



The AIDS TroubleFund

A Colt 45's, Inc. Charity Project ~ Application for Assistance

The Colt 45's, Inc. is committed to helping people with AIDS, but please read this application carefully before you apply for assistance from the AIDS TroubleFund. Many are turned down because the application was not completed properly, because proper documents were not supplied or because they simply did not qualify for assistance from the AIDS TroubleFund. Before you begin, make sure you read everything carefully. Then when you start, fill out this form completely. *Thanks for your cooperation!*

1. The Colt 45's AIDS TroubleFund will provide TEMPORARY and EMERGENCY financial assistance for:
 - Electricity → Rent (*Applicant's Legal Portion Only*)
 - Natural Gas → Telephone (*Basic Service Only*)
 - Water

2. To submit an application for assistance you must first:
 - ✓ Seek assistance from the other organizations listed on this application before applying to the AIDS TroubleFund.
 - ✓ Seek said assistance from these organizations **EACH TIME** you request assistance from the AIDS TroubleFund.
 - ✓ Submit a **NEW**, completely filled-out application for **EACH REQUEST** to the AIDS TroubleFund.
 - ✓ Fill out this application **COMPLETELY**, leaving no blank spaces of any kind.

3. ALL of the following are required to be eligible for assistance:
 - ✓ Be diagnosed with Acquired Immune Deficiency Syndrome (AIDS).
 - ✓ Be unable to work as a result of this illness, and diagnosed by a licensed physician as disabled.
 - ✓ Have applied for SSI/SSD.
 - ✓ Be under the care of a licensed physician.

4. You must submit the following before your application can be considered:
 - ✓ **Signed original** Medical Statement from your doctor, as presented **on this form**. (*Other medical statements not accepted.*)
 - ✓ Determination Letter or Recent Application Receipt from the Social Security Administration (Form CIPQY).
 - ✓ **Complete, signed** copy of your lease agreement, if you are requesting rental assistance.
 - ✓ **Complete Copy of Bills**, if you are asking for utility assistance for:
 - Natural Gas → Water
 - Electricity → Telephone (*Basic Service Only*)

**WE ONLY PAY PROVIDERS OF SERVICE.
NO PAYMENTS WILL BE MADE DIRECTLY TO ANY APPLICANT.**

5. You must also include a copy of photo identification.

6. You can drop off your *securely sealed* and completed application to:

The Brazos River Bottom, 2400 Brazos, Houston, TX 77006

7. If you can not drop off your application, you can mail it directly to us at:

The Colt 45's AIDS TroubleFund, PO Box 540803, Houston, TX 77254

8. If you have any questions or if need some help completing your application, please call or email:

The Colt 45's AIDS TroubleFund Hotline (713) 526-6077 or atf@colt45s.org

9. A **new** application is required each time assistance is requested. No assistance will be granted without the proper application on file. All decisions as to assistance will be made by the Colt 45's Inc. in accordance with the rules established by the Colt 45's Inc. *All decisions of the Colt 45's, Inc. shall be final.*

**Both Part A and Part B of this page MUST be completed before your application will be considered.
Other Medical Forms will NOT be accepted!**

Part A. APPLICANT'S MEDICAL RELEASE

The undersigned does hereby authorize the below named physician to release to the Colt 45's, AIDS TroubleFund any and all medical information which may be requested regarding my present medical condition and past medical history. Any person, firm, or entity that releases information pursuant to this authorization is hereby absolved from any and all liability that might result from such release. A copy of this authorization is agreed to have the same effect as an original.

Applicant's Signature: _____ Date: _____

Part B. PHYSICIAN'S CERTIFICATE (required every six months)

Physician's Name: _____ Physician's Telephone No: _____

Physician's Address: _____ Physician's FAX No: _____

Patient's Name: _____ Patient's Age : _____

The above named patient has applied for financial assistance from the **Colt 45's AIDS TroubleFund**. This certificate is necessary in order to ascertain the nature, extent and duration of physical and/or mental disabilities, if any. **Eligibility for financial assistance *requires* information be supplied by the current attending licensed physician.**

1. Does the patient meet the CDC criteria for AIDS? No Yes

Other (explain) _____

AIDS-RELATED OPPORTUNISTIC INFECTIONS and/or INDICATORS (required for AIDS diagnosis)

- | | |
|--|---|
| <input type="checkbox"/> Candidiasis, esophageal | <input type="checkbox"/> Kaposi's Sarcoma (specify locations) _____ |
| <input type="checkbox"/> Candidiasis, respiratory | <input type="checkbox"/> Lymphoma, Burkitt's |
| <input type="checkbox"/> Cervical Cancer, invasive | <input type="checkbox"/> Lymphoma, primary of brain |
| <input type="checkbox"/> CMV (specify location) _____ | <input type="checkbox"/> M.A.C. |
| <input type="checkbox"/> Coccidioidomycosis disseminated | <input type="checkbox"/> PCP |
| <input type="checkbox"/> Cryptococcosis, extrapulmonary | <input type="checkbox"/> Progressive Multifocal Leukoencephalopathy |
| <input type="checkbox"/> Histoplasmosis disseminated | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> HIV Encephalopathy | <input type="checkbox"/> Other (please identify) _____ |
| <input type="checkbox"/> HIV Wasting Syndrome | _____ |

2. Remarks: _____

3. Physician's Signature: _____ Date: _____

APPLICATION FOR ASSISTANCE

This application must be completed *fully* to be considered by the AIDS TroubleFund, and must be accompanied by all required attachments.

PLEASE PRINT NEATLY OR TYPE (*every blank MUST be filled*)

Full, Legal Name: _____ Date of Birth: _____ Age: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip: _____ S.S.#: _____

Home phone: _____ Alternative Name & Phone: _____

We will NOT return telephone calls to pagers! Date of AIDS Diagnosis: _____

Do you have a roommate/spouse? No Yes Roommate/Spouse's Name: _____

Do you have dependent children? No Yes How many? _____ Ages: _____

How many persons live in your household? _____ Who are they? _____

Are you presently employed? No Yes If no, Last date worked: _____

Employer: _____ Telephone: _____

Previous Employer: _____ Telephone: _____

Are you presently disabled? No Yes Date of Disability: _____

Have you applied for SSI/SSD? No Yes If No, Why? _____

***You must attach a current copy of the Determination Order or Receipt of Claim from Social Security, i.e. Form CIPQY, that is no more than 1 year old, each time you apply

Were you approved for SSI/SSD? No Yes If Yes, What Date? _____

If No, Why? _____

You must seek assistance from at least three (3) other organizations FIRST, EACH TIME you seek assistance from The AIDS TroubleFund.

Fill out the following table completely, telling us to which Charitable Organizations you have applied:

Charitable Organization	Have You Applied?	Date of Application	Amount Received	Contact Person
AIDS Foundation	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____
Bering Omega Community Services	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____
Harris County Social Services	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____
Catholic Charities	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____
OTHER	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____
	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____
	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____
	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____
	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	\$ _____	_____

If you were denied assistance from **any** organization, please state why: (use separate piece of paper, if necessary) _____

Do you have a Case Manager? No Yes Where: _____

Name of Case Manager: _____ Telephone: _____

Amount Requested

TYPE OF ASSISTANCE YOU ARE SEEKING (✓ = what you need to attach to this application)

\$ _____

RENT: ✓ **COMPLETE COPY** of your signed lease **must** be attached for rent help (every page!)

Landlord's Name: _____ Phone: _____

Address for mailing Rent Payment:

Check Paid to: _____

Street / PO Box: _____

City: _____ State: _____ Zip: _____

\$ _____

NATURAL GAS: ✓ **Complete, copy of bill must** be attached (not the original)!

\$ _____

ELECTRIC: ✓ **Complete, copy of bill must** be attached (not the original)!

\$ _____

WATER: ✓ **Complete, copy of bill must** be attached (not the original)!

\$ _____

TELEPHONE: ✓ **Copy of First Page** of current bill **must** be attached (not the original)!

Please explain any circumstances that arose as to why you weren't able to pay these bills. _____

PERSONAL FINANCIAL INFORMATION

\$ _____

Present Salary/Income

\$ _____

Child Support Paid Out

\$ _____

Amount of SSI/SSD

\$ _____

Monthly Rent Payment

\$ _____

Amount of VA/Military Benefits

\$ _____

Monthly Car Expense (Gas & Insurance ONLY)

\$ _____

Employer's Long-term Disability Insurance

\$ _____

Monthly Food & Clothing (Approximate)

\$ _____

Private Long-term Disability Insurance

\$ _____

Monthly Utility Bills (Approximate)

\$ _____

Child Support Received

\$ _____

Monthly Medical Services (Approximate)

\$ _____

Other Income - List

\$ _____

Other Expenses - List

FORMS OF PUBLIC ASSISTANCE AND AMOUNTS YOU RECEIVE

Do you receive any form of public assistance i.e. (AFDC, WIC, Lone Star Card)?

No Yes

Amount

Type of Assistance Received

Amount

Type of Assistance Received

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

Please supply **any** other information you want us to consider:

I, the undersigned, have completed the foregoing Application for Assistance from the **AIDS TroubleFund** for the purposes of securing financial assistance. I certify that all answers contained herein are true and correct. I agree that the **Colt 45's Inc.** may make any such inquiry as they deem necessary to verify such information, including, without limitation, credit checks and confirmation of the physician's certificate with my physician. Further, I specifically authorize the **Colt 45's Inc.** to provide, receive and exchange information with **other care and service providers** regarding my past and present benefits provided by these agencies to me. I authorize all agencies to release information to the **Colt 45's Inc.** regarding past and present benefits provided by those agencies to me. I release the **Colt 45's Inc.** and all persons, firms and/or entities providing information to the **Colt 45's Inc.** from any and all liability which may arise as a result of the exchange of this information. A copy of this release shall have the same effect as the original.