



Individual and Family Grant Application

“To support the health and wellness of people living in our service communities.”

The **CHN Foundation** is available to help area children, adults, and families who are diagnosed with a serious medical, dental or mental health condition and lack the financial resources to help them. This Foundation provides support through selected funds to help when an illness becomes a life changing situation. Some of these funds include:

Children’s Fund: Lucille Schultz Caring for Kids Fund helps children and their families who are experiencing financial difficulties due to serious medical conditions.

Adult Fund: Michael D. Chier Memorial Fund provides financial assistance and supportive services to adults with serious medical conditions.

Helping Hands for Cancer Fund provides financial assistance and supportive services to individuals diagnosed with cancer.

Who may apply?

All residents of the Community Health Network service area zip codes may apply.

Service Area Zip Codes

Almond.....54909	Fairwater.....53931	Montello53949	Plainfield54966	Waukau.....54980
Berlin54923	Green Lake54941	Neshkoro54960	Poy Sippi.....54967	Waupaca.....54981
Brandon53919	Hancock.....54943	Omro.....54963	Princeton.....54968	Wautoma.....54982
Cambria53923	Kingston.....53939	Oxford53952	Randolph53956	Westfield53964
Coloma54930	Manchester53945	Packwaukee....53953	Redgranite54970	Wild Rose54984
Dalton53926	Markesan53946	Pickett.....54964	Ripon54971	
Eureka54934	Marquette.....53947	Pine River54965	Saxeville54976	

CONFIDENTIALITY

The CHN Foundation will abide by the CHN Confidentiality Policy. The CHN Foundation may request permission from families receiving help to use their name or information in stories promoting the CHN Foundation.

APPLICATION – Please Print

Applicant/Patient: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Employer: _____ Current Job: _____

Spouse's Name: _____ Current Job: _____

Responsible Party, Guardian or Power of Attorney: _____

Address: _____

Total Number of People Living in Household: _____ How many are your dependents? _____

List Name & Age: _____ List Name & Age: _____

List Name & Age: _____ List Name & Age: _____

List Name & Age: _____ List Name & Age: _____

MEDICAL INFORMATION

Please describe the medical problem/diagnosis, dental or mental health needs. Remember, the more we know, the more likely we can help. (If more space is needed, please attach a written letter.)

Patient's Physician/Dentist: _____

Phone Number: _____

Where is the patient receiving health or dental care services? _____

FUNDING REQUEST

Please check from the list below what you are requesting and the amount. (Attach a copy of the bill, invoice, receipt, or quote.)

_____ Medical, dental or mental health treatment	\$ _____
_____ Transportation costs to and from appointments or treatments	\$ _____
_____ Lodging and meals while receiving out-of-town medical care	\$ _____
_____ Specialized equipment or supplies needed for care and treatment	\$ _____
_____ Supportive services for other family members	\$ _____
_____ Financial assistance, such as medication expenses	\$ _____
_____ Health Insurance Premiums	\$ _____
_____ Other assistance as needed (tell us what you need help with)	\$ _____
_____	\$ _____
_____	\$ _____

(If more space is needed, please attach a written letter explaining your funding request.)

WHAT OTHER HELP DO YOU HAVE TO MEET THIS NEED?

_____ Private Health Insurance

_____ Church, service groups, school, benefit fund

_____ Medical Assistance

_____ Other _____

_____ Family, friend

_____ None of the above

Have you applied to CHN Foundation before? Yes No If yes, When: _____

Have you applied for CHN Community Care? Yes No If yes, When: _____

MONTHLY INCOME

	Patient/Applicant	Spouse
Monthly Wages (Paychecks)	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
Pensions	\$ _____	\$ _____
Public Assistance	\$ _____	\$ _____
Child Support	\$ _____	\$ _____
Unemployment/Workman's Compensation	\$ _____	\$ _____
Rental Property Income	\$ _____	\$ _____
Please list any other income sources:	\$ _____	\$ _____

The CHN Foundation will need proof of income, and may ask for other financial information.

STATEMENT OF ASSETS

Do you own a home? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the current market value? _____
Do you have a mortgage balance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount owed? _____
Do you own a rental property? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the current market value? _____
Do you have a mortgage balance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount owed? _____
Do you own any other property? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the current market value? _____
Do you have a mortgage balance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount owed? _____
Do you own a business? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the current market value? _____
Type of Business? _____	
Inventory Less Indebtedness: _____	
Any Liens against any of the properties listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please List: _____

A copy of your most recent property tax statement(s) may be required.

CASH AND DEPOSIT ACCOUNTS

Do you have a Savings Account? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your balance in that account? \$ _____
Name of Bank/Credit Union: _____	
Do you have a Checking Account? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your balance in that account? \$ _____
Name of Bank/Credit Union: _____	
Do you have any Certificates of Deposit (Bank CD's)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes , than list value(s) of each: \$ _____ \$ _____ \$ _____ \$ _____	
Do you have an IRA, Keogh, Stocks, and Bonds? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes , than list value(s) of each: \$ _____ \$ _____ \$ _____ \$ _____	
Do you have a life insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cash surrender value? \$ _____

VEHICLES / PERSONAL PROPERTY

	<u>Make</u>	<u>Year</u>	<u>Loan Balance</u>	<u>Estimated Value</u>
Auto/Truck	_____	_____	\$ _____	\$ _____
Auto/Truck	_____	_____	\$ _____	\$ _____
Auto/Truck	_____	_____	\$ _____	\$ _____
Snowmobile	_____	_____	\$ _____	\$ _____
Boat/Motor	_____	_____	\$ _____	\$ _____
Motorcycle/Scooter	_____	_____	\$ _____	\$ _____
Motor Home/Camper	_____	_____	\$ _____	\$ _____
Other (specify)	_____	_____	\$ _____	\$ _____

YOUR MONTHLY EXPENSES

Rent _____ Telephone _____ Cell Phone _____
Electricity _____ Water/Sewer _____ Heat _____
Child Support _____ Internet _____ Cable _____

	<u>Who you pay (Company)</u>	<u>Monthly Payment</u>	<u>Balance</u>
Mortgage	_____	\$ _____	\$ _____
Auto	_____	\$ _____	\$ _____
Auto	_____	\$ _____	\$ _____
VISA/Master Card	_____	\$ _____	\$ _____
Charge Card	_____	\$ _____	\$ _____
Charge Card	_____	\$ _____	\$ _____
Other Loans	_____	\$ _____	\$ _____

(Attach a separate sheet if you have other monthly expenses.)

Have you sold any property (real estate, stocks, bonds, savings, etc.) to someone else in the past six months? Yes No
If yes, please tell us the value of the property sold: _____

AUTHORIZATION / PERMISSION AND VERIFICATION

By signing below, I authorize and permit the CHN Foundation to verify any information given on this application in the determination of my eligibility and proof/verification of my residency.

I understand that written proof of my income must be provided before my eligibility can be determined for this application if the request is in excess of \$500.

The information given in this application is true and accurate to the best of my knowledge and represents my current financial status.

Who referred you to the Foundation? _____

(We may contact your qualified medical professional, social worker, or counselor for more information.)

Patient/Applicant Signature: _____ **Date:** _____

Responsible Party Signature: _____ **Date:** _____
(If under 18, or Power of Attorney)

Please Return Application To:
CHN Foundation
225 Memorial Drive
Berlin, WI 54923



Question?
Call (920) 361-6524 or
(800) 236-1283 ext. 6524
www.chnwifoundation.org