



Masonic Assistance Program (MAP) Application 2021

Application needs to be resubmitted annually for review.

Please attach all requirements with application.

Last Name		First Name		M.I.	Birth Date	Social Security No.	Family Size
Street and Apt. #		City	State	Zip Code	Home Phone	Cell Phone	
Employer Name & Address						Own	Yes <input type="checkbox"/> No <input type="checkbox"/>
						Rent	Yes <input type="checkbox"/> No <input type="checkbox"/>
Work Phone		City	State	Zip Code	Annual Income	Gross Monthly Income	
Masonic Lodge Name, Number and City:						Member in Good Standing?	
						Yes <input type="checkbox"/> No <input type="checkbox"/>	
Medical/Dental Insurance		Name of Health Insurance Company				Do you own property?	
Yes <input type="checkbox"/> No <input type="checkbox"/>						Yes <input type="checkbox"/> No <input type="checkbox"/>	
I am currently covered under:				Print email:			
Medicare and/or Public Aid							
Yes <input type="checkbox"/> No <input type="checkbox"/>							
<u>Spouse and/or Dependent Information</u>							
Last Name		First Name		M.I.	Birth Date	Social Security No.	Cell Phone
Employer Name						Annual Income	
Employer Address		City	State	Zip Code	Work Phone	Monthly Income	

Checklist:

- I am requesting **MEDICAL ASSISTANCE**.
- I am requesting **DENTAL ASSISTANCE**.
- I reviewed the application and all questions are answered.
- I have attached my most recent Federal Income Tax return.
- I have attached my savings/debit (2 month) bank statements.

Send to:

Ruthie Rivera
Masonic Family Health Foundation, Inc.
836 W. Wellington Ave., CFE Room 189
Chicago, IL 60657
Ruthie.rivera@aah.org (773) 296-7423

All material you provide is held in strict confidence.

By signing below, I understand that if the above information is untrue, any charity granted to me may be forfeit, future requests may be denied and I will be responsible for payment of all medical bills.

Other Information:

If you have additional documents that may help in making a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: rent or mortgage payments, loan payments, or medical bills, etc..)

Applicant Certification: I certify that the above information is true and complete to the best of my knowledge. I understand that as part of the financial screening process, my employment or credit history may be verified.

Applicant Signature: _____

Date: _____