



WARM THE CHILDREN
Participant Eligibility Form

Applicants Must Meet Income and Residency Guidelines

Please complete the following information – ***Print Clearly!***

(Required for Program Participation)

The 2026 WTC Shopping Season will begin November 7, and end December 12, 2026.

Name (Custodial Parent)

Social Security Number

Address

City, County, State and Zip Code

Phone – *Only 3 attempts will be made by shopper to contact you*

Alternate Phone

Total Number of Adults Living in Home

Total Number of Children Living in Home

Child's Name

Age

Birth Date

Responsible Adult

Relationship

INCOME:

Name: _____ Employer: _____

Hrs/Wk: _____ Wages/Hr: \$ _____ Monthly Income: \$ _____

Name: _____ Employer: _____

Hrs/Wk: _____ Wages/Hr: \$ _____ Monthly Income: \$ _____

★★ PLEASE READ ★★

The authorization form on the back of this page **MUST** be completed by the custodial parent or guardian, and **must be signed and witnessed** by a person of your choosing before approval is given for shopping. Transportation to the store is not provided.

You will not be contacted by a shopper, and you will not be notified if this form is not properly completed.

This completed and signed form may be mailed to the Eagle River Rotary Foundation WTC, PO Box 1191, Eagle River, WI 54521, or may be brought to the Vilas County News-Review at their new office at 701 North Railroad Street in Eagle River. Additional forms may be obtained at the News-Review or duplicated.

In Cooperation with the Vilas County News-Review

Soc. Security/Mo:

\$

Child Support/Mo:

\$

Unemployment/Mo:

\$

Tips/Mo:

\$

Other:

\$

TOTAL:

\$

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

★

Name of Recipient of Service

★

Street or Box Number

★

Date of Birth

★

City, State and Zip Code

I authorize the Vilas County Human Services Department (HSD), 330 Court Street, Eagle River, WI 54521

to disclose to: Warm The Children Program operated by the Eagle River Rotary Foundation, PO Box 1191, Eagle River, WI 54521
(Name of Organization or individual) (Address)

and authorize: Warm The Children Program operated by the Eagle River Rotary Foundation, PO Box 1191, Eagle River, WI 54521
(Name of Organization or individual) (Address)

to disclose to the Vilas County Human Services Department, 330 Court Street, Eagle River, WI 54521, information from my confidential record. I understand that the specific type of information to be disclosed includes:

Verification of the Income I have reported on the Warm The Children Eligibility Application Form and/or verification that the income I have reported on that form falls below 200% of the Federal Poverty Level.

and that this disclosure is being made for the following purpose(s): To establish my family's eligibility for the Warm The Children Program.

(Specify date, event, or condition upon which consent will expire, unless revoked earlier. The release shall not extend more than one year from the date signed). **This authorization expires on** Six months from the date of signature below.

I understand that I may request a copy of this authorization from Vilas County Department of Social Services and that I have the right to inspect and receive a copy of the material to be disclosed upon my request. I understand that the information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Not Applicable

Signature of Receipt of Services if over age 12

(Date)

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Signature of Parent or Guardian

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Witness of Parent/Guardian Signature

★

(Date)

I have been advised and understand the risk involved with the electronic transmission of my client records. With this understanding, I am giving my permission for records/client information outlined above to be FAXED between the above named parties. **Please Initial (_____)★**

The following statements are applicable only to protected health and drug and alcohol abuse information and services.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that Vilas County HSD may not condition treatment, payment, enrollment or eligibility for benefits on my decision to sign this authorization except regarding: a health plan enrollment or eligibility.

Right to Withdraw This Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Vilas County HSD. I am aware that my withdrawal will not be effective until received by Vilas County HSD and will not be effective regarding the uses and/or disclosures of my health information that Vilas County has made prior to receipt of my withdrawal statement.

NOTE TO RECIPIENT OF MEDICAL RECORD INFORMATION: This confidential information is not to be released to other sources without again seeking the permission of the client.

NOTE TO RECIPIENT OF DRUG AND ALCOHOL ABUSE INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Unless the records of your program are also subject to the Federal Law, Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.