HEALTH & PRESCRIPTION SERVICES

Ref: _____

APPLICATION FOR ASSISTANCE

Name: _____ Age: _____ Date of Birth: _____

Spouse: _____ Age: _____ Date of Birth: _____

SSN: _____ Telephone (or contact): _____

Street Address: _____

City, State, Zip: _____

Have you ever been helped by this agency before? ☐ Yes ☐ No Type of illness or injury: _____

Service or prescriptions needed: _____

Name of doctor: _____ Date of last visit: _____

FAMILY COMPOSITION: NAMES, AGES, RELATIONSHIP TO APPLICANT - LIST ALL MEMBERS OF HOUSEHOLD

Name	Age	Relationship

Notes: _____

Last date of employment: _____ Do you have health insurance? _____

Reason for leaving: _____

FINANCIAL RESOURCES AND AMOUNT RECEIVED

Wages:	Unemployment:5	VA:	Savings:
SS:	Retirement:	TANF:	
SSI:	Food Stamps:	Work Comp:	
Pension:	Utility Rebate:	Checking:	**Total:**

MONTHLY EXPENSES AND AMOUNT PAID FOR EACH

Rent:	Life Ins:	Gas:	Medicine:
Mortgage:	Car Payment:	Cable:	Fines:
Loans:	Lights:	Internet:	Food:
Car Ins:	Water:	Cell:	**Total:**

Car year, make and model: _____

STATEMENT OF UNDERSTANDING

As an applicant for financial assistance, I certify that I will provide all information regarding income, financial resources, property, and expenses. I understand that Health & Prescription Services will use any means possible, including legal action, to recover any assistance whether used on my behalf or that of a dependent, issued due to misrepresentation or omission of the information requested above.

Applicant signature: _____ Date: _____

Parent/Guardian/Spouse signing on behalf of minor/severely ill applicant: **(Print your name)** _____

HEALTH & PRESCRIPTION SERVICES

HAPS ASSISTANCE NETWORK

SHARED CASE MANAGEMENT SOFTWARE
CHARITY TRACKER
RELEASE OF INFORMATION (ROI)

Client's Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ SSN:_____ Phone Number:_____

Street Address:_____

City, State, Zip:_____

The **Health and Prescription Services Charity Tracker Assistance Network,** "hereinafter referred to as "CharityTracker", is a shared, computerized record keeping system that captures information about people experiencing need for emergency services, including but not limited to assistance with utility bills, medications, rent/mortgage payments, etc. Health and Prescription Services (Administrating Agency) administers CharityTracker on behalf of participating agencies of the CharityTracker Assistance Network, including _____Health and Prescription Services_____(Participating Agency).

I understand that all information gathered about me is personal and private and that I do not have to participate in CharityTracker. I have had an opportunity to ask questions about CharityTracker and to review the basic identifying information, which is authorized by this release for the CharityTracker Assistance Network Participating Agencies to share. T also understand that information about nonconfidential services provided to me by CharityTracker participating agencies may be shared with other CharityTracker Participating Agencies. This Release of Information will remain in effect for 3 years from the date noted under my signature at the bottom of this page unless I make a formal request to this Organization that I no longer wish to participate in CharityTracker.

Dependent's Name	Date of Birth	Social Security Number

I authorize Health and Prescription Services, as a CharityTracker Participating Agency, to share my basic, identifying and nonconfidential service transactions/information with other CharityTracker Participating Agencies. I authorize the use of a copy of this original to serve as an original for the purposes stated above. I further authorize Health and Prescription Services (Participating Agency), as a CharityTracker Participating Agency, to share my dependent's basic, identifying and non-confidential service transactions/information with other CharityTracker participating agencies.

_____ _____

Client and/or Parent-Legal Guardian's Authorizing Signature Date

_____ _____

Agency Representative Signature Date

The original of this Release of information shall be kept on file with the Agency for a minimum of three years from its expiration date.

HEALTH & PRESCRIPTION SERVICES

RELEASE

I, _____

hereby authorize Health & Prescription Services, Inc. to investigate fully my eligibility for monetary assistance from Health & Prescription Services, Inc., as defined by established eligibility criteria and policies.

I understand that this investigation may include, but is not limited to, an inquiry of my financial status, assets, creditors, social media and/or credit reporting agencies. I understand that Health & Prescription Services, Inc. will use any means possible, including legal action, to recover any monies issued due to misrepresentation of the information requested to process my application.

I further irrevocably grant Health & Prescription Services, Inc. and its implementing agency or agencies the absolute right to copyright, use, publish, and distribute my case history for any lawful purpose, including, but not limited to, editorial, artistic, promotional, or advertising purposes; however, while I acknowledge that my case history may be disclosed for the referenced purposes, I understand that my identity will be kept confidential. I acknowledge that a copy of this release may be honored as fully as the original document.

Dated, this the _____ day of _____ , _____.
Date Month Year

_____

Signature of Applicant or Designate Signee

_____

Signature of Witness

HEALTH & PRESCRIPTION SERVICES

Date: _____

To Whom It May Concern:

I provide (Applicant's Name) _____

with (Check all that apply):

☐ Food ☐ Clothing ☐ Shelter ☐ Transportation

☐ Financial ☐ Utility Assistance ☐ Other (explain): _____

_____

_____

This client does not have any type of income and I am their sole support.

Sincerely,

_____

Signature of person providing support

Print Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____