Moving Mountains Foundation
Application for Assistance

*****If applying as an organization only fill out responsible party and organizations name*****

Applicant's or organizations name: _____

Date of Birth: _____

Age:_____Gender: □ Male □ Female Diagnosis: _____

Responsible Party (If applicable): _____

Address:_____City:_____State:_____Zip: _____

Telephone: (Home):_____(Email): _____

Household Information

Child lives with_____Number of dependents in household: _____

Household annual income: _____

Emergency Contact Name:_____Telephone:_____

Funding Information Does the individual have health insurance? Yes____No_____

Has funding been requested from additional sources? Yes____No_____

If yes, please list why funding was not provided:

_____

_____

_____

Amount requested from Moving Mountains Foundation $ _____

Medical Information (Health care professional associated with funding request)

Healthcare professional's name:_____Clinic Name: _____

Address:_____City:_____State:_____Zip: _____

Telephone:_____Fax: _____