

Individual Equipment Application

Please return the following to 3031 S Russel St, Missoula, MT 59081:

- This application
- Letter from your healthcare provider that includes relevant diagnoses, specific request for funding, and any other relevant information
- Proof of income (pay stub, last year's 1040 or W-2, or a letter from employer)

Your Name:

Address:

City, State, ZIP:

Phone number:

Email:

Equipment requested:

Diagnoses relevant to this equipment:

How will this equipment make your life better?

Funding Information

Cost of equipment:

Household income:

Number of people in household, including you:

Medical Expenses (excluding the equipment):

To qualify for funding on the basis of financial need, household income (minus outstanding medical expenses) must be at or below the federal poverty line. If you do not meet this standard, we require a 25% funding match, met either through funds, in-kind donations, or community service contributions.

Household contribution to cost:

If you wish to contribute to the cost of your equipment through community service, contact us.

Do you have health insurance? If so, what is the name of your insurance company?

Has funding been requested from your insurance or additional sources?
If funding was denied, please state why.

Has Moving Mountains Foundation served you before?

- No
- Yes, through grants or funding
- Yes, in some other way

Check all that apply:

(This question will not be considered in determining whether you qualify; it is only to report data to Moving Mountains Foundation's generous benefactors).

- Under 18
- Veteran
- Family member of a veteran
- Active-duty military personnel
- Family member of active-duty military personnel

Anything else we should know?

Medical Information

Name of healthcare provider associated with this request:

Clinic name:

Address:

City, State, ZIP:

Telephone:

Fax:

Signature

I certify that the information on this form is true to the best of my knowledge and give Moving Mountains Foundation permission to contact my healthcare provider as necessary.

Please contact foundation@mmtherapycenter.com or call (406)-396-4130 with any questions.

Thank you for applying! We hope we can be of service to you.