NATIONAL PHILOPTOCHOS • DEPARTMENT OF SOCIAL WORK

Please email, mail or fax this application to:

NATIONAL PHILOPTOCHOS • 126 EAST 37TH STREET • NEW YORK, NY 10016

Confidential Social Work # 212.977.7782 • Fax 212.977.7784 • Main # 212.977.7770

Email: socialwork@philoptochos.org

APPLICATION FOR ASSISTANCE

If you are seeking financial assistance, please note the policies and procedures on page 4.

PLEASE ATTACH CURRENT PHOTO OF APPLICANT

DATE ____/_____/_____ REFERRED BY: ____________________

NAME OF APPLICANT ____________________

ADDRESS ____________________ Apt________

________ ________ ________ ________
CITY STATE ZIP CODE **METROPOLIS**

TEL: HOME (_____) ________ WORK: (_____) ________ CELL: (_____)________

DATE OF BIRTH (DOB): ________ **SSN** XXX-XXX-_____ **EMAIL ADDRESS** ________

MARITAL STATUS: _____ **NAME SPOUSE/PARTNER**________ **LIVES IN HOUSEHOLD** __Y __N **SPOUSE/PARTNER'S DOB:** ________

TYPE OF HOUSING ________ **AMT. MORTGAGE OR RENT**________ /PER MONTH

NAME / ADDRESS LL: ____________________

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

____________________ **RELATIONSHIP**________

OTHERS IN 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 ____ PERM RESIDENT/GREEN CARD ___ UNDOCUMENTED ___ GREEK NAT'L. ________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: ____________________

____

____

WHAT HELP HAVE YOU RECEIVED OR CURRENTLY ARE RECEIVING FROM ANY OF THE FOLLOWING?

Source	Type / Amt. of Help Received	Date(s)
NATIONAL PHILOPTOCHOS ________	TYPE / AMT. OF HELP RECEIVED________	DATE(S)________
METROPOLIS PHILOPTOCHOS ________	TYPE / AMT. OF HELP RECEIVED________	DATE(S)________
PHILOPTOCHOS CHAPTER________	TYPE / AMT. OF HELP RECEIVED________	DATE(S)________
OTHER CHURCH ________	TYPE / AMT. OF HELP RECEIVED________	DATE(S)________
SOCIAL SERVICE AGENCY ________	TYPE / AMT. OF HELP RECEIVED________	DATE(S)________
GOV'T. / PUBLIC BENEFIT(S) ________	TYPE / AMT. OF HELP RECEIVED________	DATE(S)________
OTHER ________	TYPE / AMT. OF HELP RECEIVED________	DATE(S)________
OTHER ________	TYPE / AMT. OF HELP RECEIVED________	DATE(S)________

CONSENT FOR RELEASE OF INFORMATION: ____SIGNED ____MAILED ____VERBAL PERMISSION ____REFUSED

TO BE COMPLETED BY ALL APPLICANTS:
HOUSEHOLD INCOME / EMPLOYMENT INFORMATION:

TOTAL MONTHLY
HOUSEHOLD INCOME: (*ALL IN HOUSEHOLD*) ______________________________

IS APPLICANT CURRENTLY EMPLOYED? ___Y ___N OCCUPATION______________________

DATES OF
EMPLOYMENT (FROM) __________ (TO)______________

IF NO LONGER EMPLOYED
STATE REASON: ______________________

APPLICANT'S INCOME: ______________________ IS THIS AMOUNT: __ANNUAL __MONTHLY __WEEKLY

INCOME TAX RETURN FILED LAST YEAR? _____Y _____N CAN YOU SEND US A COPY? ____Y ____N

SAVINGS / OTHER ASSETS: ______________________________

OTHERS IN HOUSEHOLD WITH INCOME FROM ANY SOURCE:

NAME	MONTHLY INCOME	AMOUNT CONTRIBUTED TO HOUSEHOLD

TO BE COMPLETED BY APPLICANTS SEEKING FINANCIAL ASSISTANCE
FOR HEALTH / HEALTH CARE RELATED COSTS

IF FINANCIAL ASSISTANCE IS BEING REQUESTED FOR HEALTH / HEALTH CARE -RELATED EXPENSES, THE PATIENT, OR IF A MINOR, HIS / HER PARENT OR GUARDIAN MUST SIGN THE CONSENT FOR RELEASE OF INFORMATION.

NAME OF PATIENT ______________________ **DATE OF BIRTH** __________

PRIMARY DIAGNOSIS / DISABILITY, ETC: ______________________________

____

PRIMARY MEDICAL PROVIDER(S):

HOSPITAL ______________________________

DOCTOR ______________________________

CLINIC / OTHER ______________________________

HEALTH INSURANCE: ______________________________

POLICY / ID / CASE NUMER ______________________________

EFFECTIVE DATE ______________________________

NAME POLICY HOLDER ______________________________

AMOUNT of CURRENT OUTSTANDING BILLS ______________________________

OTHER RELEVANT HEALTH INFORMATION ______________________________

FOR GREEK NATIONALS:
IF THE PATIENT IS A GREEK NATIONAL, IS S/HE COVERED BY GREEK HEALTH INSURANCE? ____YES ____NO

NAME OF GREEK INSURANCE______________________________

WHAT WILL THE GREEK HEALTH INSURANCE COVER IN THE UNITED STATES? ______________________________

____

TO BE COMPLETED BY ALL APPLICANTS:
OTHER INCOME / OTHER BENEFITS / GOVERNMENT ENTITLEMENTS / PUBLIC 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)		
OTHER DISABILITY BENEFITS e.g. –STATE DISABILITY /SHORT-TERM / LONG-TERM		
WORKERS COMPENSATION (WCB)		
UNEMPLOYMENT INSURANCE (UIB)		
VETERAN 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 / ALIMONY		
CONTRIBUTIONS FROM FAMILY / FRIENDS		
OTHER_____________		
OTHER_____________		
OTHER_____________		

ALL HOUSEHOLD EXPENSES:

ITEM	MONTHLY AMOUNT	VENDOR	OTHER DETAILS
HOUSING *(RENT/MORTGAGE)*			
REAL ESTATE / OTHER TAXES			
UTILITIES *(GAS / ELECTRIC / WATER / ETC..)*			
HEAT / HOT WATER / OIL			
TELEPHONE/INTERNET/CELL			
FOOD / DIAPERS / OTHER			
TRANSPORTATION / AUTO INS.			
HEALTH INSURANCE PREMIUMS / COBRA			
LIFE INSURANCE			
CHILD SUPPORT/ALIMONY			
LOANS (STUDENT / OTHER)			
CREDIT CARD(S) BALANCES			
OTHER ________________			
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, as long as 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.*

- **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?**

____

____

____

- **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 determine 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***

(02.2017)