

## Transgender Emergency Fund Application

The Transgender Emergency Fund is intended to assist transgender/transsexual individuals in paying for utilities, prescription co-pays, medical visit co-pays, medical bills, and other basic needs. Financial assistance is given based on need and the availability of funds. Assistance cannot exceed \$350.00 per individual per year. By participating in this program you will not in any way be publicly identified as transgender/transsexual. The Transgender Emergency Fund’s current fiscal sponsor is AIDS Project Worcester, Inc. (APW) but APW is not in any other way responsible for the raising, management, or distribution of funding and assistance. In order to be eligible, you must submit the following information:

- 1) A completed application
- 2) A copy of bills and/or receipts
- 3) Proof of income or assets
- 4) An original signed Release of Information

Personal Information:

Legal Name: \_\_\_\_\_ Preferred Name (if different): \_\_\_\_\_

Preferred Pronoun (He/Him, She/Her, Ze/Hir, etc): \_\_\_\_\_

Current Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_

Combined Household Income:

Household Member	Source of Income	Gross Monthly Income
	Total Monthly Income	
	Total Annual Income	

Example of Income Sources: Earned wages including overtime and tips, SSI, SSDI, Private Disability Insurance, Welfare Benefits, VA Benefits, Alimony, Child support, Trust income, Investment Income.

Please provide proof of all income and assets.

Utility Company Information:

Which utility are you applying for assistance? Electric    Gas    Oil

Please indicate the utility companies and amount to be applied to each account

Company name: \_\_\_\_\_ Acct #: \_\_\_\_\_ Amount: \_\_\_\_\_

Company name: \_\_\_\_\_ Acct #: \_\_\_\_\_ Amount: \_\_\_\_\_

Company name: \_\_\_\_\_ Acct #: \_\_\_\_\_ Amount: \_\_\_\_\_

Medical/Prescription Information:

Do you currently have health insurance? Yes No

Does your insurance exclude transgender/transsexual health care? Yes No

Do you need personal reimbursement for medical costs? Yes No

Please indicate whether you need assistance for prescription or medical co-pays and how much is needed. Please note that you must provide copies of all receipts.

Prescription Co-pays? Yes No Amount: \_\_\_\_\_

Medical Co-pays? Yes No Amount: \_\_\_\_\_

Please indicate the name of the medical practice or hospital, account number, and how much is needed below.

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Account #: \_\_\_\_\_

Amount: \_\_\_\_\_

Please return all materials to the Transgender Emergency Fund, c/o APW, 85 Green Street, Worcester, MA, 01604. Application and payment will not be processed unless all materials are submitted.

*Administrative use only*

Amount given: \_\_\_\_\_ Date: \_\_\_\_\_ Account: \_\_\_\_\_

## Authorization for Release of Information

Client's name: \_\_\_\_\_

I hereby authorize the Transgender Emergency Fund to coordinate utility and/or medical payment assistance for me. I understand that the check provided will have the name of the fiscal agency (AIDS Project Worcester, Inc.) on it.

Items to be released: Payment via APW check or money order

For the purpose of: Coordinating utility/medical assistance

To whom information is being released:

Company/Agency & Contact Name	
Address	
Phone	

Witness Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Client Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

**This authorization will expire twelve (12) months from the date above unless revoked earlier. This authorization can be revoked at any time but not retroactive to the release of information already made in good faith.**