NAMI Mobile Care Fund Application

NAMI Care Funds are used to assist individuals living in Mobile County living with a mental health condition and/or a family member with financial need. The application is the first step to receiving NAMI Mobile Care Funds. You will be contacted after the Care Fund Committee receives your application.

DATE RECEIVED BY NAMI:_____

☐ **APPROVED** _____ **DATE** _____ **AMOUNT APPROVED**

☐ **DISAPPROVED (Reason for denial)**_____

_____

REFERRED BY:

☐ Self ☐ Mental Health Professional ☐ Parent/legal guardian/family member ☐ NAMI member

DATE OF APPLICATION:_____

First Name: _____ Last Name:_____

Email:_____ Phone:_____

Address:_____ City, State, Zip_____

Name and contact information of person referring applicant, if other than "Self":

Name_____ Email _____

Phone_____

PLEASE CHECK THE BOX BELOW FOR THE FUND YOUR ARE REQUESTING:

- ☐ **General Fund** (These funds are to be used only for an individual living with a mental illness and may be used to provide for the following: clothing, personal care items, household goods, food or special needs as recommended by a clinician.)
- ☐ **Dental Fund** (These funds are to be used only for an individual living with a mental illness. Applicant must provide proof that the dental procedure is necessary and must also provide itemized cost from the service provider. The granted funds will be used to pay for the procedure or to offset the cost. Cosmetic procedures are not included.)
- ☐ **Transportation & Lodging** (These funds are to provide financial assistance with travel and, if needed, lodging so that family members/guardians can visit a relative receiving psychiatric treatment in an inpatient treatment facility.)
- ☐ **Educational Grant** (These funds may be used for an individual living with a mental illness or a family member. The workshop/conference must be related to mental illness. The person should be a NAMI Mobile member in good standing & should participate in NAMI meetings, activities, etc. The applicant should be willing to present the information at a future NAMI meeting. Please provide in writing the reason the grant should be awarded.)

If this request is for dental assistance, please complete the following information:

Are you living with a mental illness? _____Yes _____No (If no, you do not qualify for dental funds)

Do you have any dental insurance? _____Yes _____No

What is the amount of your request? _____(Please attach a copy of estimated charges/treatment plan from the dental provider)

Contact information of the dental provider:

NAME OF DENTIST:_____

ADDRESS:_____ CITY:_____

PHONE:_____

Please provide a brief description of your request and why financial assistance is necessary:

_____

_____

_____

_____

Amount requested_____ (Please attach a copy of bill or estimate from provider, to whom payment will be made directly upon approval.)

_____

NAMI Care Fund Committee Use Only:

NAMI Care Fund Committee Determination (Limit $500)

Amount Requested_____ Approved_____ Disapproved_____ Date_____

If disapproved, reason for denial_____

_____

Sent for full board approval (All Requests Over $500) Date_____

Amount Requested_____ Approved by full board _____ Disapproved_____ Date_____

If disapproved, reason for denial_____

_____

Please complete application, scan and email with a copy of necessary documents to: NAMIMobile1@gmail.com or send by mail to **NAMI Mobile, P.O. Box 161522, Mobile, AL 36616**