46 W Catawissa Street, Nesquehoning, PA 18240
TurnToUsInc.org - FB/TurnToUs
(570) 732-4220
Alicia@TurnToUsInc.org

TURN TO US Application for Assistance

****** PLEASE READ CAREFULLY ******

Assistance provided by Turn To Us is made possible because of generous donors and fundraising activities. To apply for financial assistance, emotional support, and to attend Turn To Us client-only events, we ask that you please complete the attached application.

You must meet the following criteria to apply for our assistance:
1. The applicant must have an autism or cancer diagnosis from a physician
2. The applicant must reside in Carbon County or immediate surrounding towns including but not limited to Tamaqua

Please be aware:
1. You will not be discriminated against or denied aid because of your race, religion, color, national origin, sex, political affiliation, income level, or type of disease.
2. Financial assistance (Keegan's Kash and Utility Assistance) depends on how your diagnosis has affected your family's ability to pay their medical and non-medical bills. If approved for assistance, funds are paid directly to the vendor/service provider.
3. ALL sections of the application must be complete and accurate for the organization to review the request. We need these statistics when applying for grants and funding.

Failure to provide complete and truthful information is the basis for denial. Completed applications should be forwarded to:

Turn To Us, 46 W Catawissa St, Nesquehoning, PA 18240 or Alicia@TurnToUsInc.org

We collect only the personal information that we need for providing services to our clients, including personal information needed to:

- Determine what services a client qualifies for
- Enroll a client in a program
- Send out information

We normally collect client information directly from our clients. We may collect your information from other persons with your consent or as authorized. If you have a question or concern about any collection, use, or disclosure of personal information by Turn To Us, Inc. or about a request for access to your personal information, please contact Alicia Kline, Executive Director.

NOTE: You MUST include proof of diagnosis with your application.

Why are you turning to us?

_____ Assistance with Prescriptions
_____ Assistance with Medical Bills
_____ Emotional Support
_____ Connection to Resources
_____ Clothing
_____ Other: ____________________________
_____ Gas Gift Cards
_____ Transportation
_____ Wish Granting
_____ Assistance with Food
_____ Utility Assistance

Any other concerns or questions?

SECTION 1: PERSONAL INFORMATION - Please PRINT all information clearly and complete all questions.

CLIENT'S NAME ____

ADDRESS ____

Is the client under 18? YES or NO If yes, name of parent/guardian: ____

PHONE Home (____) ________________ Cell (____) ______________________

Email ____

Client's Date of Birth ____________________________ Age _______ Male or Female

Please Circle One: Minor Single Live-In Significant Other Married Divorced Widow/Widower

Spouse Name ____ Age ________

Total number of people in household _________
Number of dependent children in household ______

Names, Ages, and Date of Birth of Children
____
____
____

Assessment (If filling out for a minor, answer as the parent/guardian)

Do you have secure, safe, and steady housing? Yes No
If no, explain ____
Do you have transportation? Yes No
How many days a week do you engage in exercise? None 1-3 4-6
If you work out, how many minutes a day? ______________________

Do you have any vision or hearing problems? Yes No
What is your highest level of school completed? _________________________
What is your primary language? _______________________________________

Do you understand what the medical providers have told you about your diagnosis?	Yes	No
Do you feel overwhelmed by your diagnosis?	Yes	No
Do you take medication?	Yes	No
Do you take your medication as prescribed?	Yes	No
Do you have a computer, laptop, or smartphone?	Yes	No

How worried are you that your food will run out before you get money to buy more?

Very Worried　　Worried　　Varies Month to Month　　Not worried

How worried are you that you will not have money to pay monthly bills?

Very Worried　　Worried　　Varies Month to Month　　Not Worried

Do you have medical debt? Yes No

If yes, what is your best estimate? ___________________________________

Who does the grocery shopping? ____

Do you eat fruits and vegetables as recommended? Yes No

Where you get your fruits and vegetables? ______________________________________

Who prepares and cooks your meals? ____

Do you feel tense, restless, nervous, anxious, or are unable to sleep at night because you are troubled?	Yes	No
Do you ever feel lonely or depressed?	Yes	No

How often do you get together or talk to family and friends? ____

Do you belong to any clubs, churches, or organizations?	Yes	No
Do you use tobacco products or smoke?	Yes	No
Do you have a dentist?	Yes	No
Do you have a primary care physician?	Yes	No
Are you a Veteran?	Yes	No

SECTION 2: DIAGNOSIS and HEALTH INSURANCE INFORMATION

Diagnosis ____

Please send in a copy of the paperwork from your physician or hospital showing your diagnosis.

Are you in active treatment? YES or NO

What was the initial date of your diagnosis? _______

Is this a recurrence? YES or NO If yes, what was the date of the recurrence _______

Treatment Facility ____Phone __________________________

Nurse Navigator/Social Worker ____Phone __________________________

Do you have health insurance? YES or NO

If YES, please indicate the type of insurance: (Check all that apply)

_____ Private Insurance
_____ Medicaid
_____ Medicare Only
_____ No Insurance
_____ Medicaid Pending
_____ Medicare + Medicaid
_____ Medicare + Supplement
_____ Charity Care
_____ VA Program

Do you have prescription coverage?
Yes No

SECTION 3: INCOME
CLIENT/PARENT:

Do you currently have a job? YES or NO
If no, did your or your child's diagnosis cause you to lose your job? YES or NO
Are you on Social Security Disability? YES or NO

What is your disability? ____

CAREGIVER or SPOUSE

Does your spouse/partner or caregiver have a job? YES or NO
Has your or your child's diagnosis caused a job loss? YES or NO

INCOME
What is your total income (employment, SS, assistance, food stamps, alimony, etc.)? (This is used for statistics)

______________ per month ________________________ per year

EXPENSES
Mortgage or rent: _________________________
Cable: __________________________
Phone: __________________________________
Internet: ________________________

Water: __________________________________
Sewer/Garbage: __________________
Electric: _________________________________
Oil/propane: _____________________
Food: __________________________________
Car payment: ____________________
Medical bills: ______________________________
Prescriptions: __________________________
Loans: ___________________________________
Insurances: ____________________________
Other: ___________________________________

Total monthly expenses: ____________________________________

Circle or list the type and amount of assistance received on average per month:

Supplemental Security Income ___________________
Social Security Disability Insurance ___________________
TANF / Cash Assistance ___________________
Food Stamps ___________________
LIHEAP ___________________
Other:

SECTION 4: PERSONAL STATEMENTS – PLEASE PRINT NEATLY

What would assistance from Turn To Us mean to you and your family:

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____
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____

Briefly describe HOW YOUR DIAGNOSIS HAS IMPACTED your ability to pay your bills, your emotions, your family:

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SECTION 6: **MEDIA**

How did you learn of Turn To Us?
___ Social Worker Please List Office or Hospital: _________________________________
___ Doctor/Nurse Please List Office or Hospital: _________________________________
___ Brochure
___Community Event
___ Newspaper/TV
___ Facebook/Twitter
___ Word of Mouth
___ Other ____________________________________

MEDIA RELEASE

I hereby give my permission for Turn To Us and /or its representatives to use photographs, audiotape records, or videotape of my family or myself and to use our names, these images or voice recordings in publications, slides, videotapes, motion pictures, or on the internet.

I understand these visual images or voice recordings will be used to inform families, volunteers, the media, and the general public about Turn To Us' programs, services, or events. I gladly give this authorization to support the public awareness and fundraising efforts of Turn To Us.

I understand this authorization shall continue until terminated in writing. Signing the Media Release form is not a requirement to receive assistance from Turn To Us.

Patient's Name (Print) ____
Patient's Signature ____ Date ________

Please send the completed form and proof of diagnosis to
Turn To Us
46 W Catawissa Street
Nesquehoning, PA 18240
570-732-4220