

Beneficiary Application Form

**PLEASE SEND TO aliciacachat@yahoo.com
OR MAIL TO:

HELPING HANDS OF CINCINNATI
5800 Windsong Ct.
Cincinnati, OH 45243



PERSONAL INFORMATION:

Name: _____

Social Security #: _____

Date of Birth: _____

Email: _____

Phone: _____

Marital Status: ()Single ()Married ()Partner

Mailing Address: _____

Head of Household: _____

City, State, Zip: _____

Dependents: _____

EMPLOYMENT INFORMATION:

Are you employed? _____

Full/Part Time: _____

Employer: _____

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)

BY CHECKING 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: _____