Application for Assistance

Please send completed form and doctor's note to info@HelpingHandsSupport.net. Allow 14 days for response.

Date: _____

Patient Name: _____

Street Address: _____

City, State and Zip: _____

County: _____ Email: _____

Home Phone Number: _____ Cell Phone: _____

Please include:

- **A letter from your treating physician on their letterhead including the diagnosis, date of dx, and proposed length and course of treatment.**
- **Completed and signed application. Incomplete applications may not be considered.**

Specify Type of Assistance requested:

☐ Travel Voucher ☐ Food Gift Card ☐ Consulting/Advocate ☐ Utility Assistance (attach invoice)

Other (Provide details): _____

Have you applied for or received support of any type from another organization? ☐ Yes ☐ No

Organization Name: _____

When: _____ ☐ Approved ☐ Denied How much: _____

If requesting representation, I authorize a Helping Hands agent to speak on my behalf. ☐ Yes ☐ No

Terms of Acceptance: I have rendered no goods or services in exchange for this donation. I agree Helping Hands shall not be liable for any loss or damages incurred by me or a third party as a result of this donation. I waive any and ALL claims against and release Helping Hands from all liability associated with the use of these donations. I agree to hold harmless Helping Hands, its donors, affiliates and officers from and against any loss, cost of damage including attorney fees relative to this donation.

Signature _____

Office Use only:

Request Status: Date Approved ⬭ Date Denied ⬭ Reason

Type of Support Granted: _____

Details: _____

Helping Hands Authorized Representative:_____