



**APPLICATION FOR EASTERN STAR ASSISTANCE**

**Assisted Care:** [ ]  
**Cancer Aid:** [ ]  
**Benevolence:** [ ]  
**(Check appropriate Box)**

FOR GRAND SECRETARY ONLY:  
Date Received: \_\_\_\_\_  
Case # Assigned: \_\_\_\_\_

**\*\*Applicant is eligible to apply to only one Eastern Star Assistance Fund per 12 month period.**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City: \_\_\_\_\_ Phone: \_\_\_\_\_  
County: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Are you a member of the Order of the Eastern Star? [ ] Yes [ ] No  
Chapter Name: \_\_\_\_\_ No.: \_\_\_\_\_ District: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Do you have any dependents?: [ ] Yes [ ] No If yes, please specify:  
Spouse: \_\_\_\_\_ Minor Children (number of): \_\_\_\_\_ Others: \_\_\_\_\_ Ages of Others: \_\_\_\_\_  
Do they contribute to the household expenses?: [ ] Yes [ ] No If yes, indicate the amount in the income block.  
Are you currently [ ] Employed or [ ] Retired?: (Check One)  
Name of Employer: \_\_\_\_\_ Address of Employer: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
If self-employed, amount earned: \$ \_\_\_\_\_ If unemployed, give last date of employment: \_\_\_\_\_  
If married, is spouse employed?: [ ] Yes [ ] No  
Name of Employer: \_\_\_\_\_ Address of Employer: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you applied for assistance during the last five years (5) through any other organization or club, government, private or fraternal, and if so, please provide the circumstances, name, address and phone number: (If additional space is needed continue on back of form.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INCOME:**

**\*\*Please list all gross income (before taxes) that you receive on a monthly basis in the spaces indicated below. Place a zero or N/A in the spaces that do not apply.**

**MONTHLY:**

Gross Salary \$ \_\_\_\_\_  
Social Security Income \$ \_\_\_\_\_  
Disability Income \$ \_\_\_\_\_  
Pension/Retirement Income \$ \_\_\_\_\_  
Worker's Compensation Benefits \$ \_\_\_\_\_  
Spouse's Monthly Salary/Earnings/Income \$ \_\_\_\_\_  
Salary/Income of Other person(s) living in Household \$ \_\_\_\_\_  
Food Stamps \$ \_\_\_\_\_  
Other Monthly/Quarterly Income earned:  
Interest/Dividends/Stocks/Bonds/Savings, Etc. \$ \_\_\_\_\_  
**TOTAL HOUSEHOLD INCOME** \$ \_\_\_\_\_

**EXPENSES:**

Please list all expenses you pay each month. Place a zero or N/A in the spaces that do not apply.

Monthly Rent/Mortgage Payment \$ \_\_\_\_\_

Monthly Taxes for Home/Property (If not included in your mortgage payment) \$ \_\_\_\_\_

Monthly Utilities (Electricity, Gas, Water, Sewer, etc.) \$ \_\_\_\_\_

Telephone Home: \$ \_\_\_\_\_ Cell: \$ \_\_\_\_\_ Total \$ \_\_\_\_\_

Cable/Satellite, etc. \$ \_\_\_\_\_

Monthly Car Payment \$ \_\_\_\_\_

Other Transportation Expenses (Including auto insurance) \$ \_\_\_\_\_

Food/Clothing \$ \_\_\_\_\_

Loan Payments (Personal, 2<sup>nd</sup> Mortgage, Credit Cards, etc.) \$ \_\_\_\_\_

Medical Expenses (Not covered by Medicare or Insurance) \$ \_\_\_\_\_

Other Monthly/Quarterly Expenses \$ \_\_\_\_\_

**TOTAL MONTHLY EXPENSES** \$ \_\_\_\_\_

**List of Current Medication: (Please Print)**

Name of Drug:	Frequency Purchased	Amount Paid
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

**INSURANCE:**

Is applicant: Under Medicaid?:  Yes  No Under Medicare?:  Yes  No

Enrolled under Part B of Medicare?:  Yes  No Enrolled under Part D (Prescription Drug) Program?:  Yes  No

Retired Military?:  Yes  No Amount of Co-pay: Primary Insurance: \$ \_\_\_\_\_ Secondary Insurance: \$ \_\_\_\_\_

Do you receive Refunds/Reimbursements for prescriptions?  Yes  No How Much: \_\_\_\_\_

Name of Company	Type of Coverage	Effective Date
_____	_____	_____
_____	_____	_____

List any Other Source of Aid:

\_\_\_\_\_

**ASSETS:** (List below or on back of form) (Continued on Reverse  Yes  No)

List all Personal and Real Property Owned by applicant such as home, land, automobile, cash, stocks, bonds, savings, IRA, Life Insurance Policy, etc.)

	Estimated Value
(1) House	\$ _____
(2) Automobile	\$ _____
(3) Retirement Account (401k, Employers, etc.)	\$ _____
(4) Savings, CD's, Stocks, Bonds, Trust Fund etc.	\$ _____
(5) Property (Other than residence)	\$ _____
(6) Other Investments Not Previously Listed	\$ _____
(7) _____	\$ _____

**LIABILITIES:** List indebtedness and amount      Balance Due:

(1) \_\_\_\_\_ \$ \_\_\_\_\_

(2) \_\_\_\_\_ \$ \_\_\_\_\_

(3) \_\_\_\_\_ \$ \_\_\_\_\_

(4) \_\_\_\_\_ \$ \_\_\_\_\_

\*\*\*EXPLAIN IN DETAIL THE REASONS AID IS REQUESTED AND OTHER INFORMATION YOU WOULD LIKE TO SHARE WITH THE INVESTIGATING COMMITTEE:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Use additional space on back of form if needed) (Continued on Reverse [ ] Yes [ ] No)

**If there is any other financial information, or extenuating circumstances, that the Committee should consider regarding your financial situation, please explain, in writing, on a separate sheet of paper. If you have any questions about information requested on this form, please contact the Chairman of the Chapter investigating committee or the Chairman of the Grand Chapter Committee.**

Under penalty of perjury, I hereby certify that the information provided herein is true and correct and that this financial information is provided to the Eastern Star committee with the understanding that it will be relied upon to determine my eligibility and is subject to verification.

*I agree to provide any additional information or documentation necessary, such as financial documents or tax returns, to verify any statement given on this form and hereby give permission to the same to obtain verification of such information if needed. This permission includes verification of bank and/or other financial records. I must report to the Eastern Star Assistance Committee in writing within 10 days any significant changes in my financial condition.*

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

SPONSORING CHAPTER Name and Number: \_\_\_\_\_

**TO BE COMPLETED BY THE INVESTIGATING COMMITTEE**

Who completed the application form? \_\_\_\_\_

Have all questions on the application been answered?: [ ] Yes [ ] No      Did you visit in the home?: [ ] Yes [ ] No

Are the individual expenses listed on the application reasonable?: [ ] Yes [ ] No

Have copies of previous month's bills been requested when an expense seems unusually high?: [ ] Yes [ ] No

Is the applicant reimbursed for medicine and drug expense?: [ ] Yes [ ] No

What has the chapter done to assist the applicant?: \_\_\_\_\_

What has the applicant done to try to improve his/her financial situation?: \_\_\_\_\_

We the members of the Investigating Committee appointed to investigate and report upon this application, recommend [ ] Approval or [ ] Disapproval. Other Comments: \_\_\_\_\_

_____	_____
(Name)	(Phone #)
_____	_____
(Name)	(Phone #)
_____	_____
(Name)	(Phone #)

*Place Chapter Seal*

Secretary of Chapter: \_\_\_\_\_ GC ID # of Applicant: \_\_\_\_\_

Secretary's Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**CONSENT FOR REQUESTING AND OBTAINING OF HEALTH AND FINANCIAL INFORMATION**

\*\*Person Giving Consent (Please Print)

Name: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number(s): Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**PLEASE READ THE FOLLOWING STATEMENT CAREFULLY:**

**Purpose of Consent:** By signing this form, you are giving consent to the Grand Chapter of Georgia, Order of the Eastern Star, to request and obtain your protected health information and/or your financial information to verify information you provided the Grand Chapter of Georgia, Order of the Eastern Star, on your application for monetary assistance.

**Right to Revoke:** You have the right to revoke this Consent at any time by giving written notice of your revocation to the Contact Person listed below. Please understand that revoking this Consent will not affect any action taken by the Committee prior to receiving your revocation, and we may decline to provide monetary assistance if you revoke this Consent.

**Contact Person for Revocation of Consent is:** The **Chairman of the** \_\_\_\_\_ **Committee, Grand Chapter of Georgia, Order of the Eastern Star.**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving you permission to obtain and use my protected health and financial information to verify and evaluate the information I provided the Grand Chapter of Georgia, Order of the Eastern Star, on my application for monetary assistance.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If a personal representative signs this Consent on behalf of the applicant, complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number(s): Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

**FOR USE BY THE GRAND CHAPTER ASSISTED CARE, CANCER AID OR BENEVOLENCE COMMITTEES**

DATE RECEIVED: \_\_\_\_\_ CHAIRMAN: \_\_\_\_\_

APPROVED: [ ] YES [ ] NO DATE \_\_\_\_\_ MEMBER: \_\_\_\_\_

DISAPPROVED: [ ] YES [ ] NO DATE \_\_\_\_\_ MEMBER: \_\_\_\_\_

AMOUNT: \$ \_\_\_\_\_ MEMBER: \_\_\_\_\_

CASE # ASSIGNED: \_\_\_\_\_ MEMBER: \_\_\_\_\_

(Check One)

- Composite Residue Fund Interest
- Assisted Care Fund/Marsengill
- Benevolence
- Cancer Aid

AMOUNT: \$ \_\_\_\_\_  
 Beginning Date of Assistance: \_\_\_\_\_  
 Ending Date of Assistance: \_\_\_\_\_

**TO BE COMPLETED BY CANCER AID APPLICANTS ONLY**

Name of Applicant: \_\_\_\_\_ DATE: \_\_\_\_\_

(To be completed when the applicant is applying for assistance based on care and treatment of Cancer or other medical conditions which require applicant to be under the care of a physician.)

*I \_\_\_\_\_ hereby authorize the release of my medical information, including diagnosis and prognosis, by my physician to the Grand Chapter of Georgia, Order of the Eastern Star, for verification of my medical condition and/or listing of my present medication.*

Name of Physician: \_\_\_\_\_  
(Print or Type)

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**TO BE COMPLETED BY PATIENT'S PHYSICIAN**

I am treating the above named person for the following medical condition:

Does the patient's condition require follow up or frequent doctor visits?  
 Yes  No How often: \_\_\_\_\_

Does the patient's condition require prescription medication?  
 Yes  No

Is this patient being treated for cancer?  Yes  No

Is the cancer?  Curable  Incurable

Is illness terminal?  Yes  No

Where is cancer or suspected cancer located?: \_\_\_\_\_

Complete Explanation: \_\_\_\_\_

Date patient was last seen by you: \_\_\_\_\_

In my opinion the above patient has (or is suspected of having) a cancerous condition and will require care and treatment of:  
 Chemotherapy  Radiation  Maintenance Doses of Medication

Medical Physician: \_\_\_\_\_ M.D. \_\_\_\_\_  
(Signature) (Medical ID #)

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Date: \_\_\_\_\_