

SWIFT EAGLE CHARITABLE FOUNDATION

P.O. Box 1977 • Avon, Colorado 81620 • phone 970-390-4745 • 970-300-2652 • info@swift eagle.org

APPLICATION FOR ASSISTANCE

NO INCOMPLETE APPLICATIONS WILL BE ACCEPTED. (4 pages)

DATE: _____

Have you previously applied for assistance from Swift Eagle Charitable Foundation? YES NO When: _____

APPLICANT INFORMATION

NAME: _____ AGE: _____ DATE OF BIRTH: _____

PHYSICAL ADDRESS: _____ OWN RENT TYPE OF DWELLING: _____

MAILING ADDRESS: _____ YEARS AT CURRENT ADDRESS: _____

PREVIOUS ADDRESS: _____ YEARS AT PREVIOUS ADDRESS: _____

PHONE: _____ EMAIL: _____ YEARS IN EAGLE COUNTY: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

RESIDENCE STATUS: US CITIZEN LEGAL RESIDENT UNDOCUMENTED RESIDENT SSN# _____

If legal resident, type of Visa and Expiration Date: _____

PLEASE LIST 3 NON-FAMILY CHARACTER REFERENCES AND CONTACT INFORMATION:

1. _____ PHONE: _____

2. _____ PHONE: _____

3. _____ PHONE: _____

MAY WE CONTACT THESE REFERENCES? YES NO _____

APPLICANT EMPLOYMENT INFORMATION

EMPLOYER: _____ TYPE OF BUSINESS: _____

ADDRESS: _____

PHONE: _____ CONTACT PERSON: _____

POSITION HELD: _____ YEARS THERE: _____

PREVIOUS EMPLOYER: _____ YEARS THERE: _____

FAMILY MEMBERS LIVING WITH YOU (Please include parents, spouse, children, and any other close relatives)

NAME	AGE	RELATIONSHIP	OCCUPATION	US CITIZEN	LEGAL RESIDENT	UNDOCUMENTED RESIDENT
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL INSURANCE INFORMATION (if applicable)

DO YOU HAVE MEDICAL INSURANCE? YES NO NAME OF INSURANCE CARRIER _____

POLICY #: _____ CONTACT PERSON: _____ PHONE #: _____

DOES YOUR EMPLOYER OFFER MEDICAL INSURANCE? YES NO

IF YOU DON'T HAVE MEDICAL INSURANCE, OR THERE IS A PROBLEM WITH YOUR CURRENT POLICY, PLEASE EXPLAIN: _____

SPECIFIC ASSISTANCE REQUESTED

IF APPROVED, WHAT WOULD THE GRANT BE USED FOR? _____

Please Include any applicable bills for which you are requesting assistance. _____

Attach related bills and previous 2 bank statements

1. HAVE YOU SET UP A PAYMENT PLAN WITH YOUR MEDICAL CREDITOR(S)? APPLIED FOR AID/FORGIVENESS OF BILL(S)? _____

2. HAVE YOU CONTACTED EAGLE COUNTY HEALTH & HUMAN SERVICES? _____ 970-328-8840

3. HAVE YOU CONTACTED OTHER CHARITABLE ORGANIZATIONS FOR ASSISTANCE? YES NO LIST ORGANIZATIONS: _____

MAY WE CONTACT THESE ORGANIZATIONS FOR INFORMATION? YES NO _____

Signature

Date

4. WHAT OTHER IMMEDIATE STEPS HAVE YOU TAKEN TO REDUCE/ADDRESS YOUR EXPENSES AND NEED? _____

BACKGROUND INFORMATION Please use this space to describe the circumstances leading to the present situation of need. Attach any additional documentation, bills or information that may be helpful in explaining the situation and the necessity. _____

WHAT IS YOUR LONG TERM PLAN TO ACHIEVE FINANCIAL STABILITY? _____

PERSONAL FINANCIAL INFORMATION: PLEASE COMPLETE THE FOLLOWING

ASSETS	DEBTS/OBLIGATIONS	MO. PAYMENT
Cash in bank: \$ _____	Credit card balances:\$ _____	\$ _____
Stocks/bonds: \$ _____	Stock loans: \$ _____	\$ _____
Cash value of Life Insurance: \$ _____	Life insurance loans:\$ _____	\$ _____
Real Estate:		
Residence: \$ _____	Mortgage balance: \$ _____	\$ _____
Rentals: \$ _____	Mortgage balance: \$ _____	\$ _____
Other: \$ _____	Mortgage balance: \$ _____	\$ _____
Automobiles: (year/make)		
_____ : \$ _____	Auto loan/lease: \$ _____	\$ _____
_____ : \$ _____	Auto loan/lease: \$ _____	\$ _____
_____ : \$ _____	Auto loan/lease: \$ _____	\$ _____
Retirement accounts:		
IRAs: \$ _____	Loans against	
401K: \$ _____	Retirement funds: \$ _____	\$ _____
Pension: \$ _____		
Other: \$ _____		
Other assets: (describe)		
_____ : \$ _____	_____ \$ _____	\$ _____
_____ : \$ _____	_____ \$ _____	\$ _____
_____ : \$ _____	_____ \$ _____	\$ _____

GROSS MONTHLY INCOME

Salary of applicant: \$ _____

Salary of spouse: \$ _____

Salary of other relatives living with applicant: \$ _____

Other household income:
(describe)

_____ \$ _____

_____ \$ _____

_____ \$ _____

Alimony/child support or maintenance: \$ _____

MONTHLY EXPENSES

Mortgage or rent: \$ _____

Homeowners' dues: \$ _____

Utilities: \$ _____

Medical Insurance: \$ _____

Other insurance:
(describe)

_____ \$ _____

Food: \$ _____

Medical Bills: \$ _____

Prescriptions: \$ _____

Childcare: \$ _____

Alimony/child support or maintenance: \$ _____

