



MEMRA

Emergency Assistance Application

The MEMRA mission and ultimate goal as an organization is to provide resources to help socially, financially and spiritually to those in need. With support that provides monetary relief to anyone with a medical emergency situation. To provide individuals with solutions, results, benefits and information plus the ability to service people from devastation of a medical setback. The monies benefits shall be awarded in the form of emergency/financial aid. The Memra Medical Relief Services are provided to citizens regardless of diagnosis, ethnic, age, gender, religion, disability, marital status, national origin, race or creed.

If you would like to request assistance from the MEMRA FUND, please complete this form, fill it out and answer all required sections. Promptly return the signed and completed form along with requested documents if applicable.

1 TYPE OF ASSISTANCE REQUESTED:

1 st Request:	2 nd Request: (must be a non-monetary request)
--------------------------	---

When submitting your request for relief or assistance please be advised the Short Form Application applies only to individuals requesting \$150.00 or less, without medical health insurance benefits and currently unemployed. After submitting your application the medical committee will review all requests within 24 to 72 hours.

2 RESIDENCE INFORMATION:

Last:		First:		Middle Initial:	
Address:		City:		State:	Zip Code:
Home Telephone:		Cellular:		Message/Fax:	
Mailing Address (if different from residence address):		City:	Length:	State:	Zip Code:

3 PERSONAL INFORMATION:

Social Security Number:		Issue State:	Gender:	Date of Birth:	Marital Status:
Identification Number:		ID:	DL:	State:	Place of Birth:
					Nationality:

4 CONTACT INFORMATION:

Contact Name 1:		Relationship:		Telephone:	
Address:		City:		State:	Zip Code:

Please describe in brief detail the reason for your emergency request to receive assistance.

5 ACKNOWLEDGEMENT:

APPLICANT SIGNATURE: (Please indicate relationship to applicant:)	RELATIONSHIP:	DATE:
--	----------------------	--------------

By signing this form you certify that the information given is true and correct to the best of your knowledge. Customer acknowledges that he/she has read and understands this agreement and agrees to, and accepts the terms and conditions for emergency relief/advancement.

Applications Requesting Medical Equipment, Certain Medical Supplies, Pharmacy Prescriptions, Emergency Services, Office Visits, Burial Assistance, Hospital Procedures/Tests, the following documentation is required: A Statement from a Licensed Medical Facility, Primary Physician, City/ State/ Federal Government Agency.

Please Do – Not Write Below This Line • Committee Use Only

Referral submitted by:	Relationship:	Date:		
<p>The following documents are attached or available (as applicable or requested):</p> <p> <input type="checkbox"/> Government Agency <input type="checkbox"/> Medical Records/Facility Statement <input type="checkbox"/> Utilities/Bills/Statements <input type="checkbox"/> Physician Statement <input type="checkbox"/> Income & Earnings Statements <input type="checkbox"/> Medical/Pharmacy Prescription <input type="checkbox"/> Other Income & Earnings Statements <input type="checkbox"/> Other (specify): _____ </p>				
Committee comments and recommendations for relief/assistance:				
Reviewed and sent to Committee by:	Date:			
Committee Signature:	Date:			
Committee Signature:	Date:			
Approved:	Denied:	Pending:	Waiting List:	Interoffice Code:

Emergency:	Accidental:	Acute:	Chronic:	Terminal:	S/L Term:	Temp H/S:
-------------------	--------------------	---------------	-----------------	------------------	------------------	------------------