Compassionate Caregivers Fund
Aid Application

Please complete this form and send to:

- *Via email to admin@compassionatecaregiversfund.org*

Employee Name:	**Date:**
Address:	
Last 4 digits of Social Security Number *(ID purposes only)***:**	**Community:**
Home Phone:	**Work Phone:**
Current Job/Position:	**Gross Salary:**
Please check one ☐ Hourly ☐ Salary	**Please check one** ☐ Part-Time/Per Diem ☐ Full-Time
Amount Requested ***(max amount $500)*****:** $	
Please answer the following questions *(information given will be confidential).*	
1. What is the purpose of this request? Describe the circumstances that led to the emergency.	
2. How will the Fund Aid be spent? Please describe.	

3. When do you need the Fund Aid?
4. Have you used up significant portions of personal funds/savings to meet this emergency? Please describe.
5. Have you ever applied for Aid from this fund before? If so, when and what was the result?
6. If not awarded, what are the alternatives to meet the emergency? Please describe.
7. Other comments/information that would be helpful in reviewing this application? Please provide any additional information you'd like to share that may help the committee make a recommendation.
8. Will any of these expenses by covered by insurance? Please provide details.

I certify that the information provided in this Aid Application is true and correct to the best of my knowledge. Any intentional misrepresentation of information contained in this application will result in forfeiting this and any future grant application. I authorize the Committee administering this program to verify my employment earnings records, and any other information needed to process my Aid Application.

_____I understand that the Compassionate Caregivers Fund Aid Review and Approval Committee will take reasonable measures to protect my privacy. However, I understand that my anonymity cannot be guaranteed.

____I understand that Aid funds may not be available at this time, and that my application does not guarantee approval of funds.

____I have completed an Income, Expense and Debt Verification form and agree to provide additional information to the Compassionate Caregivers Fund Aid Review and Approval Committee, if requested.

Applicant Signature:	**Date:**

For Committee Use Only

Fund Aid Approval:

☐ Yes

☐ No

Reason:

Amount Approved: $

Make Check Payable To:

Compassionate Caregivers Fund

INCOME, EXPENSE and DEBT VERIFICATION

Name of Applicant: _____ Date of Hire: _____

Number of adults in household: _____

Number of children in household: _____

Income:

MONTHLY Income *(please include all household earnings)*	$

Expenses:

Monthly Cost of utilities	$
Monthly Cost of housing	$
Monthly Cost of food	$
Monthly Cost of transportation	$
Monthly Cost of clothing & personal items	$
Other Expenses	$
TOTAL amount MONTHLY living expenses	$

By signing your name, you are agreeing to the following: I hereby state that the aforementioned information is accurate and true to the best of my knowledge.

Applicant Signature *Date*

All forms can be submitted:

- *Via email to admin@compassionatecaregiversfund.org*