



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 Participant's Full Name: _____

Date of Birth: / / Social Security Number: - -

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

Phone Number: _____ Is this a new need? YES NO Monthly earned income \$ _____

Date unable to work ___ / ___ / ___ Date treatment began for illness or injury ___ / ___ / ___

Is condition due to an injury? YES 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 participants is based on 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 Participant 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 participant is a Christian and lives a lifestyle in line with biblical principles.
- To the best of my knowledge, the above named Manna participant is unable to perform normal work duties because of their disabling illness or injury.

Pastor printed name and Signature/Date

Church Name/Telephone/Email



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

Signature of Manna Participant: _____ Date: _____

Employer Name: _____ Employer Phone Number: _____

Employee Name: _____

Has Employee returned to work? YES NO If yes, date ___/___/___ Full-time Part-time ___ Hours worked

Date of hire ___/___/___ Last date worked ___/___/___

Major job duties/responsibilities: _____

Lifting required? Office work (0 - 10 lbs.) Light (11 - 25 lbs.) Medium (26 - 60 lbs.) Heavy (More than 60 lbs.)

How is employee's compensation calculated? hourly salary bonus commission salary + commission

Prior to date last worked how often was employee paid? weekly bi-weekly semi-monthly monthly

Gross Monthly Pay \$_____ Bonuses \$_____ Overtime \$_____ Commission \$_____ W-2 Earnings \$_____

Over the past 6 months how much gross salary was paid to this employee? \$_____ Date paid through ___/___/___

Was the employee working when injured? YES NO If yes, is employee entitled to Worker's Compensation? YES NO

Note: If worker's compensation was denied, a copy of denial is required.

Name of person completing this form: _____ Phone Number: _____

Title of person completing this form: _____ E-mail: _____

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.



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

Signature of Manna Participant: _____ Date: _____

Manna Participation Date: _____

1. MannaParticipant'sFullName: _____

Date of Birth: / /

Social Security Number: - -

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? YES 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? YES NO 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 participation date above? YES 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 should not do): _____

LIMITATIONS (what the patient cannot do): _____

10. Can the patient sit stand walk lift speak clearly remember? (check if yes)

Comments: _____

11. Date restrictions and limitations began ___ / ___ / ____

12. Does the patient currently use tobacco? YES 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 participation date above? YES NO

14. Referring physician or other treating physician(s): _____

Print or type name of Physician completing Form: _____

Medical Degree: _____ Medical Specialty: _____

Phone Number: _____ Fax Number: _____ Tax ID Number: _____

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

Signature of Physician: _____ Date: _____

Are you related to the patient? YES NO If yes, what is the relationship? _____