



## COMMUNITY HELPERS OF RUTHERFORD COUNTY

Client Name \_\_\_\_\_

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Address \_\_\_\_\_  
Number & Street

Spouse's Name \_\_\_\_\_

City State Zip Code

Rutherford County resident: ☐ Yes ☐ No  
\_\_\_\_ Years \_\_\_\_ Months

EMAIL: \_\_\_\_\_

Phone#: (\_\_\_\_) \_\_\_\_\_

### LIST ALL INDIVIDUALS LIVING IN THE HOME: [PLEASE PRINT]

Name	Relationship	Sex	Race	Date of Birth	Social Security #
	Self				

### LIST ALL SOURCES OF HOUSEHOLD INCOME: ☐ Man ☐ Woman ☐ Child

Wages ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly \$ \_\_\_\_\_

Employer(s) \_\_\_\_\_

Social Security \$ \_\_\_\_\_

Supplemental Social Security (SSI) \$ \_\_\_\_\_

Do you have transportation? Yes No

Social Security Disability (SSD) \$ \_\_\_\_\_

Do you have GED/High School: Yes No

Unemployment \$ \_\_\_\_\_

Comments: \_\_\_\_\_

Worker's Compensation (or Temporary Disability) \$ \_\_\_\_\_

Child Support / Alimony \$ \_\_\_\_\_

Veteran's Benefits \$ \_\_\_\_\_

Referred by: \_\_\_\_\_

Food Stamps \$ \_\_\_\_\_

**Medication Applicants** must **FIRST** apply:

Other (Student Loans/Grants, etc.) \$ \_\_\_\_\_

Dispensary of Hope Eligible/Non-Eligible (circle one)

Families First \$ \_\_\_\_\_

If non-eligible, please check why- Medication: ☐ Unaffordable  
☐ Unavailable ☐ Over TennCare Limit ☐ Insured Medicare Eligible

<b>TODAY I NEED HELP WITH MY:</b>	<input type="checkbox"/> Electric	<input type="checkbox"/> Gas	<input type="checkbox"/> Water	<input type="checkbox"/> Rent	<input type="checkbox"/> Dental	<input type="checkbox"/> Medical
<b>Amount Requested:</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	Insurance: <input type="checkbox"/> NO <input type="checkbox"/> Yes Co-Pay \$ _____ Name Insurance Co. _____

### Applicant Certification

I certify that all the information provided in this application is true & correct. I understand providing false information will result in no assistance & case file permanently closed. **CHORC** has the right to refuse assistance for inappropriate behavior directed toward CHORC staff at all times]

I AUTHORIZE THE VERIFICATION OF ANY AND ALL INFORMATION LISTED FOR THE PURPOSE OF CERTIFICATION

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature of Witness \_\_\_\_\_

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_