



RAINBOW CONNECTION
Tuscarawas Society for Children & Adults, Inc.

P.O. Box 288
New Philadelphia, Ohio 44663
(330) 343-8686

RETURN TO:

APPLICATION FOR ASSISTANCE

Name of Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

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 \_\_\_\_\_

Please list dollar amounts of any: Savings 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? \_\_\_\_\_

<b>LIVING COSTS</b>
---------------------

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