



APPLICATION FOR FINANCIAL ASSISTANCE

I. AWCI MEMBER COMPANY EMPLOYEE APPLICANT INFORMATION

First Name _____ Last Name _____ SSN _____

Address _____

E-mail _____ Home Phone _____ Cell Phone _____

Work Phone _____ Fax _____

Male Female Date of Birth _____

Marital Status Married Separated Divorced Unmarried

APPLICANT INFORMATION To be completed if the applicant is not the AWCI Member Company employee (i.e. spouse, widow or other authorized family member).

First Name _____ Last Name _____ SSN _____

Address _____

E-mail _____ Home Phone _____ Cell Phone _____

Work Phone _____ Fax _____

Male Female Date of Birth _____

Marital Status Married Separated Divorced Unmarried

Dependents of Applicant

Table with 4 columns: Name, Date of Birth, Relationship to Applicant, Live with Applicant? and 6 rows.

II. Funding Request

Please specify emergency financial needs by listing amounts and creditors below.
Copies of invoices must be attached and submitted with this application.

\$	
\$	
\$	
\$	
\$	

Please describe the costs the applicant/family has already paid for the situation that led to this application.

III. Other Sources of Funding/Support

AWCI Cares was created to be a program of last resort for individuals and families in crisis. As such, please provide information on other sources applied to for assistance, the date the request was made and results of this outreach.

If you have not yet contacted other support organizations, please contact the Foundation for sources of financial support.

Is the applicant and/or his/her family interested in receiving free professional support services via phone or e-mail with a licensed social worker? Yes Not at this time

IV. Financial Information

Estimated Monthly Family Expenses	Family Assets
Rent/mortgage:	Checking:
Utilities/phone:	Savings/CD:
Child care:	Money Market:
Transportation:	Stocks/Bonds:::
Medical bills/other debt:	Real Estate:
Food:	Retirement (if applicant is deceased):
Other:	Life Insurance (if applicant is deceased):
	Other:
TOTAL	TOTAL

Check all other sources of income and indicate income from each	
Social security/retirement	Alimony
Pension	Public assistance
Salary	Short term disability
In-kind (room and board)	Child support
Family/friends	SSD (Soc. Sec. Disability)
Unemployment	SSI (Supplemental Security Income)
Sick leave	Other company benefits
Other union benefits	Other

TOTAL monthly family income: _____

Bankruptcy Filed or Pending: No Yes _____
 Date, status, amount _____

Bills currently in Collections: No Yes _____
 Date, status, amount _____

V. Health Insurance and Medical Information

- Does the applicant have medical insurance? Yes No
- Is the applicant’s spouse/dependent family covered by this policy (if applicable)? Yes No
- Are prescription drugs covered? Yes No
- Are office visits covered? Yes No
- Policy expiration date _____

Indicate type of insurance

Medicaid	Medicaid pending	Emergency Medicaid
Medicare only	Medicare plus Medicaid	Medicare plus other supplemental
Public health insurance	Private health insurance	VA program
	Charity coverage	

VI. Employment Status of Applicant. Please check appropriate box below.

Employed Self-employed Unemployed N/A

Employer Name _____

Employer Location _____

Dates of Employment From _____ To _____

Last Job Title/Occupation with Employer _____

Supervisor/Contact Number _____

If not currently working, date expected to return to work _____

VII. Additional Considerations

Are there any other circumstances or situations that may assist in making a determination?

VIII. Authorization. Please initial each point listed below and sign at the bottom.

The high demand for assistance through the AWCI Cares program demands that we continue to provide financial aid to employees of AWCI member companies while being good stewards of the pledges to our program and honoring our legal and ethical guidelines. Incomplete applications will not be evaluated.

All information contained in this application will be retained by AWCI Cares and revealing details (including names, location and employer) will not be released to any other party without the express written consent of the applicant. The application, once verified, will be sent to the AWCI Cares Leadership Team for review with the applicant names, locations, employers and creditors removed to ensure that an unbiased decision will be made on the case.

I certify the information in this application to be factual. I understand that AWCI Cares and the Foundation will not consider an incomplete, misleading or inaccurate application.

I understand that if my grant request is approved, AWCI Cares will not send any funds directly to me, but will instead remit payments to the vendors as listed in my application and approved by AWCI Cares.

I understand that AWCI Cares will not consider paying for the following items:

- Credit card payments not directly related to the situation
- Cable/satellite TV bills
- Telephone or other telecommunications bills that are the result of excessive use
- Any costs associated with a second vehicle
- Cosmetic repairs to vehicles
- Optional travel needs
- Check cashing facility bills
- Nonessential home remodeling costs
- Repayments of debts to family or friends
- Any costs associated with a second or vacation home
- Routine costs incurred by the applicant and/or family that do not directly relate to the situation warranting the application for financial assistance
- Funeral costs that include fees beyond the burial, not to exceed \$2,500.

I understand that while grant requests should be submitted for the essential needs of the applicant and/or their family, the average grant disseminated by AWCI Cares is approximately \$2,500.

This application is considered complete, once submitted. Additional bills requiring assistance will require the submission of an additional grant application. If the applicant makes any payments to the bills, invoices, etc. attached to this application while this application is under review, the applicant must make Leslie Taylor aware at taylor@awci.org or (703) 538-1614.

I authorize verification of the information in this application by the Foundation on the Wall and Ceiling Industry.

Signature _____

Name _____ Date _____

Please send completed application with supporting documentation to:

Leslie Taylor, Foundation of the Wall and Ceiling Industry

513 W Broad Street, Suite 210

Falls Church, VA 22046

Confidential fax: (703) 538-1734

Tel: (703) 538-1614

taylor@awci.org