Mary W Mackinnon Fund Guidelines

(This fund is for elderly residents of the Town of Sidney who are in need of this help)

Any unpaid medical bills / pharmacy receipts should be sent to:

The Mary Mackinnon Fund
c/o Community Bank N.A.
245 Main St
Oneonta, NY 13820
Attn: Thomas Crabtree

Benefits are paid on a weekly basis including any reimbursement checks payable to the recipient. A letter will be sent detailing the payments that were made on behalf of the recipient quarterly.

Items Covered:

Medical Expenses:

- Any co-pays or co-insurance
- Emergency room services
- Lab charges
- Diabetic supplies
- Emergency medical transport

Dental Services

- Pay full cost of most dental

Hearing Aids

- Covered in full including repairs

Eye Glasses

- Covered in full

Prescriptions

- Full reimbursement with receipts or proof of purchase

Items that are *not* covered

- **Any chiropractic care that is not covered by Medicare**
- **Massage therapy**
- **Durable medical equipment**
- **Prescription sun glasses**
- **Non-emergency medical transport**
- **Over-the-counter medication**
- **Nursing home care**

MARY W. MACKINNON FUND
COMMUNITY BANK N.A., TRUSTEE
245 MAIN STREET, PO BOX 430
ONEONTA, NY 13820

APPLICATION FOR ASSISTANCE

TO QUALIFY FOR ASSISTANCE, SOME DEGREE OF NEED OR HARDSHIP MUST BE ESTABLISHED. THEREFORE, A STATEMENT OF THE INCOME, ASSETS, AND LIABILITIES OF THE PROPOSED BENEFICIARY SHOULD ACCOMPANY THIS APPLICATION. ALL SUCH INFORMATION WILL BE HELD IN STRICTEST CONFIDENCE. APPLICANTS MUST ALSO BE SIDNEY RESIDENCE, AGE 65 OR OVER

APPLICATION IS HEREBY MADE FOR FINANCIAL ASSISTANCE IN THE FOLLOWING CASE:

NAME OF PROPOSED BENEFICIARY: _____

DATE OF BIRTH: _____

RESIDENCE OF TOWN OF SIDNEY SINCE: _____

WILL THIS BE A SINGLE OR CONTINUING REQUEST? _____

IF THE LATTER, FOR WHAT LIKELY PERIOD? _____

ARE YOU THE BENEFICIARY OF ANY ONGOING TRUST FUNDS? _____

REMARKS, ADDITIONAL INFORMATION OR COMMENTS REGARDING THE NEED IN THIS CASE:

_____

_____

PLEASE COMPLETE AND RETURN THE ATTACHED FINANCIAL QUESTIONNAIRE ALONG WITH THIS APPLICATION. COPIES OF MEDICAL BILLS AND MEDICARE STATEMENTS FOR SPECIFIC EXPENSES TO BE CONSIDERED MAY ALSO BE ATTACHED.

_____ _____

SIGNATURE OF APPLICANT, PHYSICIAN. HOSPITAL, NURSING HOME MANAGER, CASE WORKER, OR OTHER PERSON OR AGENCY MAKING RECOMMENDATION

DATE

MARY W. MACKINNON FUND
COMMUNITY BANK NA, TRUSTEE
245 MAIN ST., ONEONTA, NY 13820

FINANCIAL QUESTIONNAIRE

1) Applicant Name_____ 2) Soc. Sec. No._____

Co-Applicant Name _____ Soc. Sec. No._____

3) Address _____

4) Phone_____ 5) Birthdate_____ 6) Marital Status_____

Birthdate_____

7) Assets:		8) Income (Monthly):	Husband	Wife
Cash	$ _____	Wages	$ _____	_____
Checking	_____	Social Security	_____	_____
Savings	_____	Interest	_____	_____
CD's	_____	Dividends	_____	_____
Mutual Funds	_____	Pensions	_____	_____
Stocks	_____	IRA's	_____	_____
Bonds	_____	Unemployment	_____	_____
Real Estate	_____	Rental	_____	_____
Personal Property	_____	Child Support	_____	_____
Other	_____	Other	_____	_____
Total Assets	$ _____	Total Income	$ _____	_____

9) Expenses (Monthly):

Rent/Mortgage _____
Food _____
Utilities _____
Loans _____
Credit Cards _____
Other _____

Total Expenses $ _____

10) Enter amount of medical expense, paid and unpaid, in the last 12 months. Do not include those covered by insurance.
Paid: $_____ Unpaid: $_____

11) Health Care Insurance:

Medicare # _____
_____
Medicaid # _____
Veterans # _____
Other _____
_____

I hereby certify that this information is true to the best of my knowledge.

_____ _____

_____ _____

Signatures of Applicants Date