Wayne County Committee
For Crippled Children & Adults, Inc.
PO Box 406 * Wooster, Ohio 44691 * to call 330-263-6363

Thank you for your interest in assistance from the Wayne County Committee for Crippled Children and Adults.

The Wayne County Committee for Crippled Children and Adults is dedicated to assisting individuals for the relief of pain, suffering and inconvenience from medically determined disabilities.

Applications for assistance are considered based on: financial need, relationship to our mission, and the availability of funds. Please fill out the enclosed application as completely as possible. This will help the Committee understand your needs and the assistance you are requesting. It is especially important to provide specific details about the amount of help that you need.

If you are asking for help with **MEDICAL SUPPLIES OR MEDICATIONS**, we will need to know the specific medical supply or medication, who prescribed them, and their cost. (Please attach a prescription from your physician).

If you are asking for help in obtaining **MEDICAL EQUIPMENT**, we will need a statement from your doctor so that we can understand the medical reason(s) for your request. (Please attach a statement/prescription).

The Committee meets once a month, therefore your application MUST be received at the United Way's office (215 S. Walnut St., Wooster, OH 44691) by the 1st Friday of the month in order to be considered during that month. If received past that date, your application will be considered the following month.

If you have any questions or need assistance in completing your application, please contact **United Way's WHIRE** at 330-263-6363 or 330-264-5601, M-F 8 am–5 pm.

The Committee primarily covers medical equipment, medical supplies, and other services for individuals with physical or medical disabilities.

The Committee does not generally cover surgery, outstanding medical or hospital bills or food. The committee does not pay for Medicaid spend downs or insurance co-pays and/or deductibles. Please see guidelines below.

Guidelines

- Client must be a resident of Wayne County for 90 days
- Client must have valid ID
- Prescription help will not cover narcotics
- Client cannot be helped more than once in the same year
- No Co-Pays or deductibles
- No spend downs for Medicaid
- Client cannot have insurance that covers the need
- Prescriptions are required for medication and equipment requests

RETURN APPLICATION TO: UNITED WAY, 215 S. WALNUT ST., WOOSTER, OH 44691

Updated 7/12

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

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? _____
_____
_____
_____
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 #
_____
_____

Approved 1/14/2014

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:

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

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.

Approved 1/14/2014