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CHASE HAWKS MEMORIAL ASSOCIATION, INC.



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 PRIORITIZE 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:

OFFICERS

Scott Chesarek
President

Jim Reiter
Vice President

Jody Lamp
Secretary

Rose Larsen
Treasurer

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

APPLICANT'S 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: _____

SPOUSE 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? _____

DIRECTORS

Jack Bell

John Craig, MD

Corby Freitag, MD

Sylvia Gusick

Howard Hawks

Rick Lennick

John Roberts

Christa Ryan

Lynn Sandvick

Carol Trawick

KIDS 'N COWBOYS PROGRAM

Tim Crowley
Administrator



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?

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

YOUR FEDERAL PROGRAM STATUS:

___ MEDICAID	___ APPROVED	___ APPLICATION IN PROCESS
___ MEDICARE	___ APPROVED	___ APPLICATION IN PROCESS
___ SOCIAL SECURITY	___ APPROVED	___ APPLICATION IN PROCESS
___ HOUSING ASSISTANCE	___ APPROVED	___ APPLICATION IN PROCESS

___ 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? _____

DO YOU RENT? _____ MONTHLY RENT? _____ HOW LONG @ 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 ONLY STAFFED A FEW HOURS PER DAY. PLEASE DO NOT COME BY TO DISCUSS YOUR SITUATION, THE COMMITTEE THAT REVIEWS THESE APPLICATIONS DOES NOT MEET THERE. THE STAFF WORKERS DO NOT REVIEW OR APPROVE THESE APPLICATIONS. YOU NEED NOT CALL OR COME BY TO CHECK THE STATUS OF YOUR APPLICATION; WE WILL NOTIFY YOU OF ANY NEED FOR MORE INFORMATION AND ANY DECISION MADE BY THE COMMITTEE. INCLUDE THE BEST NUMBER WHERE YOU CAN BE REACHED; IF YOU HAVE NO PHONE, LEAVE AN ADDRESS WHERE YOU CAN BE CONTACTED.

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 AND AUTHORIZES THE CHASE HAWKS ASSOCIATION, INC. TO VERIFY THE INFORMATION PROVIDED AND SHARE IT WITH OTHER COMMUNITY SERVICE ORGANIZATIONS.

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

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.

APPLICANT NAME (Please Print): _____

APPLICANT SIGNATURE: _____

DATE: _____ PHONE: _____

CHASE HAWKS MEMORIAL ASSOCIATION, INC.
Return by Mail, or Fax to (406) 248-1019

