

Are you an Amesbury Resident? Yes \_\_\_\_\_ No \_\_\_\_\_ Length of time as resident \_\_\_\_\_ years

Date of Application \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Sr. Jr.

Street \_\_\_\_\_ Unit or Apt. Number \_\_\_\_\_

City \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

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

Do you have Health Insurance now? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Primary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_ Policy # \_\_\_\_\_

Additional Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_ Policy # \_\_\_\_\_

Medicare Part D Rx Coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ Subscriber \_\_\_\_\_ Policy # \_\_\_\_\_

Is this related to Workers Compensation? Yes \_\_\_\_\_ No \_\_\_\_\_

**PLEASE PROVIDE DETAILS OF NEED:** (use additional paper if needed) \_\_\_\_\_

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

Monthly Household: Wages \_\_\_\_\_ Social Security Check \_\_\_\_\_ Disability \_\_\_\_\_ Unemployment \_\_\_\_\_ Other \_\_\_\_\_

**TOTAL MONTHLY HOUSEHOLD INCOME \$** \_\_\_\_\_

Monthly Expenses: Rent/mortgage \_\_\_\_\_ Heat \_\_\_\_\_ Electricity \_\_\_\_\_ Auto payment \_\_\_\_\_ Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Internet \_\_\_\_\_ Food \_\_\_\_\_ Insurance \_\_\_\_\_ Medical Insurance \_\_\_\_\_

Medical \_\_\_\_\_ Medications \_\_\_\_\_ Credit Cards \_\_\_\_\_

**TOTAL MONTHLY EXPENSES: \$** \_\_\_\_\_

**TOTAL AMOUNT OF MONEY REQUESTED: \$** \_\_\_\_\_

The AHCTC cannot reimburse applicants directly, but *will pay the providers* for incurred services. Applications **MUST** be **completely filled out** and all requested bills/ invoices **MUST be the ORIGINALS** in order for the AHCTC to consider your request. Incomplete and or copies of applications/bills will be returned.