



WAYNE COUNTY COMMITTEE FOR CRIPPLED CHILDREN & ADULTS, INC.

**Return Application to:  
UNITED WAY WHIRE**

**215 South Walnut Street, Wooster OH 44691**  
330-263-6363 or 330-264-5601, FAX # 330-264-5607  
[www.wcccca.org](http://www.wcccca.org)

Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Name of Parents IF Applicant is under age 18: \_\_\_\_\_  
Address \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Cell: \_\_\_\_\_  
Length of residence in Wayne County: \_\_\_\_\_ In Ohio: \_\_\_\_\_  
Email: \_\_\_\_\_

**MEDICAL INFORMATION**

Medical Diagnosis or Disability: \_\_\_\_\_  
Date disability began: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_  
Doctor's address: \_\_\_\_\_  
Your height: \_\_\_\_\_ Your weight: \_\_\_\_\_  
Do you have insurance? \_\_\_Yes \_\_\_No IF Yes, Name of Insurance Company: \_\_\_\_\_  
Do you have medication insurance? \_\_\_Yes \_\_\_No IF Yes, Name of Insurance Company: \_\_\_\_\_

**INFORMATION ABOUT REQUEST**

What help do you need from the Committee? *(Please note that you will need to include a prescription from your doctor and two quotes for any equipment/construction/building requests.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Total amount being requested \$ \_\_\_\_\_

**(This amount MUST be filled in for the committee to consider approval of the request.)**

Other Sources/Agencies Contacted for help:

Where: \_\_\_\_\_ How Much? \_\_\_\_\_ Declined \_\_\_\_\_  
Where: \_\_\_\_\_ How Much? \_\_\_\_\_ Declined \_\_\_\_\_  
Where: \_\_\_\_\_ How Much? \_\_\_\_\_ Declined \_\_\_\_\_  
Where: \_\_\_\_\_ How Much? \_\_\_\_\_ Declined \_\_\_\_\_

IF you are requesting assistance with prescription MEDICATIONS: Please list PREFERRED PHARMACY (MUST be within WAYNE County) and ALL MEDICATIONS with approximate price and dosage information (milligrams and number of times taken per day, etc.). You can use additional paper if necessary.

Pharmacy (Name, Address, and Phone #): \_\_\_\_\_

Medications: (Name, Milligrams and Number of Times taken a day and cost) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF you are requesting assistance with MEDICAL EQUIPMENT, please list PREFERRED SUPPLIER: Name, Address and Phone #

\_\_\_\_\_

**PERSONAL/FINANCIAL INFORMATION**

Are you a Veteran?  Yes  No If Yes, have you applied for assistance with the VA?  Yes  No

Total Number of persons in the home: \_\_\_\_\_ Please list Names and Ages:  
 \_\_\_\_\_  
 \_\_\_\_\_

Present Monthly Household Income (includes all person(s) income from all sources): \$ \_\_\_\_\_

Sources of household income: \_\_\_\_\_

Normal monthly income (if different from present monthly income): \$ \_\_\_\_\_

Why the difference in present from normal monthly income? \_\_\_\_\_

Does anyone in the household own real estate?  Yes  No Mortgage per month \$ \_\_\_\_\_

If yes, value of real estate \$ \_\_\_\_\_ Amount owed \$ \_\_\_\_\_

Do you rent?  Yes  No Rent per month \$ \_\_\_\_\_

Are you behind in your rent or mortgage?  Yes  No

Utility Expenses (not paid through any type of assistance—Out of pocket expenses):

Gas/Fuel \$ \_\_\_\_\_ Electric \$ \_\_\_\_\_ Phone \$ \_\_\_\_\_ Water/Trash \$ \_\_\_\_\_

Do you have other income/assets: (for example stocks, bonds, personal property, automobiles, etc.)?  Yes  No

Are you eligible or have you applied for any of the following:

	Yes	No	Applied	Unknown	Amount & Other Info
Unemployment Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sick or Accident Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insurance Benefits/Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medicaid/TANF/Medical Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Support Payments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Veterans Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SSD/SSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ohio Bureau for Children with Medical Handicap (BCMh)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Assistance: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Assistance: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any other circumstances that the Committee should consider when reviewing your application? \_\_\_\_\_

Have you ever applied to the Committee before?  Yes  No If Yes, When? \_\_\_\_\_

I hereby release all information to the Wayne County Committee for Crippled Children and Adults, authorize that it is true to the best of my knowledge, and give permission for the committee or their agency, WHIRE, to investigate the above information and discuss it among themselves and/or other agencies or programs that may have a concern or be of some assistance. **I understand that if the committee grants my request, I may be asked to provide my first name and picture for use on the committee's website and printed publications. I agree to comply with their request.**

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*It is the policy of the Wayne County Committee for Crippled Children and Adults, Inc., that no person shall be denied services on the basis of race, ethnicity, age, color, national origin, sexual orientation, physical or mental handicap, or developmental disability according to Title VI of the Civil Rights Act of 1964; or any person with "HIV" or Aids-related complex; or in any manner prohibited by the laws of the State of Ohio and the United States.*