Rocky Strong, Inc.
PO Box 23, Hyde Park, NY 12538
(845) 518-2030
www.rockystrong.org
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Rocky Strong Service Agreement

Rocky Strong, Inc. is a 501(c)3 non-profit corporation whose mission is to provide financial assistance to caregivers and their seriously ill family member who is currently in treatment and demonstrating a financial need in Dutchess County, NY and surrounding areas.

Guideline requirements for application review:

1. Caregivers are defined as any member of a family who is responsible for caring for a seriously ill family member (child, spouse, or themselves) and who are legal guardians of children 18 years of age or younger and currently living in the home.

2. The illness of such family member is defined as potentially life-threatening and is currently undergoing treatments or requires current short or long term medical interventions by a physician.

3. If qualified for assistance, Rocky Strong will not provide any financial compensations until family member's treating physician has provided Rocky Strong with a written statement on such physician's letterhead describing the family member's qualifying diagnosis and course of treatment with start and end dates of said treatments. Letter can be faxed confidentially to (845) 889-4172, emailed to rockystrong023@gmail.com, or mailed to PO Box 23, Hyde Park, NY 12538. ***All information is confidential.***

4. Caregiver and family must reside in Dutchess County, NY and/or surrounding area.

5. Family is facing a financial hardship due to (but not limited to) loss of work, loss of second income, medical expenses, etc. and is currently behind in financial obligations because of illness.

6. Financial assistance is at the discretion of Rocky Strong.

Rocky Strong Family Intake Form

Family Information Date_____

Caregiver's Name: _____ Email:_____

Address:_____City:_____State_____Zip:_____

Phone Number:_____(**Home or Cell**) Best Time(s) To Reach You _____

Please list the name and ages of all members in the caregiver's household (including caregiver)

Name	Age	Relation

Referred By (name/organization - if applicable)_____

Address:_____City:_____State_____Zip:_____

Phone Number:_____(Home or Cell) Email:_____

Brief description of illness in the household and the financial hardship the family is facing due to the illness:

_____

_____

_____

_____

_____

B) Services Needed:

- ❑ Transportation
- ❑ Payment of past due/delinquent household bill
- ❑ Grocery & Food
- ❑ Accommodations
- ❑ Gas Card
- ❑ Other: Please specify what is needed_____