P.O. Box 12, E. Claridon, OH 44033
440-321-5596
www.ClaridonCommunityHelps.org

ASSISTANCE APPLICATION

Please complete this form if you are in need of assistance. Claridon Community Helps will be contacting you for more information as to how we can work together to resolve the situation.

CONTACT DETAILS

Name:________________________________

Address: ______________________________

____

Phone Number: ______________________

Email: ________________________________

GENERAL INFORMATION

Age: _____ Male / Female

Active Military Service or Veteran Y / N

Are you employed: Full Time
Part Time
Not Employed

Currently Enrolled in School Y / N

How many people live in your household? _____

How many are adults? _____

Are other adults employed? Y / N

Sources of income in your household:

Unemployment SNAP
Disability OWF
Child Support Medicaid

DESCRIPTION OF NEED

____

____

____

____

____

____

____

____

____

Signing below gives us permission to share your name with others in our group to better assist you.

____
Signature

____
Date

CCH Case Number: ___________________