Quota Club of Northern Colorado

Application for Financial Assistance

We offer financial assistance to Deaf and Hard of Hearing women and children for various needs including summer camp fees, hearing aids and accessories.

Applicant's Name:_____ Age:_____
Address: _____
_____
Phone_____Email_____
Preferred method of contact?_____

If the applicant is a minor, who has legal guardianship?
Name:_____ Phone_____
Mailing address: _____
_____
Email_____

If you do not speak English, is there someone we can use as an English speaking contact?
Name_____ Phone_____

Please explain your need:_____
_____
_____

List members of your household (applicant)	Relationship	Age	Monthly Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have medical insurance to help with this need? (CHP+, Medicaid, Medicare, private) _____ If not, have you applied for insurance? _____
What amount will insurance pay?_____

What other sources of financial assistance have you tried (agencies, relatives)?_____
_____

Continued on next page

What financial resources do you have such as savings, stocks, property, etc? Please list value._____
_____

Do you have unusual expenses such as outstanding medical bills, expensive medication, or treatments? _____
_____

Are you a full time or part time student and/or are you employed? _____

If so, where and how many hours per week?

_____

If we fund your request, we will pay the vendor/medical provider directly.

Vendor/Provider's

Name:_____Phone:_____

Mailing address:_____
_____

**If you are applying for hearing assistance, please supply a hearing test performed within the past 12 months.

**If you are working with a therapist, audiologist or other professional, please sign the release of confidential information form below so that we may communicate with your provider.

Confidentiality Statement

I understand that in order to meet my needs, Quota Club of Northern Colorado will share my hearing test and application information. I agree to allow Quota to communicate with the necessary medical professionals or agencies in order to help with this request for assistance. I understand that I have the right to obtain a copy of my records from QCNC for up to five years.

_____

Signature of Applicant or Legal Guardian

Mail application to:

QCNC
PO Box 1415
Fort Collins, CO 80522

OR

email application to:

fcquota@gmail.com