MCS FUND
MEESHA C. SAXTON
SUPPORT FOR SICKLE CELL CHAMPIONS
2060 West 65th Street Cleveland, Ohio 44102
Phone: 216)466-3801 Email: MCSaxton.Funds@gmail.com

****

RE: PROCEDURES FOR REWARDING CHECKS TO REQUESTING AGENCIES

All rewards issued in response to request for rewards funding from the Meesha C. Saxton Funds will be mailed directly to vendors, social workers, or agency directors.

Checks are never mailed to the social worker making the fund request.

We require the signature of the LSW making the application. Additionally, we require up-to-date LSW licenses for all social workers.

We thank you in advance for your understanding and look forward to continuing to work with your agency on providing Supportive Services & Advocacy serving the needs of people plagued by this disease.

Teresa S. McCurry, Director

Melvina Saxton, President

MCS FUND
MEESHA C. SAXTON
SUPPORT FOR SICKLE CELL CHAMPIONS
2060 West 65th Street Cleveland, Ohio 44102
Phone: 216)466-3801 Email: MCSaxton.Funds@gmail.com

Directions for Completion of Application

1. Applicant must be an adult 18 years or older, reside in Cuyahoga county, **and** be an individual with documented sickle cell disease.

2. The form **must be filled out in its entirety** by a social worker, case worker or medical professional. **If the form is not filled out completely, the application will not be processed and cause a delay.** All contact with the MCS ~ Fund must be with the social worker; we do not take calls from clients. We require a copy of the licensure of the social worker or medical professional and a copy of the 501c3 status for your agency. **EACH APPLICATION MUST INCLUDE A SIGNATURE OF THE LSW, LISW, MEDICAL PROFESSIONAL, OR AGENCY DIRECTOR MAKING THE REQUEST. APPLICATIONS WILL NOT BE PROCESSED WITHOUT A SIGNATURE**

3. Please include all client information. **We require a valid social security number (last 4 digits) to process the application.**

4. Keep in mind that all checks are made out to a VENDOR, checks are never written to a client or a social service agency or requesting medical professional/ agency. Please identify the payee for each check request (for example: name of landlord, AT&T, etc.). If you are asking for payment on an invoice, a copy of the invoice statement must be included with the application, along with a Federal Tax Identification Number for the vendor.

5. **For utility assistance,** we **require** a copy of the client's most updated bill in order to write a check on their behalf.

6. **For rent assistance,** we **require** a written statement of verification from the Landlord showing amount of rent due and payable, and including the landlord's address, phone number and Federal I.D number. In the absence of a Federal Tax I.D number, a social security number for the Landlord will be acceptable. The address of the tenant must also be on the back up. The vendor information on the application and information on the back up, whether it is a statement or a lease agreement, must match.

7. Notifications of approval/denial will be given (in writing, email and/or by phone) within seven to ten business days from the MCS office. If approved, you will receive notification and payment amount, method of payment and dissemination of funds prior to processing.

8. Rewards may be received **ONLY ONE-TIME PER CALENDAR YEAR** for each client. If your client has received funding from MCS ~ FUND through another agency, they are not eligible for the remainder of that year. The maximum grant is $150. Please represent your client's needs realistically.

   PLEASE make sure to fill in your agency name and complete address with ZIP code so that we may mail the check to you immediately. You are responsible for getting the check to your client. Checks must be used within 90 days of the date on the check, after this, the check automatically becomes VOID. If a check is not used for any reason, please send it back to us.

9. The preferred method of making a request is via email to: MCSaxton.funds@gmail.com. Applications mailed to the office may take longer to process: **2060 West 65th Street, Cleveland, OH 44102**

Thank you **Revised August 2019**

MCS FUND
MEESHA C. SAXTON
SUPPORT FOR SICKLE CELL CHAMPIONS
2060 West 65th Street Cleveland, Ohio 44102
Phone: 216)466-3801 Email: MCSaxton.Funds@gmail.com

PLEASE FILL APPLICATION OUT COMPLETELY OR THE APPLICATION WILL NOT BE PROCESSED

Name: _____ Intake Date: _____

(Last) (First) (Initial) Birthdate/ Age: _____

SOCIAL SECURITY# XXX-XX-_____ (INCLUDE ONLY LAST FOUR DIGITS; EX. XXX-XX-9999)

Address: _____

Referred by: _____

Applicant's Phone # _____ Marital status: S M D W

Email address: _____

Signature of Applicant _____

Name of Agency Director/Licensed Social Worker _____

Signature of Licensed Social Worker _____

Agency Name and Address: _____

Phone #_____ Fax #: _____

Are You: ____ Individual with sickle cell disease (SCD)

____ Parent/Legal Guardian/Caregiver of Individual with SCD

____ Spouse of Individual with SCD

____ Member of a local Sickle Cell Support Group

REQUEST	AMOUNT REQUESTING (Maximum $150)	PAYABLE TO WHOM
Rent / Mortgage		
Utilities*		
Transportation, Lodging, Meals		
Prescriptions		
Ancillary Item/Equipment		
Education/Funeral Burial		
Other (To be considered)		

MCS FUND
MEESHA C. SAXTON
SUPPORT FOR SICKLE CELL CHAMPIONS
2060 West 65th Street Cleveland, Ohio 44102
Phone: 216)466-3801 Email: MCSaxton.Funds@gmail.com

*If this is a utility request, please provide the client's most **updated** utility bill.

INCOME OF APPLICANT:

Current Employer: _____ Position: _____

Monthly Salary: _____

Please indicate if your client receives any of the following (Please check all that apply.):

SNAP _____ SSI _____ SSDI _____ OTHER _____ Child Support _____

APPROVAL PROCESS

Notifications of approval/denial will be given (in writing, email and/or by phone) within seven to ten (7 to 10) business days from the MCS office. If approved, you will receive notification and payment amount, method of payment and dissemination of funds prior to processing.

WAIVER CLAUSE – MCS ~ FUND will make all decision related to the approval of request and reserves the right to deny any request for assistance revise policies or further restrict funding when necessity dictates. All approval for assistance will be contingent upon the availability of funds for that purpose. To that end, MCS ~ FUND has the right to consider each application on a case-by-case basis and make exceptions to these guidelines if extenuating circumstances arise. This includes the authority to question and disallow expenses not properly approved or supported by the appropriate documentation.

VENDOR INFORMATION: Please fill out vendor information completely (NOTE: *checks are never made out to applicants*.)

COPY OF INVOICE, UTILITY BILL OR LEASE AGREEMENT MUST BE INCLUDED WITH THIS APPLICATION

**** Fed. TAX I.D. for vendor must be included** _____

For Sole Proprietor/ Landlord, Social Security No. may be used. _____

** Name of Vendor _____

**Address of Vendor _____

_____

** Telephone No. for Vendor _____ Amount Requested (**Max. $150**) _____