THE MEDICAL NEEDS FOUNDATION

Application for Assistance – CONFIDENTIAL

This application **must** include:

- Financials
  - Copies of your last 2 years of federal tax returns (1040 form)
  - Copies of your last 2 months of recent checking and savings statements
  - Copies of credit card statements used for medical expenses
  - If you receive Social Security Disability, you must include your award letter
  - If you have been approved for charity care, you must include a copy of the letter from the hospital.
  - If you have a used retirement funds to finance this medical event, include copies of those statements.
- Medical
  - Your physician is required to complete and sign a medical history form regarding your condition. Please have the physician's name, office address and phone number legible.
- Other organizations
  - Include documentation of other funding you may have received in the past year.
- Instructions:
  - Complete this form to the best of your ability. We will use it to guide our conversation
  - **All information is confidential and is only used to assess applicant's status as a potential MNF recipient. Your application information in part or in total may be shared via email with MNF board and those medical professionals that MNF needs to transact with on your behalf. By signing and submitting this application you are permitting the MNF to discuss your medical information with parties involved with your case.**
  - When completed, mail or scan entire application with supporting documentation to:
    - ***Medical Needs Foundation Outreach PO Box 303 Mountain Lakes NJ 07046***
    - ***themnfoutreach@gmail.com***

Contact information can be found on our web page www.themedicalneedsfoundation.org or above email

Please provide use with your contact information:

1.Date	**2. This application is for:** ***please circle*** **_____ Self _____Spouse/Partner _____ Child _____Client I am assisting**
3. Date of Birth:	**4. Applicant's Name:**
5. Address:	
6. Email:	**7. Alternate Email:**
8. Cell Phone Preferred	**9. Alternate Phone:**

Please list your specific requests for financial assistance from MNF. Include the estimated cost for each.

Medical Requests, Needs, Items	Estimated Cost

Family Social Information

Please fill in your family/dependent information:

Name	Age	Relationship	Do they live with you?

Please let us know about your current living situation:

Do you use Veteran Services like the VA? _____ If yes, do you receive VA benefits? _____

If yes, please let us know what services have you accessed or attempted to access through the VA and the outcome?

Employment History

Please provide us with yours or your spouse/partner's employment history including corresponding dates:

Who is your current employer?	
Who is your spouse/partner's current employer?	
If not currently employed, were you (or your spouse/partner) employed prior to medical event?	
When was the date of your last day of employment? (or spouse/partner)?	
Are you currently on short term disability if you were employed? If yes, when did that begin and for how long?	
If on short term disability, when do you or your doctor project it to end?	
When your better, do you anticipate returning to work? If so, when? And will this be to the same job and hours?	
Have you been able to work during this medical event?	
If you are currently unemployed, are you receiving unemployment benefits? If so, for how long and when will they expire?	
Are you unable to work or have you taken a leave or reduced hours due to the care of the applicant?	
If you are not working or receiving benefits, what is your main source of income?	
If your spouse/partner is not working, what is their source of income?	
Please include any employment details you feel are important to this application.	

Insurance and Assistance Information

Please fill in the information known and include corresponding dates:

Medicare Medicaid Short Term Disability Social Security Disability

What health insurance do you have? Please indicate if it is through employer, ACA, COBRA, Medicare, Medicaid, none or something other.	
If you are on Medicare, do you carry supplemental health insurance? If so, who is the carrier and what is the cost?	
Are you eligible for Social Security Disability Benefits, Medicare, or Medicaid? If not, please explain why? Have you been denied Medicare? If you are not eligible for SSD, Medicare, Medicaid, please disregard questions pertaining to it.	
Are you receiving Medicare through Social Security Disability Insurance? If yes, how much is your award? Please include your award letter.	
Have you applied for Social Security Disability (SSD)? If so, when did you apply and where are you in the process?	
If you have not applied to SSD, why not?	
If you are on SSD, how long have you been receiving benefits? When will you be eligible for Medicare/Medicaid? Please include your award letter.	
Are you on Short Term Disability?	
If so, when did your short term disability begin? How many weeks have you left?	
If you are not on short term disability, why not?	
While on short term disability or SSD (without Medicare) are you paying for health insurance like COBRA or another carrier? If so, who is the carrier and what is the cost?	
If you are on short term disability, do you expect to return to work? If so, when? Can you return to the same work? If you aren't planning to return to work, when will you be applying for SSD?	
Have you applied for Medicaid? If so, when and where are you in the process? Were you denied for Medicaid? If so, Why?	
Are you dependents on Medicaid insurance? If not, what insurance are covered under?	

Insurance and Assistance Information

Charity Care Public Assistance Outside Fund Raising

Are you currently on Charity Care? If so, Please include your award letters for the year.	
Have you been denied for charity care? If so, why?	
If you did not qualify for Charity Care previously, have you reapplied?	
What other assistance have you applied for? For example food stamps, use food pantry, heating/electric programs, rent subsides.	
Have you or has someone else or organization raised money for you on your behalf through social media, go fund me, church appeals etc.? If so, please explain and include what the money was used for.	
Have you sought care from local clinics? For example Zufal, Fellows Clinics at Morristown Hospital, Dental Clinic.	

Private Disability and Life Insurance

Do you carry private disability insurance? What is the premium for your policy?	
Are you currently drawing on or made a claim to your private disability insurance? If so, please include when you started it, how much is the benefit and the particulars of the policy.	
Do you carry long term health care policy?	
Do you have life insurance policy? What are the particulars of your policy? For example, the cash surrender the insured amount, did you take a loan out against it.	

Private/Employer Health Insurance

What is insurance carrier for applicant?	
Who does it cover in the family?	
Does the family have different health insurance?, If so, what is the plan/carrier and the monthly cost?	
For the applicant's insurance plan, what is the monthly premium?	
For the applicant's insurance plan, what are is the individual and family deductibles, out of pocket maximums, co-insurance maximums, and co pays? Who much have you paid toward the above for the year? Please include your most recent Explanation of Benefits or Summary of Benefits.	

Insurance and Assistance Information

Private/Employer Health Insurance

For applicant's insurance, please explain your coverage. For example, I pay $15 copay until I reach $1000 individual deductible then the insurance pays 80% until I reach out of pocket of $5000 then insurance pays 100%. Please include in network and out of network coverage details.	
Do you have a drug plan? If so, what is it and explain its coverage, what remains for deductibles and out of pocket. Please include a recent Explanation of Benefits and/or Summary of Beneifts	

Financial Information

Please include your previous 2 years 1040's, and any banking statements for the last 2 months

Please complete on a monthly basis

Income

Net pay	
Pension	
Social Security	
Cash payments for work	
Short Term Disability plus the months remaining	
Long Term Disability	
Unemployment and months remaining	
Welfare	
Private Disability Benefit **If you are receiving this benefit, when did it begin?**	
Retirement disbursement from 401K, Annuity.	
Child support and alimony	
Other sources of income like rental income, or private loans for support, sale of home or other property, 401k/retirement fund one time disbursement	
If you list Zero income, how are you meeting financial demands?	

Liabilities/ Expenses

Average household expense for utilities, gas, car insurance, food	
Tuitions	
Rent	
Home owner's/renter's insurance	
Health insurance premiums	
Drug insurance premiums	
Life insurance premiums. Please include explanation of benefit and/or cash value. Do you have long term care rider?	
Long term Care premium	
Private Disability Insurance premium. **If you are receiving this benefit when did it begin?**	
Property Taxes	

Financial Information

Please complete on a monthly basis

Liabilities Loans

Loan	Monthly Payment	Pay off Amount
Mortgage		
Home Equity Loan		
Car		
Student Loans		
Credit Cards		
Personal Loans		

Other Liabilities

Do you owe property taxes and how much?	
Do you owe water/ sewer and how much?	
Are you in foreclosure or at risk of foreclosure?	
Are you behind in rent payments?	
Do you owe child support or alimony? How much?	
Do you owe income taxes? How much?	
Do you owe utilities? How much?	
Have you bills in collection? If so, how much? Have you been called to court?	
Have you declared Bankruptcy? If so please explain.	
Have you been given an eviction notice?	

Assets

Checking and savings monthly average	
Other financial assets: 401K, Annuity, Trusts, Retirement accounts. Please list total balance.	
Do you own your home? What is the value?	
Do you own other property? What is the value?	
Do you have a pension? What is or will be monthly benefit? If you receive a pension please include Benefit Statement	

Referrals

Do you have a case worker or social worker? If so, please list their contact information	
How did you hear of MNF?	

Mission

Medical Needs Foundation's mission is to provide a onetime financial bridge due to a medical event. If you were to receive a grant, please tell us how it would bridge or assist you during your medical event. Include the medical the applicant's medical history of the condition and the financial hardship created by the condition. Please feel free to include any information that you feel would assist the MNF Board in understanding your situation.

All the information provided in this application and subsequent information gathered during our visit from outreach volunteer to your home will be discussed in confidence at the regular monthly meeting of the MNF Board for purposes of establishing your eligibility for a grant approval. Your information may be shared electronically. By signing below, you are granting permission for your personal information to be shared in confidence with the board and those who may be helpful to your application (doctors, social workers, insurance agents etc.). And you are certifying that all the information provided by you is true, correct and complete.

Applicant Signature:	**Date:**

Your story is very helpful to us in our fundraising efforts. We ask permission to share your story via print, email, and/or video on our web page www.themedicalneedsfoundation.org using your first name and last initial with our donors.

Applicant Signature:	**Date:**

Please return this completed application, any supporting documents, and doctor's signed medical history form to:

Medical Needs Foundation
Outreach Chairperson
PO Box 303
Mountain Lakes, NJ 07046

Medical History
to be completed by your treating physician

Doctor, your patient has submitted an application to the Medical Needs Foundation seeking financial assistance. The MNF is a private not for profit organization that financially supports those who find themselves or a family member is need of a 'bridge' – a short term financial support that will enable them to avoid catastrophic financial crisis or overwhelming burden. Please complete this form reflecting your patient's medical condition. You may return this to the patient, mail it directly to:
MNF Outreach PO Box 303 Mountain Lakes, NJ 07046 or scan to
Themnfoutreach@gmail.com

Patient Name:
Primary Diagnosis:
Secondary Diagnosis:
Medications:
Treatments: (ie: OT/PT Respiratory):
Patient History:
Needed durable equipment:
Needs of patient not being met that MNF might assist if known:
Please indicate the patient's condition: **Static/Stable Progressive Improving Terminal**

Practitioner's Signature:
Date:

Physician's Stamp Or PRINT name address phone