Cynthia Rose Foundation
Celebrating Kindness, Promoting Joy

APPLICATION FOR ASSISTANCE
LONG FORM

DATE OF APPLICATION _____

PRIMARY APPLICANT'S INFORMATION

Name: _____ Marital Status: _____

Address:_____

City_____ State_____ Postal Code_____

Email Address: _____

Telephone: Home _____ Cellular _____

Employer: _____Telephone: _____

Employer Address: _____

If Unemployed, last place and date of employment_____

City_____ State_____ Postal Code_____

SECONDARY INFORMATION (Spouse or Parent/Guardian if Primary Applicant is a Minor)

Name: _____ Marital Status: _____

Address:_____

City_____ State_____ Postal Code_____

Email Address: _____

Telephone: Home _____ Cellular _____

Employer: _____Telephone: _____

Employer Address: _____

City_____ State_____ Postal Code_____

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Who referred you to the Cynthia Rose Foundation?

Name_____ Phone Number_____

Has Applicant received assistance from other organization?_____

If Yes, What Organization_____ Date_____

Type of Assistance Received_____

Total annual household income of applicant or parent(s)/guardian: $_____

Monthly Expenses (Please list each expense – ex: Rent, Utilities, Gas, FoodEtc.):

_____Rent or Mortgage _____Food _____Utilities

_____Gas/Transportation _____Medical Insurance

_____Car Payment _____Education Expenses _____Credit Cards

_____Other (Specify) _____Other (Specify) _____Other (Specify)

Dependent Children (Please list name(s), date of birth and gender):

_____ _____

_____ _____

_____ _____

Is Applicant or parent(s)/guardian receiving any type of aid? YES_____ NO_____

If Yes, Please specify amount: _____Public Aid _____Welfare _____Food Stamps

_____Social Security _____Unemployment Insurance _____Union Benefits

_____Disability Insurance _____Other

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Why are you seeking assistance at this time? Attach a separate sheet if necessary.

_____

_____

_____

What type of assistance would help you most at this time? Attach a separate sheet if necessary.

_____

_____

_____

Please describe a moment or quote that you find inspiring. Attach a separate sheet if necessary.

_____

_____

_____

Please tell us anything additional you would like us to know about you, your life and your situation.

_____

_____

_____

Urgency of Need._____

MEDICAL APPLICANTS ONLY

Applicant or Parent(s)/Guradian's Insurance Company_____

May we contact your insurance company?_____ Phone Number_____

How much of the estimated cost will your insurance cover?_____

Is Applicant or Parent eligible for Medicaid or Medicare?_____

Does the applicant currently have a hearing or eye doctor? Yes_____ No_____ If Yes, complete below:

Dr._____ City_____ Phone_____

Dr._____ City_____ Phone_____

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I, the applicant (or Parent/Guardian), understand I may be interviewed by telephone, or in person, if additional information or clarification of this application is needed. I have answered all questions to the best of my ability.

_____ _____

Signature of Applicant Signature of Parent or Guardian

Date_____

_____FOR INTERNAL USE ONLY- PLEASE DO NOT WRITE BELOW THIS LINE_____

Date Application Received_____ Date of Review _____Member _____

Disapproved ____ Approved ____ Date _____ Approved Amount _____

Reason if disapproved _____

Service approved _____

Date letter of approval or disapproval sent to applicant _____

Referred to _____ Date Provider notified _____

Date of service _____ Date invoice paid _____

Notes: _____

_____

_____