HCMA MEMBERSHIP
SCHOLARSHIP APPLICATION

Date of Application:_____

Name:_____

Address:_____

Phone: (Home)_____(Cell)_____

E-Mail:_____

Have you spoken to the HCMA in the past?

☐ yes ☐ no

Have you had a past membership in the HCMA?

☐ yes ☐ no

Members of your household: **(please indicate if anyone else has been diagnosed with HCM)**

How would a membership scholarship help or benefit your family?

How can you contribute to our association? **(examples: Facebook fundraiser, volunteer at local event)~**

What else can you tell us about your self and/or your situation

Family Monthly Income:*

- ○ **$0 - $20,000**
- ○ **$20,001 - $40,000**
- ○ **$40,001 - $60,000**
- ○ **$60,001 - $80,000**
- ○ **$80,001 - $100,000**

Do you have:

- ☐ **Health Insurance**
- ☐ **Medicare**
- ☐ **State Assistance**
- ☐ **COBRA**