Bourbon County Medical Outreach Committee

Please return application by mail to: BCMOC, P. O .Box 605, Paris, Kentucky 40362-0605

Today's Date_____

Last Name_____ First Name_____ M.I._____

Address: Street _____ City _____

State_____ Zip Code _____

Home # _____ Work # _____ Cell # _____

Last 4 Digits of Your Social Security # _____ Birthday _____

Spouse's Name _____ Last 4 Digits of Social Security # _____

Spouse's Birthday _____

PLEASE LIST ALL MEMBERS IN HOUSEHOLD:

Name _____ Birthday _____ Sex _____ Relationship_____

Name _____ Birthday _____ Sex _____ Relationship_____

Name _____ Birthday _____ Sex _____ Relationship_____

How did you hear about us? _____

Cost of Living: Rent $_____ Utilities $_____

Source of Income: Soc. Sec. Dis. $_____ Soc. Sec. $_____

Work Comp $_____ Child Support $_____ Section 8 $_____

Place of Employment _____ Salary $_____/hr./wk./mo.

Other income (explain) $_____

If Active BCWD: Caseworker's Name _____ Phone _____

If Certified for Food Stamps: Amount $_____ Identification # _____

Have you been here before: Yes _____ No _____ Date of Last Visit _____

Type of Assistance Requesting? _____ Amt. Requesting? $_____

What assistance besides financial could improve your life situation?

_____

_____

_____

_____ (initial) I understand that a background check will be performed on all applicants.

STATEMENT OF RELATIONSHIP

I understand that BCMOC is attempting to improve my life situation and needs accurate information and to be properly assisted, a relationship of honesty and trust is necessary. Therefore, I receive this assistance on a good faith basis and I affirm that all above information is accurate and current. I release everyone associated with the organization from any liability from the receipt of this assistance, which may also include counseling help. I understand that falsification of information and any misrepresentation by me may be considered grounds for prosecution, denial of services and eliminate me from future assistance. I further give permission to BCMOC to share any of the above information with whoever may request it in the interest of improving my life situation.

SIGNATURE_____ **DATE**_____

****Upon receipt of application you will receive a letter from the committee with further information regarding your application.**

For Office Use Only

Total Bill: $_____ BCMOC: $_____

Client's Contribution $ _____

Other Contributions: 1. Contact _____ Contact Name_____

Phone # _____ Amount Received $ _____

2. Contact _____ Contact Name _____

Phone # _____ Amount Received $ _____

Committee Member Signature _____ **Date** _____

Notes_____

_____

BACKGROUND CHECK VERIFIED: _____

PHOTO ID VERIFIED: _____

BOURBON COUNTY RESIDENCY VERIFIED: _____

_____**URGENT** _____**NOT URGENT**