Riverland Area Medical Program Inc.

REQUEST FOR ASSISTANCE

PO Box 511 Lottsburg VA 22511

Date _____ Marital Status _____ Sex _____ Soc Sec # _____

Name _____ Phone: ( ) _____
Last First Middle Maiden, if applicable

Address _____ City _____ State _____ Zip _____
Street Name and Number

Date of Birth: _____ Employer: _____ Phone: ( ) _____

Spouse's Name _____ Sex ____ Marital Status: _____
Last First Middle Maiden, if applicable

Date of Birth: _____ Employer: _____ Phone: ( ) _____

People in Household

Last Name	First Name	MI	Soc Sec #	Date of Birth	Relationship	Income
						Y / N
						Y / N
						Y / N
						Y / N
						Y / N
						Y / N

Emergency Assistance Request
Enter the total amount requested in the appropriate category.

(Medical $ _____) $ _____) _____) _____)

_____

_____

Landlord's Name: _____ Phone: ( )_____

List all income sources, by month, by source and amount:

Salary $ _____, Pensions $ _____, Social Security $ _____, Food Stamps $_____,

SSI $ _____, Disability $ _____, Child Support $ _____,

Unemployment: $ _____, Other: $ _____ Other $ _____. (Identify Other)

What other Persons, or Agencies by Name and Phone Number have you contacted regarding this need and what was their response? Did they offer partial help toward this need, if so to what extent?

	Request Accepted?
Immediate Family: _____	Y / N
Friends/Neighbors: _____	Y / N
Other: _____	Y / N

Authorization for Release of Information

Riverland Area Medical Program Inc. respects your right to privacy. All information you give to Riverland Area Medical Program Inc. will be kept private and confidential, except in the following cases. All disclosures authorized below will be made only to authorized personnel and only on a confidential basis.

1. By signing below, I authorize Riverland Area Medical Program Inc. to disclose my personal information (including any health information). The purpose of this authorization is to coordinate our services with other agencies in order to gain information needed to resolve my emergency and for other general administrative needs. This may include, but not limited to, landlords, mortgage holders, utility companies, household members, family members, current or former employers, and churches.

Important Information

- I understand that signing this Authorization is voluntary. However, without my signature, Riverland Area Medical Program Inc. will not be able to fully render assistance to me.
- I understand that I may revoke this Authorization at any time by notifying Riverland Area Medical Program in writing. However, revoking this Authorization will not have any effect on actions that have been taken in reliance on Authorization before the revocation is received.

Required Signatures

_____ _____ _____

Signature of Applicant Date Signature of Officer

By signing this form I do hereby certify that the information I have given is true and accurate. I further affirm that I fully accept and agree to the terms of the Authorization for Release of Information stated above.

In order to be considered for Emergency Assistance this form must be filled out completely, signed by the applicant and the Riverland Representative

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For Office Use Only

( ) Approved Item #'s _____

( ) Refused Item #'s _____

_____ _____

Date **Signature of Officer**