

Gill Children's Services, Inc.

555 Hemphill, Suite 200 • Fort Worth, Texas 76104 • (817) 332-5070
Hours: 8:30am to 3:30pm, Monday to Friday • Fax (817) 332- 6445

Date Received _____

Application for Financial Assistance

1. _____ 2. _____
Child's Last Name, First Middle Age Date of Birth Sex Race

***Additional children you are applying for can be listed on page 3, #21.**

3. Social Security # _____ 4. Phone _____

5. _____
Residence: Number Street City State Zip

How long has the child lived in Tarrant County? _____

6a. _____
Mother's Name Age Social Security # Marital Status

6b. _____
Father's Name Age Social Security # Marital Status

6c. _____
Other Legal Guardian Age Social Security # Marital Status
(i.e. Grandparent, Step-Parent)

Does a parent live at a different address than the child? Which parent? (Circle one): Mother Father

Number Street City State Zip

7. Who has legal custody of the child? _____

8. Nearest relative or friend? _____
Name /Relationship Phone #

9. What language(s) do the parents speak? _____

10. What school is the child attending? _____
Name Phone #

11. What services, supplies or equipment are you requesting for this child? _____

12. Why does the child need the services, supplies or equipment (describe health or other problems of child)?

Gill Children's Services, Inc. - Application for assistance

13. Who prescribed, or told you that your child needed, the services, supplies or equipment?

Name _____ Phone # _____

Address: _____

14. Who will provide the services requested? (give name, address & phone # of each provider):

15. How much will each service or supply cost? _____

How much of this cost are you requesting as assistance from Gill? _____

Who will pay the difference between the total cost and the amount you are requesting from Gill?

16. Have you received assistance from Gill before? No ___ Yes ___ Date _____

17. How did you hear about Gill Children's Services? _____

18. List other community agencies or resources where you asked for help before applying to Gill. What was their answer? Agency: Answer:

19. Give name, address and phone number of a person we may contact as a reference on this request (Minister, DHS or Hospital Caseworker, etc.).

20. Where do the parents work?

Father's Employer Address Phone Monthly Take-home

Mother's Employer Address Phone Monthly Take-home

Step-parent's Employer (with whom child is living) Phone Monthly Take-home

Please attach proofs of income for mother, father and/or legal guardian: two most recent paycheck stubs, most recent income tax return, or a letter from the employer.

21. Please list ALL other adults and children who are living at the same residence as this child. You may also list additional children you are applying for here:

Name	Kinship to child	Age	DOB
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

22. Please list the family's monthly obligations: Monthly Payment

Rent/Mortgage Payment	\$ _____
Electric	\$ _____
Gas	\$ _____
Water	\$ _____
Food/Groceries	\$ _____
Home Phone	\$ _____
Cell Phone/Pager	\$ _____
Car Payment	\$ _____
Car Gas	\$ _____
Car Insurance	\$ _____
Child Care	\$ _____
Health Insurance	\$ _____
Hygiene/Personal Expenses	\$ _____
Major Credit Cards (Total Balance _____)	\$ _____
Loans (Total Balance _____)	\$ _____
Medical Bills	\$ _____
Other (Please specify) _____	\$ _____
Other (Please specify) _____	\$ _____
Other (Please specify) _____	\$ _____
Other (Please specify) _____	\$ _____

*Gill evaluates each request individually and will ask for verification of expenses if income and expenses do not match up.

23. Does the parent/guardian receive any of the following?

Child Support? No _____ Yes _____ Amount _____

TANF No _____ Yes _____ Amount _____

Housing No _____ Yes _____

WIC No _____ Yes _____

Social Security: Retirement or SSI/SSD? No _____ Yes _____ Amount _____

Who is receiving this amount? _____

Food Stamps No _____ Yes _____ Amount _____

24. Is this child covered by any insurance policy or program (including Medicaid)? Yes ____ No ____

Which insurance company? _____ (circle) Medical Dental

Policy number _____ Is this through parent's place of employment? Yes ____ No ____

Which parent? _____

25. Please comment on any financial obligations, other than usual living expenses, or any other hardships such as medical bills or outstanding debts that may hinder your ability to pay for the needed services yourself.

26. I acknowledge that Gill Children's Services, Inc. will rely on the information on this application in making its decision on this request.

I authorize Gill to consult with, or release information to any person whom they deem necessary to verify this information and the request. I understand it is sometimes necessary for Gill to do this in order to make its decision on my request. This authorization expires one year from the date below.

Signature: _____ Date: _____
Parent or Guardian

27. If someone other than the person signing #26 filled out this application, please give us the following information:

Name: _____ Relationship to child: _____

Address: _____ Phone: _____

Agency and/or Title: _____