WAYNE COUNTY COMMITTEE FOR CRIPPLED CHILDREN & ADULTS, INC.

Return Application to:
UNITED WAY WHIRE
215 South Walnut Street, Wooster OH 44691
330-263-6363 or 330-264-5601, FAX # 330-264-5607
www.wcccca.org

Name of Applicant: ______________________________ Date of Birth: ___/___/____ Age: ________
Name of Parents IF Applicant is under age 18: ____
Address__________________________________ City: ______________ Zip Code: ________
Telephone Number: __________________________ Cell: __________________________
Length of residence in Wayne County: __________________ In Ohio: ____________________
Email: ____

MEDICAL INFORMATION

Medical Diagnosis or Disability: ____
Date disability began: ____________________ Doctor's Name: __________________________
Doctor's address: ____
Your height: ______________ Your weight: ________________
Do you have insurance? _____Yes ____No IF Yes, Name of Insurance Company: ________________
Do you have medication insurance? _____Yes ____No IF Yes, Name of Insurance Company: ____________

INFORMATION ABOUT REQUEST

What help do you need from the Committee? (*Please note that you will need to include a prescription from your doctor and two quotes for any equipment/construction/building requests*.)
____
____
____

Total amount being requested $____
(This amount MUST be filled in for the committee to consider approval of the request.)

Other Sources/Agencies Contacted for help:
Where: ______________________________ _________How Much? _________Declined
Where: ______________________________ _________How Much? _________Declined
Where: ______________________________ _________How Much? _________Declined
Where: ______________________________ _________How Much? _________Declined

IF you are requesting assistance with prescription MEDICATIONS: Please list PREFERRED PHARMACY (MUST be within WAYNE County) and ALL MEDICATIONS with approximate price and dosage information (milligrams and number of times taken per day, etc.). You can use additional paper if necessary.
Pharmacy (Name, Address, and Phone #): ____
____
Medications: (Name, Milligrams and Number of Times taken a day and cost) ______________________
______________________________ ______________________________
______________________________ ______________________________

IF you are requesting assistance with MEDICAL EQUIPMENT, please list PREFERRED SUPPLIER: Name, Address and Phone #
____

Approved 1/14/2014

PERSONAL/FINANCIAL INFORMATION

Are you a Veteran? _____ Yes _____ No If Yes, have you applied for assistance with the VA? _____ Yes _____ No

Total Number of persons in the home: _____________________ Please list Names and Ages:

________________________________ _______________ _____________________________ ____________

________________________________ _______________ _____________________________ ____________

Present Monthly Household Income (includes all person(s) income from all sources): $______________________________________

Sources of household income: ____

Normal monthly income (if different from present monthly income): $____

Why the difference in present from normal monthly income? ____

Does anyone in the household own real estate? _____ Yes _____ No Mortgage per month $______________________

If yes, value of real estate $____________________________ Amount owed $____

Do you rent? _____ Yes _____ No Rent per month $______________________________

Are you behind in your rent or mortgage? _____ Yes _____ No

Utility Expenses (not paid through any type of assistance—Out of pocket expenses):

Gas/Fuel $______________ Electric $_________________ Phone $__________________ Water/Trash $_____________

Do you have other income/assets: (for example stocks, bonds, personal property, automobiles, etc.)? _____ Yes _____ No

____

Are you eligible or have you applied for any of the following:

					Amount & Other Info
Unemployment Compensation	Yes	No	Applied	Unknown	________________
Sick or Accident Benefits	Yes	No	Applied	Unknown	________________
Worker's Compensation	Yes	No	Applied	Unknown	________________
Insurance Benefits/Medicare	Yes	No	Applied	Unknown	________________
Medicaid/TANF/Medical Card	Yes	No	Applied	Unknown	________________
Support Payments	Yes	No	Applied	Unknown	________________
Veterans Benefits	Yes	No	Applied	Unknown	________________
Social Security	Yes	No	Applied	Unknown	________________
SSD/SSI	Yes	No	Applied	Unknown	________________
Pension	Yes	No	Applied	Unknown	________________
Ohio Bureau for Children with Medical Handicap (BCMH)	Yes	No	Applied	Unknown	________________
Other Assistance: ________________________	Yes	No	Applied	Unknown	________________
Other Assistance: ________________________	Yes	No	Applied	Unknown	________________

Are there any other circumstances that the Committee should consider when reviewing your application? ______________________

____

Have you ever applied to the Committee before? ______ Yes ______ No If Yes, When? ____________________________

I hereby release all information to the Wayne County Committee for Crippled Children and Adults, authorize that it is true to the best of my knowledge, and give permission for the committee or their agency, WHIRE, to investigate the above information and discuss it among themselves and/or other agencies or programs that may have a concern or be of some assistance. **I understand that if the committee grants my request, I may be asked to provide my first name and picture for use on the committee's website and printed publications. I agree to comply with their request.**

Applicant's Signature: ____ Date: ___________________________

It is the policy of the Wayne County Committee for Crippled Children and Adults, Inc., that no person shall be denied services on the basis of race, ethnicity, age, color, national origin, sexual orientation, physical or mental handicap, or developmental disability according to Title VI of the Civil Rights Act of 1964; or any person with "HIV" or Aids-related complex; or in any manner prohibited by the laws of the State of Ohio and the United States.

Approved 1/14/2014