

Beneficiary Application Form



Email form to: hhcincinnatiapp@gmail.com

A picture ID must be submitted with your application in order to be considered.

Or mail to: Helping Hands of Cincinnati
6650 Shawnee Ridge Lane
Cincinnati, OH 45243

Personal Information

Name: _____

DOB: _____

Phone: _____

Address: _____

City _____ State _____ Zip _____

Social Security #: _____

Email: _____

Marital Status: Single Married Partner

Head of Household: _____

of Dependents: _____

Form submitted by: _____

Employment Information

Are you employed? _____

Employer: _____

Employment Type: Full Time Part Time

Employer Phone: _____

Insurance Information

Primary Medical Insurance Provider: _____

Secondary Medical Insurance Provider: _____

Medical Information

Diagnosis: _____

Date of Diagnosis: _____

Are you currently receiving treatment? _____

Physician Signature _____ Date _____

Areas where financial support is needed: (please list) _____

Have you or anyone in your family recieved assistance from HHC in the past? Yes No

By checking this box, you authorize Helping Hands of Cincinnati to share your story on our website, Facebook page, and future media channels at our discretion.

Applicant's Signature _____ Date _____