

Columbia County Resources, Inc.
P. O. Box 1376
Lake City, FL 32056-1376
Telephone: (386) 752-8822
Facsimile: (386) 752-7506

Dear Applicant.

We are providing this application, because you may qualify for our ***Tough Enough to Wear Pink Medical Relief Fund.***

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom, and return the completed application as stated below.

It is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any **two** of the documents listed below.

State Income Tax Return
Employer Pay Stubs
Written documentation from income sources
Copies of all bank statements for the past three months
Qualified Medicare/Medicaid and/or other Benefits

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

You will receive a reply within fourteen (14) days upon receipt of the application. We will notify you of our determination by letter.

Please return the Financial Assistance Application, current photo ID, and any required documentation to the ***Columbia County Fairgrounds Office***, 438 S.W. State Road 247, Lake City, Florida between the hours of 8:00 AM – 4:30 PM, Monday through Friday. **Do NOT mail your application.**

Remember if you return this form your request may be included in our *Tough Enough to Wear Pink Medical Relief Fund.* Acceptance of application does not guarantee approval.

FINANCIAL ASSISTANCE APPLICATION

Applicant Name: _____ Phone: _____
 Social Security Number: _____ Date of Birth: _____
 Assistance Requested: _____
 Amount Requested: _____ Have you or a member of your household previously received assistance from this fund? _____ If so, please state the name _____

Household Occupants

(This includes spouse, children, and all other occupants living in your household)

Name (First, Middle and Last Name if different than Patient)	Date of Birth
_____	_____
_____	_____
_____	_____

Employment

Employer Name: _____ Hourly Rate _____ Hours Worked Per Week _____
 Current Gross Weekly, Monthly or Yearly Income (Before Taxes) _____
 If unemployed, date last worked _____

Spouse Employment

Employer Name _____ Hourly Rate _____ Hours Worked Per Week _____
 Current Gross Weekly, Monthly or Yearly Income (Before Taxes) _____
 If unemployed, date last worked _____

Household Income

	Applicant	Spouse	Other
Social Security			
Pension			
Unemployment			
Worker's Compensation			
VA Benefits			
Rental Income			
Stocks, Bond, 401K			
Dividend/Interest			
Child Support			
Alimony			
Other			

Have you applied for Medicaid or any other State/County Assistance? _____
 If yes and known, Case Number _____ Date Applied _____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to assist with my need prior to completing this application.

Signature _____ Date _____
 Witness Signature _____ Date _____