HANDS ACROSS THE SADDLE

P.O. Box 129 Greybull, WY 82426

Dear Applicant:

Attached is an application form for Hands Across the Saddle. Please keep in mind that Hands Across the Saddle is a non-profit organization that serves the entire Big Horn Basin. Hands Across diligently strives to partner with applicants as a "hand-up", not a "hand-out".

With that concept in mind, the organization encourages applicants to explore all avenues, i.e.; local public health office, Department of Family Services, etc. Unless your request is an emergency, briefly explain what attempts or contacts you have made to resolve the situation. In addition, it is imperative that you fill out each question completely and accurately with as much detail as necessary. If you are seeking medical, dental, or vision assistance, attach invoice copies or a cost estimate from the professional's office.

Please be patient and understand that committee review of applications occurs twice monthly. Unless you have an emergency situation, you can expect that it may take up to two weeks or more for a response. Also understand that an individual member does not have the authority to grant or deny an application; decisions are made as a committee.

If you need further information, please send your questions to: Hands Across the Saddle (at the address listed above).

Sincerely,

The Committee for
Hands Across the Saddle

Revised June, 2011

HANDS ACROSS THE SADDLE
Assistance Request Form

Date: _____

Name of Proposed Recipient: _____

Address of Recipient: _____

Phone Number: _____

Purpose of Request: (please print) _____

_____

_____

_____

How many are in living in household? _____

Is recipient employed:_____ If so, where?_____

If not currently employed, when was recipient last employed? _____

What is average monthly household income? _____

Please indicate what type assistance: _____ Medical _____ Other

What is the average monthly amount of other assistance? _____

Are you a U.S. citizen?_____ Last four digits of Social Security # _____

If medical, list medical insurance coverage: _____

Is recipient covered by medicare? _____

--Please provide copies of invoices or documents on any requested medical assistance and sign the attached release form.

For all other assistance, please make sure the above "Purpose of Request" has been completed and attach copies of documentation to verify request (ie: copies of outstanding invoices, credit card receipts, name and contact for lodging requests; any documentation to show amount of claim, contact, and remitting address).

Please list at least two reference names and contact number:

_____

(Name) *(Relationship to applicant)* *(Phone number)*

_____

(Name) *(Relationship to applicant)* *(Phone number)*

_____

(Name) *(Relationship to applicant)* *(Phone number)*

Documentation Use Only

Month Initiated:_____ Am't of Assistance Awarded:_____

Note: _____ Date Given to Recipient:_____

Committee Members Signatures:_____

AUTHORIZATION TO RELEASE INFORMATION

Applicant's Name: _____ DOB:_____

Previous Name: _____

(x) (If the name of doctor, medical facility, or any other name or facility is not provided in the space below, the committee will not be able to consider this application request.)

I authorize (x)_____ to release information
(name of doctor, medical facility, or other)

regarding the above applicant to the organization listed below:

HANDS ACROSS THE SADDLE
P.O. Box 129
Greybull, WY 82426
307-765-9312
Fax: 307-765-2281

This request applies to:

_____ Healthcare information only

_____ Other: _____

Applicant Signature: _____ Date:_____

Witness Signature: _____ Date:_____

***** This authorization expires 90 days after it is signed. *****