Todd Baird Lindsey Devlin Foundation
P.O. Box 724
Carlisle, Pennsylvania 17013
Phone: (717) 486- 4121 Fax: (717) 486-3959
Application for Benefits

Name: _____ Date: _____

Street Address: _____ Township/Municipality: _____

Town: _____ Zip code: _____ How long at this address: _____

Phone number: _____ Date of birth: _____

Social Security number: _____ Primary insurance: _____

Secondary insurance: _____ Prescription drug plan: _____

Physician: _____ Phone number: _____

Marital status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated

If married, name of spouse: _____ Date of birth of spouse: _____

Social Security # of spouse: _____ Spouse's primary insurance: _____

Secondary insurance: _____ Prescription drug plan: _____

List the names and ages any other individuals in your household: _____

_____

List one relative/alternate contact if we cannot reach you by telephone:
Name: _____ Relationship: _____
Address: _____ Phone: _____

Are you or your spouse a veteran? ___ yes ___ no

Have you applied for assistance from any agencies or organizations in the past 5 years? ___yes ___no
If yes, please list the agencies/organizations: _____
_____

Do you receive any assistance from family and/or friends at this time? ___ yes ___ no
If yes, please describe: _____

Do you currently have bed bugs in your home? ___ yes ___ no

How did you hear about the Todd Baird Lindsey Devlin Foundation? _____

Please list all your expenses:		List any balance due
Home Expenses		
Mortgage	$ _____ per month	$ _____
Rent/Lot Rent (circle one)	$ _____ per month	$ _____
Maintenance/Grounds	$ _____ per month	$ _____
Propane	$ _____ per month	$ _____
Oil/Kerosene	$ _____ per month	$ _____
Electric	$ _____ per month	$ _____
Water/sewer	$ _____ per month or quarter (circle one)	$ _____
Trash	$ _____ per month or quarter (circle one)	$ _____
Home Telephone	$ _____ per month	$ _____
Cell Phone	$ _____ per month	$ _____
Taxes		
Real estate	$ _____ per year	$ _____
Unpaid income taxes	$ _____ per year	$ _____
Insurance		
Homeowner's/Renter's	$ _____ per year	$ _____
Life	$ _____ per month or year (circle one)	$ _____
Health Premiums	$ _____ per month or year (circle one)	$ _____
Automobile		
Loan payment	$ _____ per week or month (circle one)	$ _____
Insurance	$ _____ per month, quarter, or year (circle one)	$ _____
Registration fees	$ _____ per year	
Repairs/inspection	$ _____ per year	$ _____
Fuel	$ _____ per week or month (circle one)	
Medical		
Doctor	$ _____ per month	$ _____
Dentist	$ _____ per month	$ _____
Hospital	$ _____ per month	$ _____
Medications	$ _____ per month	$ _____
Incontinent Items/Other	$ _____ per month	$ _____
Personal		
Clothing	$ _____ per month or year (circle one)	
Food	$ _____ per week or month (circle one)	
Toiletries/personal care	$ _____ per week or month (circle one)	
Credit card payments	$ _____ per month	$ _____
Loans	$ _____ per month	$ _____
Furniture/Equipment Rental	$_____ per month	
Miscellaneous		
TV and/or Internet Service	$ _____ per month	$ _____
Legal fees/fines	$ _____ per month	$ _____
Charitable contributions	$ _____ per month or year (circle one)	
Cigarettes/Alcohol	$ ____/____ per month	
Pet Expenses	$ _____ per month	
Laundromat expense	$ _____ per month	
Storage unit	$ _____ per month	$ _____

Please check the type of assistance you need at this time:

____ Rent/Mortgage ____ Real estate taxes ____ Utilities
____ Heat ____ Prescriptions ____ Medical equipment; explain: _____
____ Other, please explain: _____
Please list any past due bills and note if you have received a shutoff or foreclosure notice: _____
_____

Landlord Name: _____ Phone Number: _____

Landlord Address: _____

Please provide gross amounts of all sources of household income:

Social Security	$ _____	per month
Annuity/Pension	$ _____	per month
Disability/SSD	$ _____	per month
SSI	$ _____	per month
SSP	$ _____	per month
Employment	$ _____	per month
Workman's Compensation	$ _____	per month
Unemployment Compensation	$ _____	per month
Income tax refund	$ _____	current year
Cash assistance	$ _____	per month
Food stamps (SNAP)	$ _____	per month
LIHEAP	$ _____	per month
Rent/Property tax rebate	$ _____	current year
OTC Medications & Utility help	$ _____	per month
Family/friend assistance	$ _____	per month
Other:	$ _____	per month

Please list all your assets:	Current value	Location
Checking account	$ _____	_____
Savings account	$ _____	_____
Certificate of deposit	$ _____	_____
Life insurance	$ _____	_____
Real estate	$ _____	_____
Stocks/Bonds/Mutual Funds	$ _____	_____
Annuity/Retirement/401K	$ _____	_____
Other	$ _____	_____
Automobiles	$ _____	Make: _____ Model: _____ Year: _____
	$ _____	Make: _____ Model: _____ Year: _____

Applicant's Declaration

I verify that the statements in the foregoing Application for Benefits are true and correct. I understand that a false statement herein will cause my Application to be dismissed without any further consideration.

X_____ _____
Signature of Applicant Date

Todd Baird Lindsey Devlin Foundation
P.O. Box 724
Carlisle, Pennsylvania 17013

Name: _____ Social Security #: _____

Address: _____

I hereby authorize and request the disclosure to the Todd Baird Lindsey Devlin Foundation and its representatives information concerning myself, including my age, residence, citizenship, employment, income, resources, liabilities, medical diagnoses, physician's history and physical, current medications and any other necessary information required to determine my eligibility for assistance. It is understood that the information obtained will be used only for purposes directly related to my eligibility for benefits of the Todd Baird Lindsey Devlin Foundation and may be referred and provided to agencies from which I will be receiving benefits and services.

X_____ _____
Signature of Applicant Date

_____ _____
Signature of Witness Date

At the request of _____ ("Requesting Agency") Todd Baird
(Referral Agency)
Lindsey Devlin Foundation may be reimbursing part or all of the cost of certain services provided to me. I understand that the Foundation is not a guarantor of any such services to me or for my benefit. I understand that the Foundation will not be the direct or indirect provider of any such services.

In consideration for the Foundation reimbursing some services provided to me and intending to be legally bound hereby, I agree that I will hold the Foundation, its directors, employees, and agents and their heirs, executors, administrators, and assigns harmless from any and all claims, suits, causes of actions, damages, judgments and demands whatsoever that I may have, or which my heirs, executors, or administrators may have for, upon or by reason of any matter, cause or thing whatsoever arising from the services provided to me or for my benefit by any provider, its directors, employees or agents.

X_____ _____
Signature of Applicant Date

_____ _____
Signature of Witness Date

8/9/2023