



**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	
<input type="checkbox"/> Social security/retirement	<input type="checkbox"/> Alimony
<input type="checkbox"/> Pension	<input type="checkbox"/> Public assistance
<input type="checkbox"/> Salary	<input type="checkbox"/> Short term disability
<input type="checkbox"/> In-kind (room and board)	<input type="checkbox"/> Child support
<input type="checkbox"/> Family/friends	<input type="checkbox"/> SSD (Soc. Sec. Disability)
<input type="checkbox"/> Unemployment	<input type="checkbox"/> SSI (Supplemental Security Income)
<input type="checkbox"/> Sick leave	<input type="checkbox"/> Other company benefits
<input type="checkbox"/> Other union benefits	<input type="checkbox"/> 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**

<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicaid pending	<input type="checkbox"/> Emergency Medicaid
<input type="checkbox"/> Medicare only	<input type="checkbox"/> Medicare plus Medicaid	<input type="checkbox"/> Medicare plus other supplemental
<input type="checkbox"/> Public health insurance	<input type="checkbox"/> Private health insurance	<input type="checkbox"/> VA program
	<input type="checkbox"/> 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 \$6,000.

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 Annemarie Selvitelli aware at [selvitelli@awci.org](mailto:selvitelli@awci.org) or (703) 538-1608.

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:**

Attn: Annemarie Selvitelli  
Foundation of the Wall and Ceiling Industry  
513 W Broad Street, Suite 210  
Falls Church, VA 22046  
Confidential fax: (703) 538-1728  
[selvitelli@awci.org](mailto:selvitelli@awci.org)  
Tel: (703) 538-1608