The Help Center
1515 Provident Dr. Suite 130
574-372-3500
KosHelpCenter.org

Caseworker Use Only:
- ☐ *GSF*
- ☐ *CCF*
- ☐ *RFK*

Application for Assistance

Has anyone in your household ever applied for assistance from any of these funds before? **No** **Yes**

Good Samaritan Fund and the Cancer Care Fund are **not emergency assistance providers**.

Household Information:

Name:_____ DOB:_____ Age:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Township: _____ Phone: _____ Email: _____

Names, relationship and DOB of all individuals **living in the household**:

Last Name	**First Name**	**Relationship**	**Date of Birth**

Medical Information:

Diagnosis: _____ Date of Diagnosis_____

Physician:_____ Treatment Facility:_____

Current Treatment Plan:_____

Health Insurance

Health Insurance Provider: _____

- ☐ Private Health Insurance? Deducible/ Out of Pocket Maximum:_____
  - Employment
  - Marketplace
- ☐ Medicare Prescription Coverage? **No** **Yes** Supplemental Policy? **No** **Yes**
- ☐ Medicaid
- ☐ Healthy Indiana Plan (HIP)

Have you filed for Social Security Disability? **No** **Yes** If Yes, what is your current status?

_____

Financial Information:

Please list net household income from all sources (employment; unemployment; child support; social security; disability; food stamps, etc.) for **all household members:**

Household Member	**Income Source**	**Monthly Amount (after Taxes & Ins.)**

Have you applied for and/or received assistance from any other sources?
☐ **No** ☐ **Yes** What have you applied to? _____

State Description of Need (Please Include Contributing Medical Factors):

_____

_____

_____

Financial amount requested:_____

Monthly Household Expenses:

Type	***Paid To***	***Monthly $ Due***	***Past Due?***
Rent / Mortgage (Please circle one)			□ No □ Yes
Insurance Home & Auto			□ No □ Yes
Utilities			□ No □ Yes
Utilities			□ No □ Yes
Trash, Water, Sewage			No □ Yes
Cell/ Phone/ Cable/ Internet			□ No □ Yes
Car Payment			□ No □ Yes
Car Payment			□ No □ Yes
Food/ Gas			□ No □ Yes
Medical Payments/ Prescriptions			□ No □ Yes
Miscellaneous			***Income*** _____ ***– Expenses*** _____
	Total Monthly Expenses	**$_____**	$_____

Do You Owe on Credit Cards? □ **No** □ **Yes**

If Yes, Total Due for All Accounts:_____Monthly Payments: _____

I understand that the *information provided is accurate* to the best of my knowledge and that falsifying information will be grounds for denial of assistance.

I understand that select information from this application *may be shared* with the committee and Board of Directors of the charitable entity that provides this financial assistance.

Patient Signature:_____
Date:_____

Patient Representative:_____
Date:_____
Relationship to Patient:_____
Reason Patient Unable to Sign:_____