We want to make it as easy as possible for you to complete your application so please read and follow the instructions on the application carefully and include all information requested.

Failure to do so will delay your application process.

1. If you or a family member has received medical treatment at an area hospital, you must contact them and request financial assistance (HCAP) prior to completing your application for help from the Rainbow Connection.

2. List all the people living in your home and include their income.

NOTE: Please include copies of 1 month's income (pay stubs) including employment and all government checks and assistance * (example. Food Stamps, Social Security, Disability, etc...)

3. Please enclose a copy of all the bills you pay each month (we only need 1 month copy of each)

4. List all your prescription medications with cost and include pharmacy profile print out.

5. We are a charity, so we look at whole house income minus whole house expenses.

YOUR LOCAL HEALTH CHARITY SINCE 1950
119 3RD STREET NW - NEW PHILADELPHIA, OH 44663
PHONE: 330.343.8686
EMAIL: PERCI@TUSCRAINBOW.ORG

Please Return Application to Above Address

APPLICATION FOR ASSISTANCE

Name of Applicant _____ Date of Birth _____

Address _____ Phone _____

_____ Email _____

Head of Household, if the applicant is a child _____

Diagnosis: Description of health condition, injury, or birth defect

_____

What assistance are you requesting from this Society? _____

_____ Cost _____

***** (**Please attach copy of bill or product estimate regarding your request to this application**)

Address of Supplier or Pharmacist _____
(Pertaining To Request) _____
Phone _____

COMPOSITION OF FAMILY OR THOSE PEOPLE WHO LIVE IN YOUR HOUSEHOLD

Name	Date of Birth	Monthly Net Income	Source of income
1.			
2.			
3.			
4.			
5.			
6.			

"Monthly Net income" *per individual listed above should include monies received from employment, social security,*
child support, alimony, pensions, ADC, VA payments, or any other income received.

Total Household Income $_____

Please include copies of one month's pay stubs, or proof of Social Security check amounts with this Application.

Occupation of head of household. _____
Are you a **Veteran**? _____

Please list dollar amounts of any: Saving Accounts $_____ Certificates of Deposit $_____
IRA accounts: $_____

Name of Physician _____

Address _____ Phone _____

Do you have Hospitalization? _____ Type _____

Do you receive Medicare? _____

Do you receive Medicaid? _____ Have you applied for Medicaid? _____

Are you receiving Food Stamps? _____ If so, how much? _____

Do you receive assistance from Metro Housing? _____ If so, how much? _____
Have you applied and been approved for HEAP or PIP? _____

LIVING COSTS

Rent, House payment, or Lot payment _____
Name of Landlord _____
Property tax _____

UTILITIES

*Please list **monthly** cost or average and **include a copy of each***

Electric _____
Gas or Fuel Oil _____
Water/Sewer _____
Phone _____
Cable _____

OTHER MONTHLY COSTS

Model and Year of Cars _____Car Payment $_____

Insurances: Life $_____ Car $_____ Home $_____ Health $ _____

LIST OF CREDITORS	TOTAL DEBT	MONTHLY PAYMENT
1.		
2.		
3.		
4.		
5.		

LIST AND COST OF PRESCRIPTIONS **INCLUDE PHARMACY PROFILE PRINT-OUT**

(for anyone in your household)

NAME OF MEDICATION	COST PER MONTH
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

TOTAL MONTHLY COST _____

Does Insurance Cover Prescription Costs? _____

Pharmacy Name: _____ Phone: _____

Referred by _____ Phone _____ Date _____

Any additional comments from referring agency or person.

AGREEMENT WITH TUSCARAWAS SOCIETY FOR CHILDREN & ADULTS, INC.

(To be Read and Signed by Applicant or Guardian)

I certify that all information in the above application is correct.

I understand that this request is for the above services only and assistance for any additional or other services must be separately applied for and approved by the Tuscarawas Society For Children & Adults, RAINBOW CONNECTION. The giving of assistance for this request shall in no way obligate the Tuscarawas Society For Children & Adults beyond its approval herein.

I also understand that the information disclosed in the application may be used and disclosed to other agencies and medical providers by the Tuscarawas Society For Children & Adults personnel in order to attempt to get additional help for the applicant.

I understand that any information disclosed under this authorization may no longer be covered by the privacy provisions of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may be subject to redisclosure.

I initiate this authorization for disclosure of personal health information. I have read and I understand this authorization.

XX Date _____ Signature of Applicant or Guardian _____

****

FOR OFFICE USE ONLY

Action Taken _____