NATIONAL PHILOPTOCHOS SOCIAL WORK SERVICES

Please mail or fax to: **National Philoptochos • 126 East 37th Street • New York, NY 10016**
Social Work# 212.977.7782 • Fax 212.977.7784 • Main# 212.977.7770 • socialwork@philoptochos.org

APPLICATION FOR ASSISTANCE

(Policies and procedures for assistance are listed on Page 4)

Date _____/_____/_____

If you are known by any other name:

YOUR NAME_____ _____

ADDRESS _____ Apt_____

_____ _____ _____ _____ _____
City State Zip Code **METROPOLIS**

TEL: Home (_____) _____ Work: (_____) _____ Cell: (_____)_____

DOB: _____ **SSN** _____ -____ -_____ **Email Address** _____

Citizenship Status: ____US Citizen ____ /Green Card Perm Resident ___ Undocumented ____ Gk..Nat'l. ____Other

MARITAL STATUS: _____ Name of Spouse / Partner_____

TYPE OF HOUSING _____ **AMT. MORTGAGE OR RENT**_____ /per month

NAME & ADDRESS LL: _____

If client is a minor, name of guardian or custodial parent:
_____ Relationship_____

NAMES / RELATIONSHIP OF ALL OTHERS IN HOUSEHOLD:

Name	Relationshi	DATE OF BIRTH
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT SERVICES / ASSISTANCE ARE YOU REQUESTING? _____

_____

_____

WHAT OTHER HELP HAVE YOU RECEIVED / ARE YOU RECEIVING?

National Philoptochos	Help Received_____	Date_____
Metropolis Philoptochos _____	Help Received_____	Date_____
Philoptochos Chptr_____	Help Received_____	Date_____
Other Church _____	Help Received_____	Date_____
Social Service Agency_____	Help Received_____	Date_____
Gov't. Benefit(s)_____	Help Received_____	Date_____
Other: _____	Help Received_____	Date_____
Other: _____	Help Received_____	Date_____

REFERRED BY: _____
Contact Information _____

CONSENT FOR RELEASE OF INFORMATION: ____Signed ____Mailed Verbal Permission _____Refused

COMPLETE THIS SECTION IF YOUR REQUEST IS HEALTH / HEALTH CARE RELATED EITHER FOR YOURSELF OR FOR OTHER PERSON IN YOUR HOUSEHOLD:

NAME OF PATIENT _____ **DATE OF BIRTH** _____

PRIMARY DIAGNOSIS / DISABILITY, ETC: _____

_____

MEDICAL PROVIDER:

Hospital _____

Doctor _____

Clinic / Other _____

HEALTH INSURANCE: _____

POLICY / ID / CASE NUMER _____

EFFECTIVE DATE _____

AMOUNT CURRENT OUTSTANDING BILLS _____

OTHER RELEVANT HEALTH INFORMATION _____

_____

HOUSEHOLD INCOME / EMPLOYMENT INFORMATION:

TOTAL MONTHLY HOUSEHOLD INCOME: _____

ARE YOU CURRENTLY EMPLOYED: ___Y ___N **TYPE OF WORK / OCCUPATION**_____

CURRENT / MOST RECENT EMPLOYER: _____

Dates of **EMPLOYMENT**_____ **REASON NO LONGER EMPLOYED** _____

INCOME FROM EMPLOYMENT: _____ _____
Gross Income / Period Net Income/Period

DID YOU FILE AN INCOME TAX RETURN LAST YEAR? _____Y _____N **WILL YOU SEND US A COPY?** ____Y ____N

SAVINGS / OTHER ASSETS: _____

ARE OTHERS IN YOUR HOUSEHOLD EMPLOYED? ___Y ___N

Name	Monthly Income	Amount Contributed to Household
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER INCOME - GOVERNMENT ENTITLEMENTS / OTHER BENEFITS:

	Name/ Recipient	Amount / Period
Public Assistance / TANF		
SNAP (Food Stamps) / WIC		
Supplemental Security Income (SSI)		
Social Security Retirement/ Survivor/ Dependent Benefits (SSA)		
Social Security Disability (SSD)		
Disability (State/Short-Term/Long-Term)		
Workers Compensation (WCB)		
Unemployment Insurance (UIB)		
VA Benefits		
Union Benefits _____		
Housing Subsidy: Section 8; Other _____		
HEAP / Utility Discount Program		
Medicaid/Gov't health /Hosp. Charity Care		
Medicare (Part __A, __B; __D)		
Private Health Insurance Coverage		
Child Support		
Contributions from family / friends		
Other_____		
Other_____		

HOUSEHOLD EXPENSES:

ITEM	AMOUNT	Vendor	Other Details
Housing *(Rent/Mortgage)*			
Real Estate / Other Taxes			
Utilities *(Gas/Electric/Water/etc)*			
Heat / Hot Water / Oil			
Telephone/Internet/Cell			
Food			
Transportation			
Health Insurance Premiums / COBRA			
Life Insurance/ Other			
Child Support/Alimony			
Loans			
Other _____			
Other _____			

PLEASE NOTE OUR POLICIES and PROCEDURES:

- *Each case is evaluated individually based on its merits, documented need and abilities of those involved.*
- *As our resources are limited in amount and scope, we cannot provide ongoing financial assistance.*
- *As a nonprofit organization, we are accountable to our donors. As a result, you will be required to submit relevant documentation of income and expenses to verify your request, e.g. employment pay stubs; tax filing(s); government benefit award or denial letter(s); rental income and/or other household income; confirmation of contributions received from family / friends; copy of your lease, mortgage statement; copy of eviction / foreclosure notice, utility bills / shut-off notice; documentation of medical diagnosis; copies of uncovered medical expenses and other medical bills, etc.*
- *All information provided is confidential and will not be shared with others or with outside sources without your permission.*
- *Cases are reviewed for approval or denial by designated members of Philoptochos.*
- *Should your request be approved, please note that we do not provide direct cash assistance to the applicant(s). Our policy is to pay the provider directly, such as the landlord, mortgage holder, utility company, medical provider, hospital, funeral home, etc.*

• **Description of assistance being requested at this time (additional to info submitted on page one):**

_____

_____

_____

•**Event(s) that has (have) caused you to contact us at this time:**

_____

_____

_____

• **How have you managed until now?**

_____

_____

_____

• **Since Philoptochos cannot provide ongoing assistance, how do you plan to manage in the future:**

_____

_____

_____

• **Additional information that may help us in determining how best to help you:**

_____

_____

_____

CERTIFICATION:

I certify that the information included on this form is true and complete to the best of my knowledge.

_____ _____

Signature of Applicant *(or parent or legal guardian if applicant is a minor)* ***Date***