Beneficiary Application Form

Email form to: info@helpinghandscincinnati.org

- *A photo ID must be submitted with your application to be considered*
- *Please include a copy of a medical bill or statement with your physicians name*

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:

Referred by:

If you are working with a social worker, please list their name.

Employment Information

Are you employed?

Employer:

Employement 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

Physician Printed Name

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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

Applicant's Printed Signature