

**THE DIOCESE OF COLORADO  
OAKES HOME TRUST  
APPLICATION FOR INDIVIDUAL ASSISTANCE**

**Person submitting application:**

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

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

Telephone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**Person needing assistance:**

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

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

Relationship to person submitting application: \_\_\_\_\_

**Medical information:**

Brief description of illness: \_\_\_\_\_

Has treatment been completed?       Yes       No

If no, what is the expected duration of treatment? \_\_\_\_\_

**Medical Expenses:**

(1) Total amount of bills for which reimbursement is requested:      \$ \_\_\_\_\_

(2) Amount paid or payable by insurance:      \$ \_\_\_\_\_

(3) Amount of discount applied to line (1)      \$ \_\_\_\_\_

(4) Amount requested from Oakes Home Trust      \$ \_\_\_\_\_

Will there be additional bills?       Yes       No

If yes, what is the estimated amount that may be requested from the Trust?      \$ \_\_\_\_\_

**Resources of person requiring assistance:**

(1) Adjusted gross income:	\$ _____
(2) Social Security:	\$ _____
(3) Other income or sources of assistance not reported on line (1)	\$ _____
Specify: _____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
(4) Total:	\$ _____

**Name of person or institution to whom amount, if grant is approved, should be paid:**

Name: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Address: \_\_\_\_\_  
Name: \_\_\_\_\_ Amount: \$ \_\_\_\_\_  
Address: \_\_\_\_\_

Attach additional sheets if there are more than 2 payees.

I hereby certify that all of the information provided in this application is correct and complete.

Date: \_\_\_\_\_ [Signature] \_\_\_\_\_  
[Print Name] \_\_\_\_\_

Please attach all bills for which reimbursement is requested and submit the application to:  
Oakes Home Trust, attention: Robert Leaman  
Church Center  
1300 Washington Street  
Denver, CO 80203