The Kelly Mead Fund
Application for Support

Application Date: _____

Applicant's Name: _____ DOB: ___

Applicant's Address: _____

City, State, Zip: _____ County: _____

Home Phone: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Name of person completing application: _____ Relationship to applicant: _____

Annual gross family income: _____

Other sources of income: _____

(Child support, maintenance, trust funds, legal settlements, or monies in other special fund)

Number of persons in family: _____ (including person with illness or needing transplant)

Does any household member have special needs? (Circle) Yes / No

If yes, who and what is the special need: _____

Is the applicant covered by private insurance? (Circle) Yes / No

If yes, please specify insurance carrier: _____

Is the applicant qualified for any government programs? (Circle) Yes / No

If yes, please list agency: _____

Do you have a County Social Worker/Service Coordinator? (Circle) Yes / No

Name: _____ Phone: _____

Please provide background information about your medical situation: (list as much information as possible)

Please use additional sheets of paper as needed for fully describe circumstances

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How will you use these funds if granted?

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The following documents are required to be submitted with the application before it can be turned to the committee over for review.

_____ Doctor Documentation, stating illness
_____ Proof of expenses being paid – any receipts, travel tickets, out of town appointments & mileage

Please note the following:

- This application is for any uncovered medical expenses and costs associated with traveling to medical appointments and any other expenses that may be incurred because of illness.
- Applications will be reviewed once a month by a committee who will decide.
- Please submit documentation for expenses with your application.
- Applications *may* be awarded up to $500 every 12 months, subject to the availability of funds and approval by the committee. The committee expressly reserves the right to adjust the maximum amount awarded at any time.
- The completion of this form does not guarantee you have been approved for assistance. You will be notified after the committee has decided.

Signature of person completing application: _____ Date: _____

For Internal Office Use Only:

Reviewer Notes:

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Approved on: _____ Amount Approved For: _____

Denied on: _____ Notified Client on: _____

Client Consent and Release of Information

MAACLink is a computer system that is used locally as a Homeless Management Information System (HMIS). Use of an HMIS is required by the US Department of Housing and Urban Development (HUD) for agencies that receive HUD funding. MAACLink is not electronically connected to HUD and is only used by authorized agencies. All MAACLink users have received confidentiality training and have signed strict agreements to protect clients' personal information and limit its use appropriately.

A Privacy Notice is available at participating agencies. It provides details on how member agencies and their employees handle client information and data sharing.

I give permission to _____ (Agency Name) to collect and enter my personal and household information into the MAACLink computer system.

I understand that the MAACLink system is shared with and used by authorized agencies in my community for the purposes of:

1. Assessing the needs of low-income, homeless or other people with special needs in order to give better assistance and to improve their current or future situations.
2. Improving the quality of care and service for people in need.
3. Tracking the effectiveness of community efforts to meet the needs of people who have received assistance.
4. Reporting data on an aggregate level that does not identify specific people or their personal information.

I understand that:

- All agencies that use MAACLink will treat my information in a professional and confidential manner.
- Signing this release form does not guarantee that I will receive assistance.
- My information may be shared with a third party (utility provider, landlord, etc) in order to process the service I have requested.
- I have the right to a printed copy of my MAACLink file.

☐ (Optional) Check this box to give consent for your photo to be uploaded to MAACLink.

Client Name (Printed)	Client Signature	Date

Agency Representative Name (Printed)	Agency Representative Signature	Date

Each MAACLink agency will require you to sign this form at least annually. If after you sign this form you decide you no longer would like your information entered into MAACLink, please complete the Client Revocation Form. If you do not revoke this authorization, it will automatically expire on _____ or one year from the date you sign and date this form.