TAKE THE LEAD

Application for Assistance

TAKE THE LEAD

Making a Difference

TAKE THE LEAD, INC.
215 Washington Street
Suite 110
Watertown, NY 13601

1-800-814-1123

Email: ttl@twcny.rr.com

Website: www.takethelead.org

TAKE THE LEAD is a not-for-profit organization dedicated to providing direct services, support and care for people in the sport of dogs who are suffering from terminal disease or life-threatening illness. In order to be eligible for assistance from TAKE THE LEAD, you must have a minimum of five years active participation in AKC events. TAKE THE LEAD provides assistance by making direct payments to providers for services.

The sport of dogs is a true community. Every week, across the country, we come together to share our love of dogs, competing at shows and participating in club activities. We are in many ways a family, and occasionally members of our family face the challenges of life-threatening disease.

Current income and assets will be considered in our decision.

Name:_____

Address:_____

City:_____State:_____Zip:_____County_____

Phone: (H):_____(W):_____(Cell):_____(Fax):_____

Email:_____

Date of Birth:_____

Social Security #:_____

Involvement in Sport of Dogs:

Currently own AKC registered dogs? Yes____ No____ If yes, how many?_____

What breeds?_____

Currently active in what area of the sport?_____

Number of years:____ If not, please state why:_____

What has been your involvement in the sport of dogs? Please describe:

_____

Are you or have you ever been a member of an AKC licensed kennel club:_____

If yes, name of kennel club(s):_____

_____

References: List name, address and telephone number of two people in the sport (club member, judge, handler, superintendent, etc.). References may be contacted to verify your participation in the sport.

1._____

_____

2._____

_____

Medical Situation and Assistance:

Describe your medical situation in detail:_____

_____

_____

_____

_____

A CURRENT LETTER FROM YOUR PHYSICIAN WITH DIAGNOSIS, PROGNOSIS, AND TREATMENT PLAN MUST ACCOMPANY THE APPLICATION.

Health Insurance Information/Medical Care Coverage:

Medicare Number:_____

Medicaid: Yes___ or No___ Have you applied? Yes___ or No____

Status: Approved___ Denied____ Pending____

Medicaid Number:_____

Health Insurance: Yes_____ or No_____

Employer Insurance: Yes____ or No_____ Self Insured: Yes___ or No_____

Other Health Insurance: Yes___ or No___

If yes, please list insurance provider and address:_____

_____

Subscriber's Name:_____

Group Policy #:_____ Your Policy #:_____

Employment Status:

Full Time_____ (35 or more hrs/week) Part Time_____ (Less than 35/hrs week) Medically Unable to Work_____

Not Disabled and Not Employed_____ Retired_____

Total Assets:

Present Income: (annual gross)_____

Salary/Wages: Self_____Spouse/Partner_____Other Household Members_____

Benefits (i.e. Public Assistance, Unemployment, Social Security):_____

Disability:_____Other Income (Please explain):_____

Checking/Savings Accounts and Balances:_____

Retirement Income Accounts:_____Interest/Dividends:_____

Value of House/Real Estate Owned:_____

Trust Fund:_____ Value of Real Property:_____

Vehicles:_____ Other Assets:_____

Do you have a Go Fund Me Account? Yes__No__ If yes, please list balance:_____

A COPY OF LAST YEAR'S TAX RETURN MUST ACCOMPANY THE APPLICATION

Living Arrangements:

Own_____ Mortgage/Amt:_____ Rent/Amt:_____

Monthly Utility Costs:_____

Household Members: Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

How Can We Help You:

TAKE THE LEAD provides assistance by making direct payments to providers for services. (Example: medications, insurance premiums, utilities, rent, and other related services). Please be specific as to what you are asking TAKE THE LEAD to help you with. Be certain to list the name of the provider and include cost of services provided on a monthly basis:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Alternate Contact: I authorize TAKE THE LEAD to speak with the following persons about my application if you are unable to contact me. (i.e. social worker, lawyer, family, or friend).

Name:_____ Relationship:_____ Phone:_____

Written Authorization:

I,_____, hereby authorize you to furnish TAKE THE LEAD representatives, any and all records of any kind pertaining to me, including but not limited to, my medical history, medical or other services rendered, treatment billings, and all such related records. This authorization shall become effective immediately and shall remain in full force and effect as long as necessary.
I understand that some restrictions for receipt of or release of medical information may apply to TAKE THE LEAD as to some medical or other facilities. I hereby direct that no further authorization other than is specifically indicated in this form to be required and/or requested of TAKE THE LEAD.
The federal privacy act and other applicable governmental regulations have increased the need for security in the transfer of privileged communications, the information to be release will be from records, the confidentiality of which is protected by those regulations, and prohibits anyone from making any further disclosure of such information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.
A photocopy of this signed authorization shall be deemed as valid as an original.
I have read the above and fully understand its content in its entirety, and have asked questions about everything that was not clear to me, and am satisfied with the answers I have received.

***If for any reason your financial circumstances change, you must notify us as it may effect our level of support.**

Signature:_____ Date:_____

Social Security Number:_____ Date of Birth:_____