

# Medical Needs Foundation Application for Assistance

**TO APPLY, YOU MUST LIVE, WORK OR GO TO SCHOOL IN MORRIS COUNTY, NJ.  
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:

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Prescription Drug Coverage:

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Any Plan Limits:

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Policy Type (check all that apply):

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

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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?

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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?

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

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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.

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13. Employer Name: \_\_\_\_\_

Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

14. Occupation: \_\_\_\_\_

**15. Personal Financial Statement**

<b>ASSETS</b>		<b>LIABILITIES &amp; NET WORTH</b>	
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:	
<b>Total Assets</b>	<b>\$</b>	<b>Total Debt:</b>	<b>\$</b>

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:** \_\_\_\_\_