

**IF YOU ARE SEEKING HELP FROM THE
NATIONAL PHILOPTOCHOS SOCIAL WORK DEPARTMENT, PLEASE PRINT OUT THE
FOLLOWING, COMPLETE IT AND RETURN BY MAIL OR FAX TO:
7 West 55th Street, 7th floor • NY, NY 10019 • Tel: 212.977.7782 • Fax: 212.977.7784**

Date _____/_____/_____

YOUR NAME _____ ADDRESS _____ _____ City _____ State _____ Zip Code _____ TEL: Home (____) _____ Work: (____) _____ Cell: (____) _____ SSN _____ - _____ - _____ Email _____ Address _____ DOB: _____ US Citizen _____ /Green Card _____ Undocumented _____ Other _____ MARITAL STATUS: _____ Name of Spouse / Partner _____ TYPE OF HOUSING _____ AM'T MORTGAGE _____ or RENT _____ / per month NAME & ADDRESS LL: _____ If client is a minor, name of guardian or custodial parent: _____ Relationship _____ OTHER INDIVIDUALS IN HOUSEHOLD: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Name</th> <th style="width:25%;">Relationship</th> <th style="width:25%;">DOB</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Name	Relationship	DOB	_____	_____	_____	_____	_____	_____	_____	_____	_____	If you are known by any other name: _____ Apt _____ METROPOLIS
Name	Relationship	DOB											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											

WHAT ASSISTANCE ARE YOU REQUESTING? _____

REFERRED BY: _____	Contact Information: _____
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HAVE YOU RECEIVED / ARE YOU RECEIVING HELP FROM OTHER RESOURCES?

Nat'l Philoptochos	Help Received _____	Date _____
Metropolis Philoptochos	Help Received _____	Date _____
Local Philoptochos Chapter	Help Received _____	Date _____
Other Church _____	Help Received _____	Date _____
Other: _____	Help Received _____	Date _____
Other: _____	Help Received _____	Date _____
Other: _____	Help Received _____	Date _____

IF YOUR REQUEST IS HEALTH / HEALTH CARE RELATED EITHER FOR YOURSELF OR FOR SOMEONE ELSE 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 OF OUTSTANDING BILLS / CO-PAYS _____

OTHER RELEVANT HEALTH INFORMATION _____

EMPLOYMENT INFORMATION:

TOTAL MONTHLY HOUSEHOLD INCOME: _____

ARE YOU CURRENTLY EMPLOYED: ___Y ___N

CURRENT / MOST

OCCUPATION _____

RECENT EMPLOYER: _____

REASON NO

Dates / EMPLOYMENT _____

LONGER EMPLOYED _____

EMPLOYMENT INCOME: _____

Gross / Period Net / Period

DID YOU FILE AN INCOME TAX RETURN LAST YEAR? ___Y ___N

SEND US A COPY? ___Y ___N

SAVINGS / OTHER ASSETS: _____

ARE THERE OTHERS IN YOUR HOUSEHOLD WHO ARE EMPLOYED? ___Y ___N

Name

Monthly Income

Am't. Contributed to Household

OTHER INCOME - GOVERNMENT ENTITLEMENTS / OTHER BENEFITS:

	Name/ Recipient	Amount / Period
P.A./ TANF		
SNAP (Food Stamps) / WIC		
Supplemental Security Income (SSI)		
Housing Subsidy: Section 8; Other _____		
HEAP / Utility Discount Program		
Medicaid/Other Gov't health coverage		
Medicare		
Private Health Insurance Coverage		
Charity Care		
Social Security Retirement/ Survivor/ Dependent Benefits (SSA)		
Social Security Disability (SSD)		
Unemployment Insurance (UIB)		
Disability (State/Short-Term/Long-Term)		
Workers Compensation (WCB)		
VA Benefits		
Union _____		
Other _____		

HOUSEHOLD EXPENSES:

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

OUR POLICIES and PROCEDURES:

- *All information provided is confidential and will not be shared with outside sources without your permission.*
- *Each case is evaluated individually based on its merits, documented need and abilities of those involved.*
- *Cases are reviewed for approval or denial by designated members of Philoptochos.*
- *As our resources are limited in amount and scope, we are unable to provide ongoing financial assistance.*
- *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, if relevant; copy of lease, mortgage statement, eviction / foreclosure notice, utility bills / shut-off notice; medical bills, etc.*
- *Should your request be approved, our policy is to pay the provider directly, (landlord, medical professional, hospital, funeral home, etc.) rather than provide direct cash assistance to the applicant(s).*

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

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

• How have you managed until now?

• Since Philoptochos assistance is limited, how do you plan to manage in the future:

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

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

Signature

Date