HOMETOWN HOPE

APPLICATION

	Applicant	Primary Contact/Caregiver	Additional Contact/Caregiver
Name:			
SS#			
DOB:			
Address:			
City/Zip:			
Phone:			
E-mail:			
Relationship to Applicant:			

Status/Condition – of Applicant; if the Applicant is a minor, please provide marital status of Parent/Guardian(s)

US Citizen: ☐ Yes ☐ No	Marital Status: ☐ Single ☐ Married/Domestic Partner ☐ Separated ☐ Divorced ☐ Widow(er)	
Reason: ☐ Medical Condition ☐ Loss of Life ☐ Loss of Property ☐ Loss of Income ☐ Other:		
Cause:		Date of Loss:
Diagnosis:		Date of Diag:
Treatment:		Dr/Center:
Total Estimated Out-of-Pocket Costs/Loss Expected for the Year:		

Family Size – List all household members financially supported by the Applicant or the financially responsible party

Name	Date of Birth	Student	Relationship
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Employment Information

	☐ Applicant ☐ Parent/Guardian* (if Applicant is a minor)		☐ Spouse ☐ Parent/Guardian* (if Applicant is a minor)	
Employer:				
Address:				
Phone:		Wage:		Wage:
Position:		Ave Hrs/wk:		Ave Hrs/wk:

Monthly Household Income (check all that apply)

☐ Employment	$	☐ Disability	$	☐ Retirement	$
☐ Unemployment	$	☐ Child Support	$	☐ Investments	$
☐ Worker's Comp	$	☐ Alimony	$	☐ Rental Property	$
☐ Social Security	$	☐ Pension	$	☐ Other	$
The primary wage earner: ☐ Applicant ☐ Spouse/Partner ☐ Parent/Guardian ☐ Other:					$
If no income, please explain:					

Health Insurance/Other Assistance (check all that apply)

☐ Medicare ☐ Medicaid ☐ Health Insurance ☐ Cancer Program ☐ Veterans Administration ☐ Vocational Rehabilitation
☐ Other:

Certification

I hereby declare under penalty of perjury that all information set forth above is true and accurate in all respects and that all attachments are accurate copies of the original documents. I authorize the release of this information from my employer, agencies and/or companies listed herein, for verification of the information provided for the purpose of evaluating my eligibility for the financial assistance program.

Signature of Applicant or Parent: Date:

Signature of Spouse or Parent*: Date:

*Primary Caregiver or Responsible Party, as applicable