CEMPH FOUNDATION ASSISTANCE

APPLICACATION

Charlie E & Minnie P Hendrix Foundation

PO Box 20954

Ferndale, Michigan 48022

Phone: (313) 303-9217

Email: [charlieeminniepfoundation@gmail.com](mailto:charlieeminniepfoundation@gmail.com)

CEMPH Foundation is a community based, voluntary health organization which is dedicated to bringing forth awareness, education, advocacy, and service.

It is our belief that no one suffering from a chronic illness should live in lack or have, to make choices between feeding your family or purchasing medication. We believe in extending a helping hand instead of pointing a finger. Our goal is See One, Reach One to Educate and Empower the masses.

The maximum grant awarded is $150.00 this amount will be distributed to vendor/provider. Grant approval is not guaranteed, however, through the application process, we will work with you on locating available community resources. Financial assistance is awarded once every 12 months.

The attached packet will provide all eligibility information and documents necessary for applying. All forms must be completed in their entirety prior to consideration. Missing information will delay processing and possible denial.

Applications will be reviewed on the first day of the month following the application date (i.e. applications submitted in June will be reviewed on July 1st). Once application has been received by CEMPH Foundation, the submitter will receive a confirmation via email that the application has reached our office.

ELIGIBILTY REQUIREMENTS

Please note we have detailed the eligibility requirements for the CEMPH Foundation Assistance Grant (CEMPHF Grant). If you feel you meet the criteria, complete the attached application in its entirety and return to CEMPH Foundation for consideration.

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|  | SECTION 1: APPLICATION REQUIREMENTS  All applicants must be a resident of Michigan.   1. Applicant must have a confirmed lupus diagnosis. Ability to provide a notarized letter from a specialty physician on the physician’s letterhead that the applicant has a lupus diagnosis. 2. Applicant may only be awarded assistance from CEMPH Foundation once within a 12-month period. 3. Once the application is received and reviewed, the foundation will confirm application, documentation and available resources. 4. It is the applicants understanding that the CEMPH Foundation award is available only for or on behalf of individuals with Lupus. 5. Financial assistance will be made directly to the vendor/provider on behalf of the patient. 6. Submission of supplemental documentation to [charlieeminniepfoundation@gmail.com](mailto:charlieeminniepfoundation@gmail.com) 7. No phone calls/ email inquiries will be accepted to check the status of the application. |  |

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| SECTION 2: REASON (s) FOR FINACIAL ASSISTANCE  \*\*\*Note\*\*\* There is no guarantee that a grant will be awarded. Our grant is designed to address a verifiable emergency.  The following are appropriate requests for consideration:  Late bills to necessary utilities (water, gas, electricity).  Late or missed rent/mortgage payment  Medical expenses not covered by insurance.  \*\*\*Note\*\*\* The maximum award of $150.00 can be used to subsidize a larger bill. It must be proven that the applicant has another resource (s) to fund the remaining balance. Include documentation of prof when submitting this application.  Example (s) of unacceptable bills include, but are not limited to:  Traffic tickets.  Travel and/or hotel accommodations.  Attorney fees.  Any fees related to child custody issues.  School expenses.  Phone, internet or cable bills.  Credit card bills.  Any request for funding deemed unacceptable by the CEMPH Foundation. |

Financial Hardship Assistance CEMPH Foundation

Application form PO Box 20954

Ferndale, MI 48220

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| Important Information   * Please complete this form and mail to CEMPH Foundation PO Box 20954 Ferndale, MI 48220 |

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| --- |
| Section 1 Applicant details |

Title First Name Last Name

|  |  |
| --- | --- |
|  |  |

Contact number Residential Address

|  |  |
| --- | --- |
|  |  |

City State Zip Code County

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Requested Services: Check the services for which you are requesting financial assistance.

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| I am in need with assistance for the following (check all that apply):  Electrical Water Gas Medical Bill Prescription/Copay  If You have already received a bill, please provide us with a copy showing account information (account number, name address, medication cost, medical bill cost, facility and contact information).  Do you have health insurance? Yes No  Did you apply for Medical Assistance in the past 6 months? Yes No |

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| >If yes, please enclose copy of the Letter of Denial/ and past due amounts of bills |

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| --- | --- |
| Source of Income:  Company   |  | | --- | |  |   Address City State Phone  Wage Amount Weekly/Biweekly |

\*\*\*\*OFFICE USE ONLY\*\*\*

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| --- | --- | --- | --- | --- |
| Rec. Date | Approved | Denied | Contacted | Check # |
|  |  |  |  |  |

DISCLAIMER: I understand that the information I provide will be used only to determine financial assistance from CEMPH Foundation and will be kept confidential. I understand that the materials I send to prove my income will not be returned. I further understand that the information which I submit is subject to verification by CEMPH Foundation including, as necessary, obtaining financial information from employers and other entities listed by me in this application. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval.

My signature authorized CEMPH Foundation to verify all information provided on this form. I certify that the above information is true and accurate to the best of my knowledge.

Signature::\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Individual (If help is needed for someone under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_