Have you ever applied for any government programs for medical assistance?

____ Yes ____ No

If "yes", what programs, and what were the outcomes of your requests?

11. Have you or are you and / or any family members in the process of applying for Social Security awards? ____ Yes ____ No

If "yes", what is the status of the application?

If you have been awarded a SS benefit, what medical benefits are included, and for which family members?

12. Have you or a family member been assigned a caseworker (for health related purposes) from the State? ____ Yes ____ No

If "yes", for what purpose.

13. Employer Name: _____

Contact: _____

Phone: _____

Address: _____

14. Occupation: _____

15. Personal Financial Statement

| ASSETS | | LIABILITIES & NET WORTH | |
|--|-----------|--|-----------|
| Assets | \$ | Liabilities | \$ |
| Cash Accounts: | | Notes Payable | |
| | | | |
| | | | |
| Brokerage Accounts: | | Credit card / installment loan debt: | |
| | | | |
| Loans due from friends, relatives: | | Income taxes payable (federal & state) | |
| | | | |
| Real estate owned: | | Mortgages against real estate: | |
| Home: | | | |
| Other: | | | |
| | | | |
| Cash value of life insurance policies: | | Loans against life insurance: | |
| | | | |
| | | | |
| Personal assets and others: | | Other debt: | |
| | | | |
| | | | |
| Total Assets | \$ | Total Debt: | \$ |

Net Worth: Total Assets minus Total Debt: \$ _____

16. Salary: _____ Annual/Monthly/Weekly (circle one)

17. Certification: I (we) certify that the information provided on this form is true, correct and complete.

Signature _____ Date _____

Signature _____ Date _____

Return completed application including medical history form (to be completed by your physician) to:

**Medical Needs Foundation
Attention: Outreach Chair
P.O. Box 303
Mountain Lakes, New Jersey 07046**

MEDICAL HISTORY FORM

To Be Completed by Patient:

Name: _____

Address: _____

Insurance Carrier: _____

To Be Completed by Physician:

Name of Physician: _____

Address: _____

Patient Information:

Primary Diagnosis _____

Secondary Diagnosis _____

Medication and/or treatment (include physical or occupational therapy)

Other Treatment Contemplated (please describe)

Durable Medical Equipment needs

Functional Capacity of the Patient (please explain)

Characteristics of Disability: Static or Stable
 Progressive
 Improving

Physician Signature: _____

Printed Name: _____

Date: _____