



**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 Annual 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