Request for Emergency Financial Assistance

Applicant Name: _____

Mailing Address: _____
Street/PO Box, City, State and Zip Code

Home Phone #: _____ **Cell Phone # (if applicable):** _____

Email (if applicable): _____

Insurance Coverage (if applicable): _____

Are you currently receiving assistance from DHS or any other resource? Yes _____ No_____
Receiving of assistance is not a disqualifier. Falsification of information will result in denial of application and any future applications.

Explanation of Financial Hardship:_____
Please note, more information may be needed prior to decision of application.

_____

Explanation of Medical Situation:_____
Please note, more information may be needed prior to decision of application.

_____

_____

_____

Medical documentation of treatment ***required***. Can you provide requested documentation?
Yes_____ No_____

Name of Treating Physician: _____ **Physician Phone #:** _____

By signing below I, _____, authorize release of medical and/or financial information from my Physician(s) and/or County, State, Federal and/or Private Assistance Agencies to DDIY for verification of said request for assistance.

Signature: _____ **Date:** _____

This document serves as an application for assistance and does not bind DDIY or its members to any financial support for said applicant.

Application must be complete. Incomplete application will delay request process and possibly result in denial for assistance.

All information provided will be verified. Falsification of information will result in a denial of original application and any future applications.

All applications are reviewed by the DDIY Board. The DDIY Board has the final judgment as to what constitutes a Financial Need and Medical Situation.