GREEK ORTHODOX LADIES PHILOPTOCHOS SOCIETY, Inc.

METROPOLIS/ CHAPTER APPLICATION FOR ASSISTANCE

Please email or fax this application to

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PLEASE ATTACH

CURRENT PHOTO OF APPLICANT

If you are seeking financial assistance, please review our policies and procedures on page 4.

DATE ____________ **HOW DID YOU HEAR ABOUT US?** ______________________________

NAME OF APPLICANT ______________________________

ADDRESS ______________________________ **APT** ____________

______________ ____________ ______________

CITY/ STATE **ZIP CODE** **METROPOLIS**

HOME TEL: ______________ **WORK:** ____________ **CELL:** ____________

EMAIL ______________

DATE OF BIRTH (DOB): ____________ **SSN** XXX-XXX- ____________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED **SPOUSE/ PARTNER'S DOB:** ____________

NAME OF SPOUSE/ PARTNER: ____________ **LIVES IN HOUSEHOLD:** ☐ YES ☐ NO

TYPE OF HOUSING: ☐ RENT ☐ OWN ☐ ROOMMATE ☐ OTHER **AMT. MORTGAGE/ RENT** PER MONTH

NAME/ ADDRESS LL: ______________________________

IF APPLICANT IS UNDER 21, NAME OF CUSTODIAL PARENT OR GUARDIAN:

______________________________ RELATIONSHIP ____________

OTHERS IN THE HOUSEHOLD

NAME	RELATIONSHIP	DATE OF BIRTH

SOLELY SO WE CAN DETERMINE IF YOU MAY BE ELIGIBLE FOR PUBLIC BENEFITS OR OTHER ENTITLEMENTS, PLEASE PROVIDE:

Citizenship Status: ☐US Citizen ☐ Permanent Resident/Green Card ☐Undocumented ☐Greek National ☐Other

Is there a personal or family history of alcohol or drug abuse / addiction? … ☐ Yes ☐ No

Is there a personal or family history of mental illness? … ☐ Yes ☐ No

Are there firearms in household?... ☐ Yes ☐ No

If yes, how are they secured? ______________________________

SPECIFIC ASSISTANCE BEING REQUESTED: ______________________________

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PLEASE LIST HELP YOU HAVE RECEIVED OR CURRENTLY ARE RECEIVING FROM ANY OF THE FOLLOWING

☐ National Philoptochos	Help received		Date(s)	
☐ Metropolis Philoptochos	Help received		Date(s)	
☐ Local Philoptochos Chapter	Help received		Date(s)	
☐ Other Church	Help received		Date(s)	
☐ Social Service Agency	Help received		Date(s)	
☐ Gov't./ Public Benefit(s)	Help received		Date(s)	
☐ Other organization, family, friends	Help received		Date(s)	

CONSENT FOR RELEASE OF INFORMATION: ☐ SIGNED ☐ MAILED ☐ VERBAL PERMISSION ☐ REFUSED

APPLICANTS HOUSEHOLD INCOME/ EMPLOYMENT INFORMATION:

Are You Currently Employed? ☐Yes ☐ No Name of Employer: ______________________

Dates Employed: (From)_____(To)_____ Type of Work You do: ______________________

Your Annual Income: ____________ Can you submit recent pay stub or tax returns? ☐ Yes ☐ No

Are other in household currently working? ☐Yes ☐ No Their Monthly Income ____________

TOTAL MONTHLY HOUSEHOLD INCOME AS OF DATE OF THIS APPLICATION: ____________

If you are not currently employed: ☐Temp Layoff ☐ Permanent Layoff ☐ Seeking Employment

Have you filed for Unemployment Insurance Benefits (UIB)? ☐Yes ☐ No ☐ Not Eligible

If receiving UIB, amount of your weekly Benefit ____________ Date UIB Ends ____________

Are you receiving any other benefit? (Disability/Sick Leave/Other) ☐Yes ☐ No ____________

Are you or any member of your immediate family suffering from stress/ depression or anxiety because of your current situation? ☐Yes ☐ No

If yes, would you like a referral to a mental health counselor? ☐Yes ☐ No ☐ Not Sure

IF APPLICANT IS SEEKING FINANCIAL ASSISTANCE FOR HEALTH/ HEALTHCARE RELATED COSTS PLEASE COMPLETE THIS SECTION:

NOTE: THE CONSENT FOR RELEASE OF INFORMATION MUST BE SIGNED

Name of Patient ______________________ **Date of birth** ____________

Primary Diagnosis/ Disability, etc. ______________________

Primary Medical Provider (s):

Hospital ______________________

Doctor ______________________

Clinic/ Other ______________________

Is the patient covered by health insurance? ☐Yes ☐ No

Insurance Company: ____________ Name of Policy Holder: ____________

Amount of Current Unpaid Bills ______________________

Other Relevant Health Information ______________________

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For Greek Nationals

If Applicant is a Greek National, is s/he covered by Greek Health Insurance? ☐Yes ☐ No

If Yes, Name of Greek Insurance ______________________

What will the Greek Health Insurance cover in the United States? ______________________

NAME OF APPLICANT ____

TO BE COMPLETED BY ALL APPLICANTS

PUBLIC BENEFITS/ GOVERNMENT ENTITLEMENTS/ OTHER INCOME:

	NAME/ RECIPIENT	AMOUNT / PERIOD
Public Assistance / TANF		
SNAP (Food Stamps) / WIC		
Supplemental Security Income (SSI)		
Social Security: Pension/ Retirement / Survivor Benefits		
Social Security: Dependent Benefits (for minor children)		
Social Security: Disability Benefits (SSD)		
Other Disability Benefits: State Disability/Emp. Benefit/Private Ins.		
Workers Compensation (WCB)		
Unemployment Insurance (UIB)		
Veteran Benefits		
Union Benefits ______________________		
Housing Subsidy: Section 8; Other __________		
HEAP / Utility Discount Program		
Medicaid/ACA Marketplace / Hospital Charity Care		
Medicare (Part ☐A ☐B ☐D)		
Private Health Insurance Coverage		
Child Support / Alimony		
Contributions from family / friends		
Other: ______________________________		
Other: ______________________________		

HOUSEHOLD EXPENSES (ALL):

ITEM	MONTHLY AMOUNT	PAID TO
Housing *(Rent/Mortgage)*		
Real Estate / Other Taxes		
Utilities *(Gas / Electric / Water / etc..)*		
Heat / Hot Water / Oil		
Telephone/Internet/Cell		
Food / Other *(e.g. Diapers)*		
Transportation / Auto Ins.		
Health Insurance Premiums / COBRA		
Life Insurance		
Child Support/Alimony		
Loans (Student / Other)		
Credit Card(s) Balances		
Other ____________________		
Other ____________________		

PLEASE NOTE OUR POLICIES and PROCEDURES REGARDING FINANCIAL ASSISTANCE:

- *Our financial assistance is limited to Orthodox Christian individuals and families, regardless of immigration status provided the bills / expenses you are asking us to consider are from vendors within the United States of America.*
- *Each case is evaluated individually based on its merits, documented need and abilities of those involved.*
- *Cases seeking financial assistance are reviewed for approval or denial by designated members of the National Board of Philoptochos.*
- *All information provided is confidential and will not be shared with sources outside those named above without your permission.*
- *As a nonprofit organization, we are accountable to our donors. As a result, you will be required to submit current documentation of household income and expenses to verify your request, e.g. employment pay stubs; tax filing(s); government benefit award or denial letter(s); income from others in household; 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.*
- *As our resources are limited in amount and scope, we are unable to provide ongoing financial assistance. When necessary, information about and/or referrals and/or assistance to apply for continuing help may be made to government agencies, local nonprofits, other levels of Philoptochos.*
- *Should your request be approved, please note that we do not provide direct cash assistance to applicant(s). Our policy is to pay the provider of service directly, such as the landlord, mortgage holder, utility company, medical provider, hospital, funeral home, etc.*

- **Please describe specific help being requested from Philoptochos:**

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- **Was there an event or events that caused you to seek our help and contact us at this time?**

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- **How have you managed until now?**

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- **As Philoptochos cannot provide ongoing assistance, how do you plan to manage in the future?**

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- **Additional information that may help us determine how best to help you:**

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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*