143 Rosedale Drive
Elizabeth City, NC 27909
252-562-6593
Email: elderhelp.org@gmail.com

Request for Assistance Form

Name of Requestor: _____

Phone Number of Requestor: _____

Name of Resident (First Initial, Last Name): _____

County of Resident Residency:_____

Name of Facility of Resident Residency:_____

Type of Assistance Requested (Please Circle All That Applies):

Physician Co-Pay/Bill	**Pharmacy Co-Pay/Bill**	**Hospital Co-Pay/Bill**
DME/Supplies	**Personal Needs**	**Other**

Personal Needs (Please Explain Assistance Requested):

_____

_____

Other (Please Explain Assistance Requested):

_____

_____

Amount of Request:_____

FOR OFFICIAL USE ONLY

Request Received By: _____ Date Received: _____
Board Vote Required: YES NO Date of Board Vote: _____
Request: APPROVED DENIED Reason of Denial: _____
Signature of Board Member Reviewing Request: _____
Date of Approval: _____ Amount Approved: _____
Check Date: _____ Check Number: _____