COMMUNITY HELPERS OF RUTHERFORD COUNTY

Client Name Sample Name

◉ Single ○ Married ○ Separated ○ Divorced ○ Widow/Widower

Address 101 main st
Number & Street

City *State* *Zip Code*

Spouse's Name Sally

Rutherford County resident: ○ Yes ○ No
_____Years _____Months

EMAIL: _____

Phone#: (_____) _____

LIST ALL INDIVIDUALS LIVING IN THE HOME: [PLEASE PRINT]

Name	*Relationship*	*Sex*	*Race*	*Date of Birth*	*Social Security #*
	Self				

LIST ALL SOURCES OF HOUSEHOLD INCOME: ☐ Man ☐ Woman ☐ Child

Wages ☐Hourly ☐Weekly ☐Bi-Weekly ☐Monthly $ _____
Social Security $ _____
Supplemental Social Security (SSI) $ _____
Social Security Disability (SSD) $ _____
Unemployment $ _____
Worker's Compensation (or Temporary Disability) $ _____
Child Support / Alimony $ _____
Veteran's Benefits $ _____
Food Stamps $ _____
Other (Student Loans/Grants, etc.) $ _____
Families First $ _____

Employer(s)_____

_____

Do you have transportation? Yes ○ No ◉

Do you have GED/High School: Yes ○ No ○

Comments:_____

_____

_____

Referred by: _____

Medication Applicants must **FIRST** apply:

Dispensary of Hope Eligible/Non-Eligible (circle one)

If non-eligible, please check why- Medication: ☐ Unaffordable ☐Unavailable ☐ Over TennCare Limit ☐ Insured Medicare Eligible

TODAY I NEED HELP WITH MY:	☐ **Electric**	☐ **Gas**	☐ **Water**	☐ **Rent**	☐ **Dental**	☐ **Medical**
Amount Requested:	**$**	**$**	**$**	**$**	**$**	**Insurance: ☐ NO ☐ Yes Co-Pay $_____ Name Insurance Co. _____**

Applicant Certification

I certify that all the information provided in this application is true & correct. I understand providing false information will result in no assistance & case file permanently closed. **CHORC** has the right to refuse assistance for inappropriate behavior directed toward CHORC staff at all times]
I AUTHORIZE THE VERIFICATION OF ANY AND ALL INFORMATION LISTED FOR THE PURPOSE OF CERTIFICATION

Signature of Applicant _____ Date _____/_____/_____

Signature of Witness _____ *Date* _____/_____/_____

OFFICE USE ONLY

SS# _____-_____-_____ Name _____

Date _____/_____/_____ Visit # _____ # Adults _____ # Children _____

Income Type: Wages _____ Unemployment_____

SSD/SS/SSI/STD _____ Pension_____ Workman's Comp _____

Food Stamps _____ Child Support _____ Families First _____

Total Monthly Gross Household Income: _____

Crisis Situation: ☐Loss Income ☐Auto Repair☐Health Emergency ☐Insufficient Income ☐ Disabled/62 Plus Years ☐ Exceeds Yearly Coverage Limit

Plan:

Payment(s):

Utility Company(s):_____ Acct #:_____ Voucher:_____

_____ Acct#:_____ Voucher:_____

_____ Acct#: _____ Voucher:_____

Rent-Property Manager/Landlord:_____

Voucher:_____ Address:_____

_____

Referral(s):

☐ **MCCAA-Li-Heap Program** ☐ **CSBG Elderly/Disabled/Crisis Program(s)** ☐ **Barnabas Vision**
☐ **Greenhouse Ministries** ☐ **Operation Hope-Financial Counseling** ☐ **Nourish Food Bank**
☐ **American Career Center** ☐ **Safelink Free Wireless Phone Program** ☐ **Publix Pharmacy**

Other:_____

File Closed Till:_____

As the client requesting services, I understand, I am required to complete this referral in order to receive future assistance from Community Helpers.

Rent _____
Mortgage _____
Lot Rent _____
Electric _____
Gas _____
Water _____
Phone/Cell _____
Food _____
Internet _____
Cable _____
Car _____
Car Ins. _____
Life Ins. _____
Other Ins. _____
Day Care _____
Meds _____
Child Supt _____
Prop Taxes _____
Credit Card _____
Loans _____
Medical _____
Other _____

Total _____

Staff Initials: _____

Date: _____

No person on the basis of race, color, national origin, sex, age, disability, ancestry, status as a veteran, or any other characteristics protected by Federal, State, or Local Laws will be excluded from participation in , or be denied benefits of, or be otherwise subjected to discrimination in the operation of CHORC agency.

_____

Signature of Applicant Date