Masonic Family Health Foundation, Inc.

Masonic Assistance Program (MAP) Application 2026						
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 □ No □ Rent Yes □ No □		
Work Phone	City	State	Zip Code	Annual Income	Gross Monthly Income	
Masonic Lodge Name, Number and City:				Member in Good Standing? Yes □ No □		
Medical/Dental Insurance Yes □ No □	Name of Health Insurance Company			Referred by:		
Have you applied for Medicaid? **(Please send DENIAL)** Yes-Awaiting approval □ Yes- Not Eligible No □			**Print email:**			
Spouse and/or Dependent Information						
Last Name	First Name	M.I.	Birth Date	Social Security No.	Cell Phone	
Employer Name			Name of Health Insurance Company:			
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:

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

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: _____