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: _____ Applicant's Date of Birth: _____ Applicant's Cell #:_____

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 applicant has 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. Amount of Money Currently Owing for Medical Care:_____.

Responsible Party Signature: X _____ Date Completed: _____

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

Beneficiary Release Agreement

This is Agreement is between Mankind, Inc. (“MKI”) a Texas non-profit corporation and _____ (“BENEFICIARY”) an individual residing at _____(“ADDRESS”) , effective as of _____(“EFFECTIVE DATE”).

Whereas;

MKI was established for the purpose of charitable endeavors related to men’s health; and

MKI has identified BENEFICIARY as a Texas citizen whom is suffering economic hardship; and

BENEFICIARY has made the assertion he is in need of medical care he cannot afford, and has considerable medical related debts, as of the effective date; and

BENEFICARY has provided factual documentation about his health condition, need of care, and annual income on the “Mankind Financial Benefit Application”.

Now, therefore, it is agreed by and between MKI and BENEFICIARY as follows:

1. The MKI board of directors will consider the needs of BENEFICIARY, and availability of funds and if possible and approved, deliver a payment or other support to BENEFICIARY by US Mail to the ADDRESS..

2. BENEFICIARY will apply the whole amount to his medical debt, medical bills, and future medical care costs, or costs related to the needed medical care, and use these funds for no other purpose.
3. BENEFICIARY agrees to release and hold harmless MKI and its representatives harmless from any claim, damage or responsibility, or for any outcome which may result from this transaction.

4. BENEFICIARY shall represent MKI in a positive light to all other parties and will not disparage its reputation or that of its board members. BENEFICIARY further consents that his name, his likeness, and the details of his medical condition and his family history and his hardship and this charitable act may be used by MRI for the purpose of its own publicity and furthering its own cause in any way MKI sees fit including digital marketing on the public internet.

MANKIND, INC. (“MKI”)

Printed:_____

Signature:_____

Title:_____

Date:_____

Printed Name:_____(“BENEFICIARY”)

Signature:_____

Date:_____