LUKE 10:35 EMERGENCY ASSISTANCE FUND
APPLICATION FOR ASSISTANCE

General Information:

Name: ____

First   Last

If this application is being completed by someone other than the current/former employee, such as a family member, please explain and provide both your contact information as well as the contact information of the family member.

Permanent (Primary) Address:

Street: ____

City, State, ZIP ____

Home Phone: ____

Work Phone: ____

Mobile Phone: ____

Preferred Email: ____

Dates of employment at Catholic Charities or federation agency: ________________________

Work Location: ____

Marital Status: ____

If, because of the emergency, you cannot receive mail at your home, provide current address and/or alternate mailing address from above. Approval notification is sent to you by mail, so please provide a valid mailing address.

Street: ____

City, State, ZIP ____

To be completed only by Fund Review Committee	
Date Received	
Application Status	_____Approved______Denied_______ Withdrew ______
Amount Granted	
Log #	

Agreement and Authorization – Please Read Carefully

No current or former employee is entitled to receive a grant, either by their employment, their history of contributions to the Fund or because of any precedent inferred from a previous grant from the Fund. Grants will not be made before an applicant has demonstrated an immediate financial need and provided all required documentation.

I certify that the information provided in this grant application and any attachments to it is true and correct as of the date set forth below. My signature acknowledges and permits Catholic Charities of St. Louis to verify all information including employment status. This includes making appropriate contacts and disclosures with my creditors, health care provider and others referenced in this application to ensure that reported information is accurate.

Signature Required:_____________________________________**Date** ____________________

Please initial each item below:

____ I understand that Catholic Charities of St. Louis will take reasonable measures to protect my privacy. However, I understand that my anonymity cannot be guaranteed.
____ I understand that funds may not be available at this time, and that my application does not guarantee approval of funds.
____ I have provided supporting documentation and agree to provide additional information that may be requested by the Fund Review Committee.
____ I am not aware of any conflict of interest between myself and a member of the Fund Review Committee (if aware of conflict, check this box ☐ and provide an explanation in the space below).

Note: To help assure an impartial review process, please avoid mentioning your last name or the last names of your family members on the following pages 3-6. Your personal identifying information on pages 1 and 2 of this application and any attachments will be removed or redacted when the application is forwarded to the Fund Review Committee.

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Initials of Family Members (Spouse and Dependents Only)	Relationship	Age

Rent or own? Please circle one Rent Own

Number of Adults in Household: _______ Number of Children in Household _______

What is your annual family income from all sources: $________________________

Referral Source:

_______ Intranet

_______ Co-Worker

Human Resources

____

_____ Employee Communication/Publication

_____ Manager

_____ Other Referral Source

Which qualifying situation caused the financial hardship? Check the category below that best fits your situation.

_____ Uninsured Damages to Primary Residence Caused by Fire, Crime or Natural Disaster

_______ Uninsured Medical Expenses for Severe Illness or Injury

_____ Uninsured Expenses Arising from Death Incident

_____ Catastrophic or Extreme Circumstances

Name of Incident: ____

(Example: tornado, fire, flood, type of injury, name of illness)

Date of Incident: ________________________________

Amount Requested ($1,000 maximum): $_____________

Have you applied before to the Emergency Assistance Fund for assistance (please circle)? Y N

If yes, date applied (mm/dd/yy): ________________________________

Who has been affected by the situation? ________________________________

Is the affected person covered by medical or disability insurance?(Please circle) Y N

Have they applied for disability benefits? (Please circle) Y N

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If your **primary** home was damaged, will insurance cover part of the cost? (Please circle) Y N
Your deductible amount? ________________________________

Describe what happened to cause your financial hardship:

____
____
____
____

Describe in detail your immediate needs.

____
____
____
____
____

How will this grant help you recover from the immediate financial crisis?

____
____
____
____
____
____

Please tell us anything else that would help in understanding the circumstances of the hardship you or your family is experiencing. You are **not required** to provide personal information that would prove embarrassing or cause added emotional stress. However, the better the committee understands the events that have occurred, the better they will be able to evaluate your request.

____
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Luke 10:35 Emergency Assistance Fund

Application for Assistance

Important Note: If application is for a severe illness or injury, doctor confirmation and/or medical documentation will be required. Please ask the Healthcare Provider to complete Attachment A and return it directly to Catholic Charities.

If applying for Severe Illness or Injury, please provide the Healthcare Provider's, name, address, and telephone number:

Last Name: ______________________________

First Name: ______________________________

Street: ______________________________

City, State, ZIP ______________________________

Telephone Number ______________________________

Have other resources been considered or used, such as the American Red Cross, Salvation Army, or other similar social service agencies. Please comment on efforts and response.

Assistance Sought	Results	Date	Amount
Homeowner's or Renters Insurance			$
Auto Insurance			$
Medical Insurance			$
Social Service Organization, e.g., Red Cross, United Way, Crisis Assistance, Salvation Army			$
FEMA			$
Your Religious Community			$
Family Members			$
Loan Program			$
Other			$

If the application is approved, the Emergency Assistance Fund will make the grant(s) in the form of a check(s) payable to the vendor(s) and the applicant will be notified of the payment(s) by mail. All grants are made directly to vendors as bill payments; assistance funds are not sent directly to applicants.

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Provide the name of the vendor, the complete address, the account numbers (when relevant), amount due, and due date. Please list the vendors in order of priority. For each vendor, attach appropriate documentation (bills, lease, mortgage coupon, statement, etc.)

Vendor Name	
Vendor Address	
Basic Need Covered	
Payment Amount and Due Date	
Account Number	

Vendor Name	
Vendor Address	
Basic Need Covered	
Payment Amount and Due Date	
Account Number	

A completed application must be submitted in order for the application to be reviewed. Incomplete applications will be held for 30 days after the application has been submitted awaiting the additional information required. After 30 days, the applicant will need to apply by resubmitting a new application and all supporting documents again. We cannot make payments without clear, complete information including full account numbers and all documentation. Omitting copies of your bills will delay your application.

Checklist

- Carefully read the requirements to see if you qualify.
- Signed Declarations and Agreement page 2
- Supporting documents are necessary for evaluating and determining the eligibility of the grant request. Examples include but are not limited to:
    - Vendor documentation (bills to be paid)
    - Mortgage Coupon or Statement/Lease
    - Lodging Receipts in the case of evacuation
    - Insurance Claim Forms
    - Medical Documentation if needed (See Attachment A) and Explanation of Benefits (EOB)
    - Police, Fire, or other official incident report if for Catastrophic Circumstances
- If death incident, please provide a copy of the Death Certificate or Obituary

Please deliver completed and signed application with requested documentation to:

Catholic Charities of St. Louis
Senior Director of Human Resources
4445 Lindell Blvd.
St. Louis, MO 63108
Phone: 314.256.5914
Fax: 314.289.8037
Email: llexow@ccstl.org

ATTACHMENT A
TO BE COMPLETED BY HEALTH CARE PROVIDER IF APPLYING FOR SEVERE ILLNESS OR INJURY

To the attending physician: The current or former employee below has applied for crisis funding from the Luke 10:35 Emergency Assistance Fund of Catholic Charities for his/her self and/or the patient named below. This form is required for your patient to be considered for a grant.

Name of Applicant: ______________________________

Name of Patient: ______________________________

Patient Relationship to Applicant: ______________________________

Patient Address: ______________________________

City, State, ZIP ______________________________

Does the patient have a severe illness or injury? Please circle. Y N

Note: Severe illness or injury is defined as an illness, injury, impairment, or physical condition that a licensed physician certifies as critical, life threatening or terminal.

Date on which the patient's severe illness commenced: ______________________

Probable duration of patient's severe illness or injury: ______________________

Describe the severe illness or injury using appropriate medical facts within your knowledge (attach supplemental sheets if necessary).

____

____

____

____

Does the patient need constant care? Please circle. Y N

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Applicant Name: ____________________________________

If yes, what is the estimated amount of time that the patient will need this care?

____
____
____
____

Name and Address of Healthcare Provider of Healthcare Provider:

____
____
____
____

Telephone Number of Healthcare Provider: ____

Signature of Healthcare Provider: ____

Date: ____

Mail, fax or email completed and signed form to:

Catholic Charities of St. Louis
Senior Director of Human Resources
4445 Lindell Blvd.
St. Louis, MO 63108
Phone: 314.256.5914
Fax: 314.289.8037
Email: llexow@ccstl.org