AWCI CARES

GRANT APPLICATION FOR FINANCIAL ASSISTANCE

Instructions

1. Applicant Information
    - Name and complete contact information
    - If applicant has dependents, this section must be completed
2. Funding Request, Reason for Applying and Other Sources of Financial Support
    - Complete all questions on page 3, 4 and 7.
    - Be sure to describe the situation and costs the applicant/family has already paid.
    - Copies of bills/invoices must be attached and submitted with this application.
    - All invoices submitted must be the most current amounts due.
3. Financial Information
    - 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.
4. Health Insurance and Medical Information
    - Please complete questions on page 6 regarding insurance, deductible, prescriptions, policy, etc.
5. Employment Information
    - Complete information on page 6
6. Additional Considerations
    - Use this opportunity to provide additional circumstances or situations the grant review committee should be aware of that may assist in making a determination
7. Submit a Completed Company Verification Form
    - This form needs to be completed by applicant's immediate supervisor, company owner or human resource department.
8. Please reach out to AWCI CARES with any questions about the application or process.

I. AWCI Member Company Employee Information

First Name _____Last Name _____SSN _____

Address _____

_____

E-mail _____Cell Phone _____ Home Phone _____

Work Phone _____

☐ Male ☐ Female Date of Birth _____

Marital Status

☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Applicant Information -To be completed if the applicant is an immediate family member of the AWCI Member Company Employee (e.g. spouse, widow or child).

First Name _____Last Name _____SSN _____

Address _____

_____

E-mail _____ Cell Phone _____ Home Phone _____

Work Phone _____

☐ Male ☐ Female Date of Birth _____

Relationship to AWCI Member

☐ Single ☐ Married ☐ Life Partner ☐ Separated ☐ Divorced ☐ Widowed

Dependents of Applicant

Name	Date of Birth	Relationship to Applicant	Live with Applicant?

II. Funding Request

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

Specify emergency financial needs by listing amounts and creditors below.

Copies of bills/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.

III. Reason for Applying

Why are you applying for a grant? What are the circumstances or situations that may assist in making a determination?

IV. Other Sources of Financial Support

AWCI CARES was created to be a backstop program for individuals and families of an AWCI member company in a financial 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, co-workers, or family and friends contributed financial or other assistance to help alleviate your difficulties?

   ☐ Yes ☐ No

   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?

   ☐ Yes ☐ No

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

V. 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 Primary Residence:
Medical bills/other debt:	Real Estate - Second Home:
Food:	Retirement (if applicant is deceased):
Disability Insurance:	Life Insurance (if applicant is deceased):
Term Life Insurance:	Other:
Whole Life Insurance:	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
☐ Rent from second home	☐ SSD (Soc. Sec. Disability)
☐ Family/friends	☐ SSI (Supplemental Security Income)
☐ Unemployment	☐ Other company benefits
☐ Sick leave	☐ Other
☐ Other union benefits	
☐ Alimony	

TOTAL monthly family income: _____

Bankruptcy Filed or Pending: ☐ No ☐ Yes _____

Date, status, amount _____

Bills currently in Collections: ☐ No ☐ Yes _____

Date, status, amount _____

VI. 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	

VII. Employment Information

Employer Name _____

Employer Location _____

Dates of Employment From_____ To_____

Last Job Title/Occupation with Employer _____

Supervisor/Contact Phone Number _____

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

VIII. Additional Considerations

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

IX. Please submit a completed company verification form.

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

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

The high demand for assistance through the AWCI CARES program requires 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 executive committee for review with the applicant names, locations, employers and creditors removed to ensure that an objective 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:

- Expenses not directly related to the current situation
- Credit card payments not directly related to the situation
- Cable/satellite TV invoices
- 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.

☐ I understand that while grant requests should be submitted for the essential needs of the applicant and/or their family, the average grant awarded by AWCI CARES ranges between $2,500 and $4,000.

☐ 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 contact Annemarie Selvitelli at awci-cares@awci.org or (703) 538-1608.

☐ I authorize verification of the information in this application by the Foundation of 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
awci-cares@awci.org