Beneficiary Application Form

PLEASE SEND TO info@fightforthecauseoh.org
OR MAIL TO:

FIGHT FOR THE CAUSE , INC.
2180 Easthill Ave
Cincinnati, Ohio 45208

PERSONAL INFORMATION:

Name:_____ Social Security #:_____

Alias(es):_____

Date of Birth:_____Email:_____

Phone: _____ Marital Status: ( )Single ( )Married ( )Partner Mailing

Address:_____ Head of Household:_____ City:_____

State:_____Zip:_____ # of Dependents:_____

Please list names of Dependents:

1._____ 2._____

3._____ 4._____

EMPLOYMENT INFORMATION:

Are you employed?_____ Full/Part Time:_____

Employer:_____ Employer phone #:_____

Supervisor Name:_____ Email:_____

SPOUSE EMPLOYMENT:

Are you employed?_____ Full/Part Time:_____

Employer:_____ Employer phone #:_____

Supervisor Name:_____ Email:_____

INCOME:

Banking Instituition:_____ Bank Contact:_____

Phone:_____Annual Household Income:$_____

Checking Account Balance:$_____Savings Account Balance:$_____

INSURANCE INFORMATION:
Primary Medical Insurance provider:

_____
Secondary Medical Insurance provider:

_____

MEDICAL INFORMATION:

Diagnosis: _____ Date of Diagnosis: _____

Are you currently receiving treatment? ( ) Yes ( ) No Treatment Start Date:_____

Treatment End Date:_____ Place of Treatment:_____

Physician Name:_____

Physician Signature:_____ Date:_____

AREAS WHERE FINANCIAL SUPPORT IS NEEDED: (PLEASE LIST)

_____
_____
_____

□ BY CHECKING BOX, YOU CONFIRM ALL OF THE INFORMATION PROVIDED ABOVE IS ACCURATE, ANY FALSE INFORMATION MAY DISQUALIFY YOU FROM ANY RECIPIENT BENEFITS AND AUTHORIZE FIGHT FOR THE CAUSE, INC. TO SHARE YOUR STORY ON OUR WEBSITE, FACEBOOK PAGE AND FUTURE MEDIA CHANNELS AT OUR DISCRETION.

Applicant's Signature:_____ Date:_____

Types of Financial Assistance provided
- Applicants' mortgage, rent or other household bills
- Applicants' medical bills or medical bills of applicants' dependents
- Daycare or school tuition
- Any other type of financial assistance will need to be approved by the Fight for the Cause Board of Trustees.