

**Deep Fork Community Action Foundation, Inc.**

223 West 6th Street / PO Box 670

Okmulgee, OK 74447

P: 918-756-2826 F: 918-756-6829

rxforok@dfcaf.org

**AGEE ASSISTANCE APPLICATION**

***Please provide the following information for all household members, and the completed application:***

\_\_\_\_\_ Proof if Income for last 30-Days

(Copy of Bank Statements, Tax Return, Paycheck Stubs, SSI/SSDI Verification, Unemployment Verification, Worker’s Comp Verification, Etc.)

\_\_\_\_\_ Photo Identification

\_\_\_\_\_ Social Security Card

\_\_\_\_\_ Proof of Residence

 (Copy of Water/Electric/Gas Bill, a Lease, or a Rent Receipt)

\_\_\_\_\_ Disability Filing Verification

\_\_\_\_\_ Other Documents as Requested



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Please complete the following information:

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

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a US Citizen? \_\_\_\_\_Yes \_\_\_\_\_No Are you an Oklahoma Citizen? \_\_\_\_\_Yes \_\_\_\_\_No

Number of Children (Under 18yrs of Age) living in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this the Primary residence of all children in the home? \_\_\_\_\_Yes \_\_\_\_\_No

Are both parents living in the home? \_\_\_\_\_Yes \_\_\_\_\_No

Do you have health insurance? \_\_\_\_\_Yes \_\_\_\_\_No

If insured, Please provide the following:

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you applied for Medicaid? \_\_\_\_\_Yes \_\_\_\_\_No

 If YES, what was the date of the application? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you \_\_\_Approved or \_\_\_\_Denied?



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Is this related to a personal injury case? \_\_\_\_\_Yes \_\_\_\_\_No

If Yes, Name of Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance carrier or third party payer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected or anticipated settlement amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to a worker’s compensation case? \_\_\_\_\_Yes \_\_\_\_\_No

If Yes, Name of Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance carrier or third party payer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected or anticipated settlement amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to a disability case? \_\_\_\_\_Yes \_\_\_\_\_No

If Yes, Name of Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What is the status of your disability case? \_\_\_\_\_ Approved & Receiving Payments

 \_\_\_\_ Approved & Awaiting Payments \_\_\_\_ Denied \_\_\_\_ In Appeals



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**Dependent Information: *(List EVERYONE in the household)***

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Date of Birth | Social Security Number | Relationship |
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**Income Information: *(List ALL SOURCES of income)***

|  |  |  |
| --- | --- | --- |
| Name | Amount | Source (SS, Wages, Disability) |
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**Asset Information: *(****Please check all that apply and provide verification)*

|  |  |  |
| --- | --- | --- |
|  | Asset Type | Current Balance |
|  | Checking Account | $ |
|  | Savings Account | $ |
|  | Stocks, Bonds, CD’s, IRA’s | $ |
|  | Second Vehicle | $ |
|  | Money Market Fund | $ |
|  | Mutual Fund | $ |
|  | Rental Property | $ |
|  | Livestock | $ |
|  | Boat, RV, ATV | $ |
|  | Lottery / Gambling Winnings | $ |

**Debts / Expenses:**

|  |  |  |
| --- | --- | --- |
| Debit / Expense | Monthly Payment | Account Balance (if applicable) |
| Rent / Mortgage | $ | $ |
| Utilities | $ | $ |
| Phone | $ | $ |
| Food | $ | $ |
| Prescriptions | $ | $ |
| Hospital | $ | $ |
| Physician | $ | $ |
| Credit Cards | $ | $ |
| Loans | $ | $ |
| Payday Advances | $ | $ |
| Fuel (auto) | $ | $ |
| Insurance Premiums | $ | $ |
| Child Support / Alimony | $ | $ |
| Auto Payment | $ | $ |
| Auto Insurance | $ | $ |
| Other:  | $ | $ |
| **TOTAL** | $ | $ |

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**I hereby acknowledge that I have read this document. I certify that all the information provided is true and correct to the best of my knowledge. I understand that falsification of information will result in the denial of the application. I understand that the information which I submit concerning my income and family size is subject to verification. I assign and transfer to THE AGEE FUND all my rights to benefits, monies, and sums payable to me for sickness, rehabilitation services or likewise for medical payments (not to exceed the debit owed). I further understand that failure to disclose information and/ or payments made to me will result in denial of my application and possible legal action. I agree to pay any amounts for which I am responsible under this application.**

**I further give permission to Deep Fork Community Action Foundation, Inc., and its partner’s to share my personal information as related and required for the application process. I agree not to hold Deep Fork Community Action Foundation, Inc. or its partner’s liable for any damages that may result from the sharing of my information. I also understand that Deep Fork Community Action Foundation, Inc. and its partner’s do not discriminate against persons regardless of age, gender, race, handicap, familial status, or national origins.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Signature Date**

**OFFICE USE ONLY**

**Application sent to AGEE Fund Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approval Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approval Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Denial Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Denial Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**