Colorado Patient Care Fund

Together we can help

Telephone: (720)878-7055 **Email Address**: info@coloradopatientcarefund.org

APPLICATION FOR ASSISTANCE

Only completed and signed applications will be considered			
Name:		Date of birth:	
Phone number:		Email:	
Current address:			
City:	State:	Zip:	
Length of time:		Current rent/mortgage:	
Additional information to share about current housing situation:			
Are you employed?		Name of employer:	
If unemployed, how long?		Currently seeking work?	
Receiving unemployment benefits?		If receiving benefits, how long?	
Additional information to share about current employment status:			
Please provide information below for any programs that are currently providing financial assistance			
Program	Monthly amount	Program	Monthly amount
Social Security	$	Veterans Affairs	$
Supplemental Security Income	$	Pell Grant	$
Social Security Disability Insurance	$	Unemployment	$
Old Age Pension	$	Pension	$
Temporary Assistance for Needy Families	$	Workman's Compensation	$
Child Support	$	Low-Income Energy Assistance Program	$
Food Stamps (SNAP)	$	Government Stimulus	$
Other (please explain):			
Total Monthly Household Income: $			

Please provide information below for all monthly expenses that apply			
Mortgage/Rent:	Auto Payments:	Daycare:	Life Insurance:
Gas/Electric/Propane:	Auto Insurance:	Child Support:	Therapy:
Water/Sewer:	Health Insurance:	Internet/Cable:	Medical:
Cell Phone:	Dental Insurance:	Pets:	Clothing:
Food (without SNAP):	Public Transit:	Credit Cards:	Other:
Other (please explain):			
Total Monthly Household Expenses: $			
Assistance being requested:			
How much can the applicant contribute? If nothing, please explain:			
Amount being requested: $			
What other organizations have been contacted? For large requests, we need to know what efforts have been made to get help.			

If application is approved, Colorado Patient Care Fund will make payments directly to the vendor/agency/provider.

Checks are NOT payable to the applicant.

I, the applicant, agree to hold Colorado Patient Care Fund harmless from any and all claims, disputes, liabilities, or causes of action arising out of the agreement to provide assistance or arising out of services and goods sold or provided to recipients of assistance through Colorado Patient Care Fund. I hereby release and hold harmless Colorado Patient Care Fund, its affiliates, board of directors, representatives, employees, and partners, collectively and/or individually ("Colorado Patient Care Fund"), from and against any and all liabilities, claims, judgements, and attorneys' fees arising out of or in any manner related to any property or service. This agreement shall be interpreted according to Colorado law. It is to be construed as broadly and inclusively as is permitted by relevant Colorado law.

My signature below signifies that I have read and understand the above written waiver of liability agreement and agree to all of its terms and conditions. I acknowledge that no other warranties, guarantees, or terms and/or conditions are otherwise expressed or implied.

☐ **Documentation of your expenses is required. (Receipts, Invoices, Bills, Etc)**

Applicants Printed Name: _____ **Date:** _____

Applicants Signature: _____

FOR PROFESSIONAL USE ONLY!

Approved: **YES** ☐ **NO** ☐ **Reason:** _____

Name: _____ **Date:** _____

Signature: _____