

Story Form

Share your story with us! The information you provide the members of **ABLE** will help with the effort to preserve and expand important funding that can be helpful in gaining and keeping the services you need. Thank you for joining us and please share your story with us.

Name:

Phone # ()

Street Address:

Email (if applicable):

Age:

Date:

Location (where filled out):

What services are you concerned about?

___ Concerned about being eligible for community based **Medicaid**

___ Concerned about being eligible for **Elderly Programs and PASSPORT**

___ Concerned about **Childcare Vouchers**

___ Concerned about not being able to afford **Healthcare Services**

___ Concerned about having access to **Emergency Food**

___ Concerned about being able to pay for **Housing**

___ Concerned about the cost of paying for **Personal Identification Documents** that are necessary to get services (Driver's License, Birth Certificate)

___ Concerned about the payments I am receiving for taking care of my grandchildren (**Kinship care**)

___ Other concerns you may have, please write here: _____

-OVER-

Please tell your story below about how **(Health care, Daycare, Elderly, Etc)** is important to you and what should be done to fix the system. Please share with us as much as you can: Your story will be used as an example of what programs need to be expanded or protected.

Are you interested in becoming more involved in participating with **ABLE** to get funding for needed health and human services? Please circle: Yes No

Please check one of the following:

Yes, you may use my story as testimony on the problems, but I prefer to remain anonymous.

Yes, I understand the importance of connecting stories to 'real people.' It is okay to use my name.

Yes, my story can be used for media purposes.

Thank you. Gathering stories is an important part of this campaign. We appreciate that you shared yours.

Raising the community voice at the policy level...

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