



Wayne County Committee  
For Crippled Children & Adults, Inc.  
to call 330-263-6363

Thank you for your interest in assistance from the Wayne County Committee for Crippled Children and Adults.

The Wayne County Committee for Crippled Children and Adults is dedicated to assisting individuals for the relief of pain, suffering and inconvenience from medically determined disabilities.

Applications for assistance are considered based on: financial need, relationship to our mission, and the availability of funds. Please fill out the enclosed application as completely as possible. This will help the Committee understand your needs and the assistance you are requesting. It is especially important to provide specific details about the amount of help that you need.

If you are asking for help with **MEDICAL SUPPLIES OR MEDICATIONS**, we will need to know the specific medical supply or medication, who prescribed them, and their cost. (Please attach a prescription from your physician).

If you are asking for help in obtaining **MEDICAL EQUIPMENT**, we will need a statement from your doctor so that we can understand the medical reason(s) for your request. (Please attach a statement/prescription).

**The Committee meets once a month, therefore your application MUST be received at the United Way's office (215 S. Walnut St., Wooster, OH 44691) by the 1<sup>st</sup> Friday of the month in order to be considered during that month. If received past that date, your application will be considered the following month.**

If you have any questions or need assistance in completing your application, please contact **United Way's WHIRE** at 330-263-6363 or 330-264-5601, M-F 8 am–5 pm.

**The Committee primarily covers medical equipment, medical supplies, and other services for individuals with physical or medical disabilities.**

**The Committee does not generally cover surgery, outstanding medical or hospital bills or food. The committee does not pay for Medicaid spend downs or insurance co-pays and/or deductibles. Please see guidelines below.**

**Guidelines**

- Client must be a resident of Wayne County for 90 days
- Client must have valid ID
- Prescription help will not cover narcotics
- Client cannot be helped more than once in the same year
- No Co-Pays or deductibles
- No spend downs for Medicaid
- Client cannot have insurance that covers the need
- Prescriptions are required for medication and equipment requests

**RETURN APPLICATION TO: UNITED WAY, 215 S. WALNUT ST., WOOSTER, OH 44691**

Updated 6/21



WAYNE COUNTY COMMITTEE FOR CRIPPLED CHILDREN & ADULTS, INC.

**Return Application to:  
UNITED WAY WHIRE**

**215 South Walnut Street, Wooster OH 44691**  
330-263-6363 or 330-264-5601, FAX # 330-264-5607  
[www.wcccca.org](http://www.wcccca.org)

Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Name of Parents IF Applicant is under age 18: \_\_\_\_\_  
Address \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Cell: \_\_\_\_\_  
Length of residence in Wayne County: \_\_\_\_\_ In Ohio: \_\_\_\_\_  
Email: \_\_\_\_\_

**MEDICAL INFORMATION**

Medical Diagnosis or Disability: \_\_\_\_\_  
Date disability began: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_  
Doctor's address: \_\_\_\_\_  
Your height: \_\_\_\_\_ Your weight: \_\_\_\_\_  
Do you have insurance? \_\_\_\_Yes \_\_\_\_No IF Yes, Name of Insurance Company: \_\_\_\_\_  
Do you have medication insurance? \_\_\_\_Yes \_\_\_\_No IF Yes, Name of Insurance Company: \_\_\_\_\_

**INFORMATION ABOUT REQUEST**

What help do you need from the Committee? *(Please note that you will need to include a prescription from your doctor and two quotes for any equipment/construction/building requests.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Total amount being requested \$ \_\_\_\_\_  
**(This amount MUST be filled in for the committee to consider approval of the request.)**

Other Sources/Agencies Contacted for help:

Where: _____	How Much? _____	Declined _____
Where: _____	How Much? _____	Declined _____
Where: _____	How Much? _____	Declined _____
Where: _____	How Much? _____	Declined _____

IF you are requesting assistance with prescription MEDICATIONS: Please list PREFERRED PHARMACY (MUST be within WAYNE County) and ALL MEDICATIONS with approximate price and dosage information (milligrams and number of times taken per day, etc.). You can use additional paper if necessary.

Pharmacy (Name, Address, and Phone #): \_\_\_\_\_

Medications: (Name, Milligrams and Number of Times taken a day and cost) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

IF you are requesting assistance with MEDICAL EQUIPMENT, please list PREFERRED SUPPLIER: Name, Address and Phone #

\_\_\_\_\_

**PERSONAL/FINANCIAL INFORMATION**

Are you a Veteran? ☐ Yes ☐ No If Yes, have you applied for assistance with the VA? ☐ Yes ☐ No

Total Number of persons in the home: \_\_\_\_\_ Please list Names and Ages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Present Monthly Household Income (includes all person(s) income from all sources): \$ \_\_\_\_\_

Sources of household income: \_\_\_\_\_

Normal monthly income (if different from present monthly income): \$ \_\_\_\_\_

Why the difference in present from normal monthly income? \_\_\_\_\_

Does anyone in the household own real estate? ☐ Yes ☐ No Mortgage per month \$ \_\_\_\_\_

If yes, value of real estate \$ \_\_\_\_\_ Amount owed \$ \_\_\_\_\_

Do you rent? ☐ Yes ☐ No Rent per month \$ \_\_\_\_\_

Are you behind in your rent or mortgage? ☐ Yes ☐ No

Utility Expenses (not paid through any type of assistance—Out of pocket expenses):

Gas/Fuel \$ \_\_\_\_\_ Electric \$ \_\_\_\_\_ Phone \$ \_\_\_\_\_ Water/Trash \$ \_\_\_\_\_

Do you have other income/assets: (for example stocks, bonds, personal property, automobiles, etc.)? ☐ Yes ☐ No

Are you eligible or have you applied for any of the following:

	Yes	No	Applied	Unknown	Amount & Other Info
Unemployment Compensation					_____
Sick or Accident Benefits					_____
Worker's Compensation					_____
Insurance Benefits/Medicare					_____
Medicaid/TANF/Medical Card					_____
Support Payments					_____
Veterans Benefits					_____
Social Security					_____
SSD/SSI					_____
Pension					_____
Ohio Bureau for Children with Medical Handicap (BCMH)					_____
Other Assistance: _____					_____
Other Assistance: _____					_____

Are there any other circumstances that the Committee should consider when reviewing your application? \_\_\_\_\_

Have you ever applied to the Committee before? ☐ Yes ☐ No If Yes, When? \_\_\_\_\_

I hereby release all information to the Wayne County Committee for Crippled Children and Adults, authorize that it is true to the best of my knowledge, and give permission for the committee or their agency, WHIRE, to investigate the above information and discuss it among themselves and/or other agencies or programs that may have a concern or be of some assistance. **I understand that if the committee grants my request, I may be asked to provide my first name and picture for use on the committee's website and printed publications. I agree to comply with their request.**

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*It is the policy of the Wayne County Committee for Crippled Children and Adults, Inc., that no person shall be denied services on the basis of race, ethnicity, age, color, national origin, sexual orientation, physical or mental handicap, or developmental disability according to Title VI of the Civil Rights Act of 1964; or any person with "HIV" or Aids-related complex; or in any manner prohibited by the laws of the State of Ohio and the United States.*