Moving Mountains Foundation

Application for Assistance

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

Applicant's or organization's name: _____ Date of Birth: _____

Item being requested with description and/or link:_____

Justification for why item is needed and its impact on individual's needs:_____

_____

Amount requested from Moving Mountains Foundation $ _____

Responsible Party (If applicable): _____

Address: _____ City:_____ State: _____ Zip: _____

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

Household Information

Applicant lives with_____ Number of dependents in household: _____

Household annual income (additional documentation may be requested as needed): _____

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:

_____

_____

_____

Health care professional associated with funding request

Healthcare professional's name: _____ Clinic Name: _____

Contact information:_____