



MANNA MEMBER

(800) 264-2562

FAX: (321) 308-7779

RFA – Request for Financial Assistance to be completed by MANNA MEMBER

To help expedite your request for financial assistance, please include all relevant and requested information which supports your loss of income due to illness or injury.

Manna member's full name		DOB: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		SSN: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Home address		Is this a new need? <input type="checkbox"/> Yes <input type="checkbox"/> No	Best phone # () ()
My monthly earned income is \$	Date unable to work / /	Date treatment began for illness or injury / /	
Is condition due to an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of injury / /	Where did it occur?	
Describe how injury occurred: Using the space below and the back of this form, if necessary, provide a summary of where you work, what kind of work you perform, as well as whether or not you are able to continue drawing any income from that work. If you are self-employed, an owner or partner of a business, please elaborate on how much of your income has been reduced as result of your injury or illness.			

Please answer the questions below:

1. Have you read and do you understand the Manna Guidelines? Yes No
2. Because of this illness or injury, has your income been lost and are you unable to perform the material and substantial duties of your occupation? Yes No
3. Are you self employed? Yes No
4. Do you currently have any other source of income? Yes No
5. Do you understand that the monetary assistance you receive each month from Manna members is based on member participation?
 Yes No
6. In the past 24 months have you missed ten consecutive work days or more than 20 total days of work due to sickness or injury (not related to pregnancy)? Yes No If yes, how many total? _____
7. Have you ever collected disability income from worker's compensation, disability insurance or similar source? Yes No
(If answering yes to questions #6 or #7, please provide details on a separate piece of paper)
8. Does your doctor believe you will be disabled for at least 60 days as a result of this incident? Yes No
9. Are there any other official resources available to replace any part of your lost income after 60 days? Yes No
If so, please list _____

The above statements are true and accurate to the best of my knowledge _____

Manna Member Signature/Date

Please have your Pastor read and acknowledge the statements below by his check off and signature.

- To the best of my knowledge, the above named Manna member is a Christian and lives a lifestyle in line with biblical principles.
- To the best of my knowledge, the above named Manna member is unable to perform normal work duties because of their disabling illness or injury.

Pastor printed name and Signature/Date

Church Name/Telephone/Email

Please mail completed form to: Christian Care Ministry - Manna, PO Box 121505, West Melbourne FL 32912



EMPLOYER

(800) 264-2562

FAX: (321) 308-7779

RFA – Request for Financial Assistance to be completed by EMPLOYER

I hereby authorize the release of the below requested employment information to Christian Care Ministry from my Employer as indicated.

Signature of Manna Member: _____ Date: _____

1. Employer name		Employer phone number		
2. Employee name				
3. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: / / <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time _____ Hours worked				
4. Date of hire / /		Last date worked / /		
5. Major job duties/ responsibilities?				
6. Lifting required? <input type="checkbox"/> Office work (0 – 10 pounds) <input type="checkbox"/> Light (11 – 25 #) <input type="checkbox"/> Medium (26 – 60 #) <input type="checkbox"/> Heavy (More than 60 #)				
7. How is employee’s compensation calculated? <input type="checkbox"/> hourly <input type="checkbox"/> salary <input type="checkbox"/> bonus <input type="checkbox"/> commission <input type="checkbox"/> salary + commission				
8. Prior to date last worked how often was employee paid? <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> semi-monthly <input type="checkbox"/> monthly				
Gross Monthly Pay \$	Bonuses? \$	Overtime? \$	Commission? \$	W-2 Earnings? \$
9. Over the past 6 months how much gross salary was paid to this employee? \$ _____				
10. Date paid through? / /				
11. Was the employee working when injured? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is employee entitled to Worker’s Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No Note: If worker’s compensation was denied, a copy of denial is required.				
Name of person completing this form		Telephone number ()		E-mail address
Title of person completing this form		Signature		Date signed / /

Please include copies of the applicable information below along with this completed form:

- A. If you are an employee of a business, please send your most recent W-2 form and copies of your 3 most recent pay stubs.
- B. If you are self employed, an independent contractor, owner or a partner, please send your most recent tax return and any quarterly filings.

Please mail completed form to: Christian Care Ministry - Manna, PO Box 121505, West Melbourne FL 32912



PHYSICIAN

(800) 264-2562

FAX: (321) 308-7779

RFA – Request for Financial Assistance to be completed by PHYSICIAN

I hereby authorize the release of the below requested medical information to Christian Care Ministry.

Signature of Manna Member: _____ Date: _____

Manna Membership Date: _____

1. Manna member's full name _____		DOB: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		SSN: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
2. Occupation	Major job duties/responsibilities?		
3. Date first unable to work:	Date hospitalized:		
4. Has patient been released to work in his/ her occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No If not when should your patient be able to return to work? Full time: _____ Part time: _____			
5. Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
6. Date of first visit for the illness or injury: / /			
7. Has patient ever had symptoms of or treatment for this condition prior to the Manna membership date above? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Nature of treatment (including medication and surgery predicted)		Date of surgical procedure:	CPT Code
9. If the patient has demonstrated a loss of function, please describe restrictions and limitations below.			
RESTRICTIONS (what the patient <u>should not do</u>):			
LIMITATIONS (what the patient <u>cannot do</u>):			
10. Can the patient <input type="checkbox"/> sit <input type="checkbox"/> stand <input type="checkbox"/> walk <input type="checkbox"/> lift <input type="checkbox"/> speak clearly <input type="checkbox"/> remember? (check if yes) Comments:			
11. Date restrictions and limitations began: / /			
12. Does the patient currently use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Does the patient have a history of abuse of alcohol or drugs, or have they used tobacco twelve months prior to the Manna membership date above? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Referring physician or other treating physician(s)			
Print or type name of Physician completing Form:		Medical Degree	Medical Specialty
Street Address			Telephone number
City	State	Zip Code	Fax number
Signature of Physician			Date
Tax ID number		Are you related to the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the relationship?	

Please mail completed form and all applicable office notes and test results to:

Christian Care Ministry - Manna, PO Box 121505, West Melbourne FL 32912