Confirmation Code: _____ CRT Code: _____

APPLICATION FOR FUNDS/SERVICES AND CONSENT FOR RELEASE OF INFORMATION

Community Resource Team - Havasu Community Health Foundation - (In-Need Only)

Privacy Act Statement: *The execution of this form does not authorize the release of information other than that specifically described below. This form will authorize the COMMUNITY RESOURCE TEAM & HAVASU COMMUNITY HEALTH FOUNDATION to share provided information with other service providers when necessary, and only for the purpose of providing assistance requested by the person signing this form. Completing this form is voluntary. However, if this release is not signed, the person requesting assistance may not receive the monies or services requested.*

Name:		Date of Birth	
Address:		SSN	
City/State/Zip:		Relationship Status	
Phone Number:		Name	
Email:		Minor Children in Home	Age of Children

Own Home ____ Homeless or at risk ____ Rent ____ Name of Landlord ____ Phone ____

Other Adults living with you ____ Name(s) ____ Do they help with expenses ____ How much $ ____

Employment ____ Full-time ____ Part-time ____ Retired ____ Hours ____

Employer ____ Monthly Take Home $ ____ Other Contributions? ____

Expenses				*Bank Information*		*Other Income*	
Mortgage/Rent	$	Medical Insurance	$	Balance in Checking	$	Disability	$
Electric	$	Medical Bills	$	Balance in Savings	$	Pension	$
Water	$	Child Support	$		$	Child Support	$
Phone(s)	$	Credit Card	$	Other	$	Social Security	$
Car Payment	$	Internet	$		$	RRB	$
Car Insurance	$	Others	$		$		

Receiving any services, treatment, or assistance? ____ *If yes list the agency/service*

Agency ____

Service ____

Community Resource

13 August 2024

Requesting Services/Assistance

Employment		**Childcare**		**Counseling/Mental Health/Treatment**		**Equipment** If YES list below	
Housing		**Eldercare**		**Legal Issues**			
Transportation		**Medical Service**					
Utilities/Bills		**Dental Services**		**Others:**			
Car Payment		**Food**					
Car Insurance		**Education**					

Amount of Funds Requested **$**

What are the funds/services needed for and why?

I hereby authorize the HAVASU COMMUNITY HEALTH FOUNDATION to share my information on this form ONLY with organizations that may provide the monies, services, or items that I am requesting. This authorization does not replace the HIPAA Security Rule.

Name (Print) _____ Signature: _____

Referred by: _____ Organization/Agency _____ Date: _____

Email the completed form to CRT@havasuhealthfoundation.org for the review process.
*Come in to the office to supply copies of the **CURRENT bills** that are requested to pay and sign this form.*
Havasu Community Health Foundation 2126 McCulloch Blvd N Ste 14 Lake Havasu City, AZ 86403 Phone: (928) 453-8190 Fax: (928) 453-8236