

Helping Hands

Special Assistance **INFORMATION FORM**

I would like to apply for financial assistance through the Helping Hands pharmaceutical program. I understand the following information will be treated confidentially and will be

used only to determine qualification for assistance.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_File#\_\_\_\_\_\_\_\_\_\_ Minister  Widow 

Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home church \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pastor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total **annual** income received from **all** sources. $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Including spouses income)

Number of persons the above income supports. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note**: In order to qualify for this assistance, total **annual** **income** cannot exceed **$12,760 (for a widow/widower) $17,240 (for a couple).**

Send this completed form to the *Center for Ministerial Care*, Attn: SpiritCare,

P. O. Box 2430, Cleveland, TN 37320-2430. This information will be processed and you will be notified as soon as possible concerning the decision.

Date Signature

***HELPING HANDS PROGRAM***

**Helping Hands** is a program developed by the Church of God for our retired ministers and wives and minister’s widows in the **USA;** and was financed through private donors. This program is to assist with reimbursement of prescription medications and supplemental insurance up to **$150.00** monthly for those meeting the requirements.

If you feel **you qualify**, please:

* Fill out the application and return to: **Center for Ministerial Care**

P. O. Box 2430

Cleveland, TN 37311

* **All** **income** from **all sources** must be included in the **total** amount.
* **2021 Federal Income Requirements: (Maximum income)**

**Couple — $17,240**

**Individual — $12,760**

* Once the HH Application has been approved, an acceptance letter will be mailed with a reimbursement form and self-addressed envelope. At the end

of the month participants can contact their local pharmacy and request a printout of their prescriptions for the month. Mail this printout with your reimbursement form; and a copy of your supplemental insurance premium.

* Reimbursements are up to $150.00 monthly (per couple or widow/widower). When the reimbursement forms are processed, a check will be issued and a new reimbursement form and self-addressed envelope will be sent each month.

