APPLICATION VALID FOR SIX MONTHS FROM RECEIPT.

RETURN BY THE 1ST OF THE MONTH:
119 3rd St. NW
New Philadelphia, OH 44663
Info@TuscRainbow.org
Fax: 330.602.5517
Phone: 330.343.8686

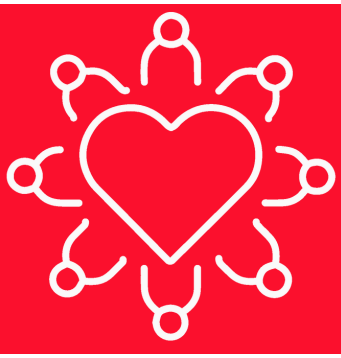
This application is for assistance from The Tuscarawas Society for Children and Adults, Inc., better known as the Rainbow Connection, a 501(c)(3) nonprofit, independent health charity dedicated to meeting the needs of disadvantaged and disabled residents of Tuscarawas County, Ohio.

The organization's Board of Directors meets regularly to review and approve applications, considering 1) whole-house monthly net income minus expenses, 2) quality-of-life improvement from assistance, and 3) qualification of the applicant(s) as it pertains to our guidelines.

Please submit this application and all supporting documents no later than the first of the month to be considered at our next board meeting. Failure to do so will delay the application process.

APPLICATION CHECKLIST

- ☐ Signed, Dated, and Completed Application
- ☐ Bills and/or Estimates for Requested Assistance
- ☐ Proof of Income. If you do not have any income, please write a letter detailing your circumstances. If your income fluctuates, please include the previous year's tax return.
- ☐ Proof of Household Expenses
- ☐ If applying for assistance with medical and/or accessibility equipment, a note from your medical provider will assist our Board in better understanding your request.
- ☐ If applying for long-term prescription assistance, provide a Pharmacy Prescription Profile Print-Out. With certain medications, Rainbow Connection may request a provider's note to better understand the request.
- ☐ If making payments on a medical payment plan(s), please include most recent statement(s).
- ☐ If applying for gasoline assistance, provide valid Driver's License and Insurance Coverage.
- ☐ If receiving outside support from government programs, other agencies, or independent fundraisers, please complete Section Three and provide any supporting documents.



WE KNOW THAT ASKING FOR HELP IS HARD.

Unexpected medical costs make life challenging for everyone, regardless of their prior financial planning or income level. No matter your situation, we thank you for trusting us to help you through this difficult time. All Rainbow Connection applications are confidential and protected by HIPAA.

SECTION ONE
HOW CAN WE HELP

This application for assistance is on behalf of:

[ ] An individual

[ ] Multiple members of the same household

Requesting assistance with (check all that apply):

[ ] Medical Bills [ ] Handicap Equipment [ ] Medical Equipment [ ] Assistive School Device

[ ] Communication Device [ ] Hearing Aid [ ] Sleep Machine [ ] Dental Bills

[ ] Sensory Equipment [ ] Travel and/or Lodging for Treatment [ ] Long-Term Prescription

[ ] Medical Alert System [ ] Other

PLEASE INCLUDE BILLS AND/OR ESTIMATES FOR ALL REQUESTS.

Name(s) of Applicant(s):_____

Address:_____

_____

Email: _____ Phone: _____

Description of Medical Condition(s) and/or Diagnosis: _____

_____

_____

Details of Request, including cost and how it will improve the quality of life for the applicant(s):

_____

_____

_____

_____

_____

_____

_____

FOR ASSISTANCE WITH EYEGLASSES, CONTACT YOUR NEAREST LIONS CLUB.

SECTION TWO
ASSETS & MONTHLY INCOME

Name(s) of All Household Members	Age & Date of Birth	Relation to Applicant	Source of Income/ Employer	Monthly Net* Income

*Net income is "take home pay," not the amount earned before deductions. Please include all individuals who reside in the home, and list all money received from wages; Supplemental Security Income; Social Security; child and/or spousal support; pensions; dividends; or any other income source. If no income, please include a letter of explanation.

Total monthly SNAP benefits for household: $_____

Total Whole-House Monthly Net Income: $_____

Add all monthly income and SNAP benefits if applicable to calculate.

PLEASE INCLUDE PROOF OF ALL INCOME SUCH AS PAYSTUBS OR TAX RETURN.

DECLARATION OF ASSETS

Account balances and assets assist the Board in understanding the scope of your request: they do not qualify or disqualify you from receiving assistance.

_____ _____ _____

Savings Certificates of Deposit IRAs

Year, Make, and Model of all Household Vehicle(s)

_____

_____

SECTION THREE
EXISTING SUPPORT

GOVERNMENT ASSISTANCE

If you or any member of your household receive the following government assistance, please list the Account Number, Coverage Start Date, and Plans if applicable.

Medicaid

_____

_____

If applying for medical and/or mobility equipment and on Medicaid, have you requested these items through Medicaid? Yes ____ No ____ If yes, please explain why you are now requesting them through Rainbow Connection.

_____

_____

Did you know? *Medicaid Effective Dates can sometimes be backdated. If you are on Medicaid and requesting assistance for a medical bill for services provided before your Medicaid coverage began, please contact the Ohio Medicaid Consumer Hotline to see if you are eligible to have your effective date backdated. Call 800-324-8680.*

Medicare

_____

_____

If applying for Prescription Assistance and on Medicare, do you have Plan D Prescription Coverage? Yes ____ No ___
If no, please explain:

_____

_____

Veterans Affairs

_____

_____

ASSISTANCE FROM OTHER AGENCIES AND/OR FUNDRAISERS

If you are receiving or have received financial assistance from other agencies or are the beneficiary of any independent fundraising efforts, please provide contact information for the agency or website addresses for the fundraiser as well as the amount received and how it was spent.

_____

_____

SECTION FOUR
MONTHLY EXPENSES

Please list all monthly expenses for your household. While food and fuel are not included below, their average cost for a household your size are considered by our Board. If applicable, an itemized list of all reoccurring prescription expenses, medical payment plans, and retail debt payments* is required in Section Four.

Housing Cost (Rent, taxes, mortgage)		Car Insurance	
Electric		Home or Renters Insurance (unless included in housing cost)	
Heating Cost		Health Insurance costs not deducted from paycheck	
Water/Sewer/Trash		Car Payment	
Phone(s)		Reoccurring Prescription & Medical Supply Expenses*	
Internet		Medical Payment Plans*	
Cost of Cable TV or Streaming Services		Unsecured Debt Payments (such as credit cards, unsecured or student loans, other moneys owed)*	
Life Insurance		Tithing or Donations	

PLEASE INCLUDE PROOF OF THESE EXPENSES.

Other Monthly Expenses for the Board to Consider: _____

_____

_____

_____

Total Whole-House Monthly Expenses (not including food and fuel): $_____

Add all monthly expenses to calculate.

SECTION FIVE
ITEMIZED EXPENSES

Rainbow Connection does not work with all pharmacies. Individuals approved for prescription assistance may need to change pharmacies. Unsecured debt balances assist the Board in understanding the scope of your request: they do not qualify or disqualify you from receiving assistance.

PLEASE INCLUDE PHARMACY PROFILE PRINT-OUT AND MEDICAL STATEMENTS.

***PRESCRIPTIONS & MEDICAL SUPPLIES**

Name of Medication/Supply	Quantity & Cost *(Note if not a monthly supply)*	Prescribed For:

***MEDICAL PAYMENT PLANS** **Total:** _____

Medical Office & Account Number	Monthly Payment	Balance

***UNSECURED DEBTS** **Total:** _____

Name of Creditor	Monthly Payment	Balance	Reason for Balance

Total: _____

SECTION SIX
MEDICAL INFORMATION & HIPAA

Please include contact information for all medical offices and suppliers that Rainbow Connection staff may need to contact to confirm diagnoses, estimates, and account balances as they relate to this application. These can include but are not limited to primary doctor, specialists, hospitals, pharmacists, dentists, suppliers, etc.

Name	Address	Phone

AGREEMENT WITH TUSCARAWAS SOCIETY FOR CHILDEN & ADULTS, INC. & HIPAA RELEASE

I certify that all information in this application is correct. I understand that this request is for the services or items requested in this application only and assistance for any additional services or items must be separately applied for and approved by the Tuscarawas Society for Children & Adults, Inc., hereafter referred to as Rainbow Connection. The giving of assistance for this request shall in no way obligate Rainbow Connection beyond its approval herein. I understand that all decisions made by the Board of Directors at Rainbow Connection are final.

I hereby release and forever discharge Rainbow Connection from any and all liability, claims, demands, damages, costs, expenses, and causes of action incurred while visiting Rainbow Connection, 119 3rd St. NW, New Philadelphia, OH 44663. I understand and acknowledge that there are certain risks associated with visiting any property, including but not limited to the risk of personal injury or property damage. I agree to assume all such risks and to hold Rainbow Connection harmless from any and all claims arising out of or in any way related to in-office visits.

I also understand that the information disclosed in the application may be used and disclosed to other agencies and medical providers by Rainbow Connection personnel in order to get additional help for the applicant. I understand that any information disclosed under this authorization may no longer be covered by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may be subject to redisclosure.

I initiate this authorization for disclosure of personal health information. I have read and understand this authorization. The below shall act as a HIPAA Release Form.

I, _____, give my permission for the agencies listed above to disclose my complete health record to Rainbow Connection, 119 3rd St. NW, New Philadelphia, OH 44663, as needed to confirm the information disclosed in this application for charitable assistance. This authorization is valid for six months from the date below. I may revoke this authorization at any time by contacting your agency.

I understand that 1) in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data; 2) I do not need to give any further permission for my health record to be shared with Rainbow Connection; and 3) the failure to sign, date, and submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive.

_____ _____

Signature(s) of Applicant(s) **Date**

DON'T FORGET TO SIGN AND DATE.