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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

Larry Bohnen

Jerry Christensen

John Craig, MD

Sylvia Gusick

Rick Lennick

Howard Hawks

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**

