



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 PIPP? ____

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 _____

2022 President's Circle Sponsors



HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I, _____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Tick as appropriate

Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

Disclose my complete health record except for the following information

- Mental health records
- Communicable diseases including, but not limited to, HIV and AIDS
- Alcohol/drug abuse treatment records
- Genetic information
- Other (Specify)

Form of Disclosure:

- Electronic copy or access via a web-based portal
- Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

a) From _____ to _____

Or

b) All past, present, and future periods

Or

c) The date of the signature in section VI until the following event:

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual’s behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

