**Pavilion Help Center**

**1515 Provident Dr. Suite 170A blue and green text on a black background

AI-generated content may be incorrect.**

*Caseworker Use Only:*

* *HAF*
* *CCF*
* *KCCF*

**574-372-3604**

**www.KosHelpCenter.org**

**Application for Assistance**

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

**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** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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)

**Financial Information:**

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

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you filed for Social Security Disability? **No Yes** Date: \_\_\_\_\_\_\_\_\_\_\_\_

What is your current status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you applied for and/or received assistance from any other sources?

**⁭ No ⁭ Yes** What have you applied to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you need assistance toward?

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.
* I understand my information will be entered into *Charity Tracker* online software network.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_ Reason Patient Unable to Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_