Beneficiary Application Form

HELPING HANDS OF CINCINNATI

Email form to: aliciacachat@yahoo.com

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:

Employment Information

Are you employed?

Employer:

Employment 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

Areas where financial support is needed: (please list)

☐ *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