APPLICATION FOR EASTERN STAR ASSISTANCE

Assisted Care: [ ]
Cancer Aid: [ ]
(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	$____________________

Revised July 2022

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, 2nd 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. <u>I must report to the Eastern Star Assistance Committee in writing within 10 days any significant changes in my financial condition.</u>

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 #)

______________________________ ____________________ *Place Chapter Seal*
(Name) (Phone #)

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 OR CANCER AID 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
[ ] 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)

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: ___________________________