Beneficiary Application Form

HELPING HANDS OF CINCINNATI

Email form to: info@helpinghandscincinnati.org

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: _____ Social Security #: _____

DOB: _____ Email: _____

Phone: _____ Marital Status: ☐ Single ☐ Married ☐ Partner

Address: _____ Head of Household: _____

# of Dependents: _____

City State Zip Form submitted by: _____

Employment Information

Are you employed? _____ Employment Type: ☐ Full Time ☐ Part Time

Employer: _____ Employer Phone: _____

Insurance Information

Primary Medical Insurance Provider: _____

Secondary Medical Insurance Provider: _____

Medical Information

Diagnosis: _____ Are you currently receiving treatment?

Date of Diagnosis: _____

_____

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