ManKind Financial Benefit Application - a Texas 501(c)3 Corporation for the benefit of Men's Health Crisis Victims, their Families, and Awareness.

Patient Name: _____ Address: _____ City: _____ State: _____
Zip Code: _____ Patient's Date of Birth: _____

Are you a resident of the State of Texas? □ Yes □ No Do you have health insurance covering services you need financial help with? □ Yes □ No

If yes, enter information: Name of Insurance Company: _____ Policy #: _____ Group #: _____

Are you eligible for COBRA? □ Yes □ No Do you have Medicaid benefits? □ Yes □ No Do you have Disability Assistance (DA) benefits? □ Yes □ No

Please list all "family" members (including you). Family members include parents, spouses (regardless of whether they live in the home) & children (natural or adoptive) under the age of eighteen (18) living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, social security benefits, public assistance, etc.

Family Members Age	Relationship to Patient	Source of Income or Employer Name	Income last 3 months	Income last 12 months
		$ Totals:		

If you reported $0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above.

_____

Please provide a brief description of your medical condition, and the financial assistance you need help with:_____

_____

_____. □ CHECK HERE if you have been diagnosed with cancer.

By my signature below, I affirm to the best of my knowledge and belief that the answers on this application are true.

Responsible Party Signature: X _____ Date Completed: _____

Please send completed form to eric@foremankind.org or jtaylor@codeauthority.com