AWCI CARES

APPLICATION FOR FINANCIAL ASSISTANCE

Grant Application

1. Applicant Information
    - Name and complete contact information
    - If applicant has dependents, please complete this section
2. Funding Request
    - Complete all questions on page 3.
    - Be sure to describe the situation and costs the applicant/family has already paid.
    - Copies of invoices must be attached and submitted with this application.
    - All invoices submitted must be the most current/recent amounts due.
3. Other Sources of Funding/Support
    - Complete questions on page 4 about other sources of funding and/or support
4. Financial Information
    - Please list the monthly expenses and sources of income
    - All lines MUST be filled for application to be considered.
    - The number 0 and N/A are not accepted.
    - If it is zero value, enter $0.00.
5. Health Insurance and Medical Information
    - Please complete questions on page 6 regarding insurance, deductible, prescriptions, policy, etc.
6. Employment Status of Applicant
    - Complete information on page 6
7. Additional Considerations
    - Use this opportunity to provide additional circumstances or situations the review committee should be aware of that may assist in making a determination
8. Submit a completed company verification form
    - This form needs to be completed by applicant's immediate supervisor, company owner or human resource department.
9. Please reach out to AWCI CARES with any questions about the application or process.

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

Name	Date of Birth	Relationship to Applicant	Live with Applicant?

II. Funding Request

Please indicate the amount of dollars you are requesting. $_____

Specify emergency financial needs by listing amounts and creditors below.

Copies of invoices must be attached and submitted with this application.

All invoices submitted must be the most current/recent amounts due.

Amount	Creditors
$	
$	
$	
$	
$	

On a scale of 1 to 5 using the descriptions below as guidance, please indicate your level of need. Number = ____

1 = It would be rewarding to receive financial assistance but will not experience additional hardship without it.

2 = I will experience substantial hardship without financial assistance.

3 = My immediate family or I have received or am about to receive critical medical services and am unable to pay for part or all of the expenses.

4 = I am facing personal bankruptcy.

5 = I am unable to continue to provide housing, utilities and enough food for my immediate family or myself

All grants awarded are paid directly to creditors, not applicant.

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.

1) Has your employer or co-workers contributed financial or other assistance to help alleviate your difficulties?

   If yes, please indicate the financial or other assistance type and the level of assistance.

2) Has any other agency/organization provided financial or other assistance to help alleviate your difficulties?

   If yes, please list the agency/organization and the financial level or type of assistance.

3) Have you received any contributions from a Crowdfunding source (e.g. GoFundMe, Kickstarter, etc.)
   ☐ Yes ☐ No
   If yes, please list the source and the financial amount of assistance.

4) Have your received any financial or other assistance from a Victims of Crime Assistance program?
   ☐ Yes ☐ No
   If yes, please list the source and the financial amount of assistance.

5) What will it mean to you personally and financially to receive assistance?

6) Has the applicant and/or his/her family received professional support services such as a licensed social worker? ☐ Yes ☐ No

IV. Financial Information

- **All lines MUST be completed for application to be considered.**
- **The number 0 and N/A are not accepted. If it is a zero value, enter $0.00.**

Estimated Monthly Family Expenses	Family Assets
Rent/mortgage:	Checking:
Health Insurance:	Savings/CD:
Utilities/phone:	Money Market:
Child care:	Stocks/Bonds:
Transportation:	Real Estate:
Medical bills/other debt:	Retirement (if applicant is deceased):
Food:	Life Insurance (if applicant is deceased):
Disability Insurance:	Other:
Term Life Insurance:	Other:
Whole Life Insurance:	Other:
Other:	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	□ Crowdfunding source (e.g. GoFundMe, Kickstarter, etc.)
□ Alimony	□ Victims of Crime Assistance program
□ 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
- What is applicant's deductible? _____
- What percent of expenses are covered after the deductible has been met? _____
- 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. Please submit a completed company verification form.

IX. Please submit current supporting documentation with application. This includes copies of most current/recent invoices as of date of application fulfillment.

X. 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:

- Arrearages not directly related to the situation
- 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 Annemarie Selvitelli aware. She can be reached at awci-cares@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 current supporting documentation to:

Annemarie Selvitelli, AWCI CARES/Foundation of the Wall and Ceiling Industry
513 W Broad Street, Suite 210
Falls Church, VA 22046
Tel: (703) 538-1608
Confidential fax: (703) 538-1728
awci-cares@awci.org