Parent or Legal Guardian Name (print): _____

SCCM cannot process the application without the last four digits of the child's social security number.

Children Age 14 and Under.: *Children over 14 will be considered on a case-by-case basis.*

Child #1 (circle) Boy / Girl Name:_____ Last 4 digits of SS#: _____ Age: _____ Date of Birth: _____ School Attended:_____ Interests/Hobbies:_____ _____ _____	Child #2 (circle) Boy / Girl Name:_____ Last 4 digits of SS#: _____ Age: _____ Date of Birth: _____ School Attended:_____ Interests/Hobbies:_____ _____ _____
Child #3 (circle) Boy / Girl Name:_____ Last 4 digits of SS#: _____ Age: _____ Date of Birth: _____ School Attended:_____ Interests/Hobbies:_____ _____ _____	Child #4 (circle) Boy / Girl Name:_____ Last 4 digits of SS#: _____ Age: _____ Date of Birth: _____ School Attended:_____ Interests/Hobbies:_____ _____ _____
Child #5 (circle) Boy / Girl Name:_____ Last 4 digits of SS#: _____ Age: _____ Date of Birth: _____ School Attended:_____ Interests/Hobbies:_____ _____ _____	Child #6 (circle) Boy / Girl Name:_____ Last 4 digits of SS#: _____ Age: _____ Date of Birth: _____ School Attended:_____ Interests/Hobbies:_____ _____ _____

Please return by November 27th to
Stanly Community Christian Ministry, Inc. at 506 S. 1st. St., Albemarle, or mail to "Helping Hands" P.O. Box 132 Albemarle, NC 28002

PLEASE INCLUDE YOUR PROOF OF INCOME (PAY STUBS FOR ONE MONTH, FOOD STAMP OR BENEFIT LETTER, AND A COPY OF YOUR CHILD('S) CURRENT MEDICAID CARD

Helping Hands

Making Christmas Bright for Stanly County

A program of Stanly Community Christian Ministry

APPLICATION FOR ASSISTANCE FOR CHILDREN

Applications are also available online at sccminc.org

Parent/Guardian Name: _____

Mailing Address: _____

Street Address (if different): _____

City:_____Zip Code_____ Cell Phone:_____

Employer:_____ Monthly Household Income:_____

Does your family receive Food Stamps (EBT) and Medicaid? YES / NO

Please include a copy of your Food Stamp approval letter and the current Medicaid card for the child/children you are applying for.

I have attached proof of INCOME to this application: YES / NO

I understand that SCCM will use this information to determine eligibility for Helping Hands assistance. I permit this agency to release this information to other agencies during the year. I further understand that Helping Hands cannot guarantee that I will receive assistance. I know that if I give false or misleading information or fail to complete this application in its entirety, assistance will be denied.

I authorize **Stanly Community Christian Ministry**, as a Charity Tracker participating agency, to share my basic identifying and non-confidential service transactions/information with other Charity Tracker participating agencies. I authorize the use of a copy of this form to serve as an original for the purposes stated above. I further authorize **Stanly Community Christian Ministry**, as a Charity Tracker participating agency, to share my dependent's basic identifying and non-confidential service transactions/information with other Charity Tracker participating agencies.

The original of this release of information shall be kept on file with the agency for a minimum of three (3) years from the date of application.

Applicant Signature X _____ **Date** _____

Agency Representative Signature X _____ **Date**_____

Office Use Only: _____ Approved _____ Denied

Questions about this application? Contact Helping Hands at 704-985-4615