Client Name:

Emergency Financial Assistance Service

Application and Instructions

MARTIN CENTER
SICKLE CELL INITIATIVE

To aid and enhance the lives of those affected by Sickle Cell

Martin Center Sickle Cell Initiative is a 501(c)(3) human services agency dedicated to aiding and enhancing the lives of those impacted by Sickle Cell Disease and Sickle Cell Trait in Central Indiana. Our programs include support and education for Sickle Cell and associated disorders. Through education, outreach, school partnerships, medical provider collaborations and advocacy, we endeavor to provide holistic services for those affected by Sickle Cell. Martin Center Sickle Cell Initiative assists the entire Sickle Cell community by providing solutions that address today's needs and reduce tomorrow's barriers for individuals and their families including providing emergency financial assistance for individuals and families with Sickle Cell or other related blood disorders.

Eligibility

Candidates for the Martin Center Sickle Cell Initiative Emergency Financial Assistance Service must:

- Be an adult with **Sickle Cell Disease** or a parent/guardian of a child with Sickle Cell Disease and a resident of Marion, Hamilton, Hancock, Morgan, Hendricks, or Boone Counties in Indiana.
- Meet certain income limit guidelines.
- Present a valid picture.
- Have a bill in client/guardian's name.
- ***Verification that the client/guardian has attempted to pay the bill through other means (such as trying to establish a payment plan, contacting other community resources, etc.)***

Application Procedure

Eligible applicants must complete and submit all of the following materials together in one package.

A completed application form must include:

1. A copy of the current bill or notice that the assistance is paying for. The bill must be in client/guardian's name.
2. Proof of income for all household members earning income.
3. Proof of residence in a Central Indiana County.
4. Proof that the client/guardian has attempted to pay the bill through other means

The client/guardian is responsible for submitting all of the materials to Cortney Owens in person at Martin Center Sickle Cell Initiative, by email to: cowens@TheMartinCenter.org or by fax at 317-927-5167.

PLEASE NOTE!

Each client may receive a maximum of up to $150 per rolling calendar year. Funds will be distributed directly to the company to which the funds are owed. These funds are not guaranteed to any one client in any given year.

Selection Criteria

Candidates are advised that this is a needs-based service. The number of participants assisted will be dependent upon the availability of funds. Assistance will be based on a demonstrated financial emergency. Financial emergencies include but are not limited to: late notices, eviction/foreclosure letters, disconnection notices, etc.

Martin Center Sickle Cell Initiative will evaluate all applications with fairness and regard for the challenges faced by each applicant.

Martin Center Sickle Cell Initiative will reserve the right to conduct interviews with applicants if it feels it is necessary to do so in order to make its final decision.

Qualifying Income Guidelines

No. of people in your household	Total monthly income	Total yearly income
1 person	less than $2,873 a month	less than $34,470 a year
2 people	less than $3,878 a month	less than $46,530 a year
3 people	less than $4,883 a month	less than $58,590 a year
4 people	less than $5,888 a month	less than $70,650 a year
5 people	less than $6,893 a month	less than $82,710 a year
6 people	less than $7,898 a month	less than $94,770 a year
7 people	less than $8,903 a month	less than $106,830 a year
8 people	less than $9,908 a month	less than $118,890 a year

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Emergency Financial Assistance Service Application

PERSONAL INFORMATION			
CLIENT'S NAME:			DATE:
GUARDIAN'S NAME (IF APPLICABLE):			HEMOGLOBIN TYPE OF CLIENT:
ADDRESS:		CITY, ZIP:	
DATE OF BIRTH OF CLIENT:	SOCIAL SECURITY NUMBER OF CLIENT:		
CONTACT INFORMATION OF CLIENT (GUARDIAN IF APPLICABLE)	HOME PHONE:	WORK:	CELL:
	EMAIL:		

TYPE OF EMERGENCY ASSISTANCE REQUESTED:
□ Rent/Mortgage □ Utilities □ Other (please list):

AMOUNT OF BILL OR PAYMENT: $	AMOUNT REQUESTED: $

MARITAL STATUS OF CLIENT OR GUARDIAN (IF APPLICABLE):	SEX OF CLIENT:	PRIMARY LANGUAGE SPOKEN IN THE HOME:	DOES THE HOME CONTAIN A U.S. VETERAN:	IS EITHER THE CLIENT OR GUARDIAN DISABLED:
□ Married □ Single □ Divorced □ Widow/Widower	□ Male □ Female	□ English □ Spanish □ Other	□ YES □ NO	□ YES □ NO

DESCRIBE THE NATURE OF THE EMERGENCY:

DESCRIBE HOW ASSISTANCE WILL HELP RESOLVE THE CURRENT SITUATION:

In order to qualify for assistance, please respond thoughtfully to this question. HOW HAS THE APPLICANT TRIED TO HANDLE THE PROBLEM? MENTION OTHER ASSISTANCE ACCESSED RECENTLY (cap, trustee, multi-services centers, ETC. – APPLICATIONS CANNOT BE PROCESSED WITHOUT THIS INFORMATION):

Income
Number of people in your household _____
(Include yourself, your spouse and your dependents)

What is your total combined household income? $_____Monthly or $_____ Yearly
(Include yourself, your spouse and your dependents)

By signing below, I certify that the statements herein are true to the best of my knowledge and grant my permission for the information contained within to be shared with Martin Center Sickle Cell Initiative staff.

Client/ Guardian Signature:	Date:

PAYMENT TO BE ISSUED TO: (Should be landlord, mortgage or utility company or other qualified vendor) Please include a copy of the mortgage coupon, rent receipt, or current utility bill:

MCSCI USE ONLY:				
Vendor Name:	Account Name:	List all dates of prior emergency assistance from this fund in last 3 years:		
Account Number:	Payment Address:			
MCSCI Staff Signature:			Date:	
MCSCI President/CEO Signature:			Date:	
Date Check Issued:	Check #:		Date:	
FAS Application Number: FAS 2016-_____	Approved: □	Denied: □	Amount Approved: $	