Masonic Family Health Foundation, Inc.

Masonic Assistance Program (MAP) Application 2022					
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.
Street and Apt. #	City	State		Zip Code	Home Phone
Employer Name & Address					Own Yes ☐ N Rent Yes ☐ N
Work Phone	City	State	Zip Code	Annual Income	Gross
Masonic Lodge Name, Number and City:					Member in Yes ☐
Medical/Dental Insurance Yes ☐ No ☐	Name of Health Insurance Company				Do you own prope Yes ☐ No
I am currently covered under: **Medicare and/or Public Aid** Yes ☐ No ☐			**Print email:**		
Spouse and/or Dependent Information					
Last Name	First Name	M.I.	Birth Date	Social Security No.	
Employer Name				Annual Income	
Employer Address	City	State	Zip Code	Work Phone	

Checklist:	**Send to:**
• I am requesting **MEDICAL ASSISTANCE**.	Ruthie Rivera
• I am requesting **DENTAL ASSISTANCE.**	Masonic Family Health Foundation, Inc.
• I reviewed the application and all questions are answered.	836 W. Wellington Ave., CFE Room 189
• I have attached my most recent Federal Income Tax return.	Chicago, IL 60657
• I have attached my savings/debit (2 month) bank statements.	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: _____

www.MasonicFamilyHealthFoundation.org

(1/5/22)