SWIFT EAGLE CHARITABLE FOUNDATION

P.O. Box 1977 • Avon, Colorado 81620 • phone 970-845-7655 • 970-300-2652 • info@swifteagle.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
____________	____	________	____________	❑	❑	❑
____________	____	________	____________	❑	❑	❑
____________	____	________	____________	❑	❑	❑
____________	____	________	____________	❑	❑	❑
____________	____	________	____________	❑	❑	❑

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. ______________________________

____

____ (USE ADDITIONAL PAGES IF NECESSARY)

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:	$ ____________

WAIVER OF LEGAL RIGHTS

Release of Confidential Information

Applicant signature(s) at the bottom of this document constitute permission for Swift Eagle Charitable Foundation or any of its members to gather information deemed appropriate by the Foundation. This information includes, but is not limited to, financial, medical, employment, housing, public assistance, or any other information needed by the Fund for maintenance of its non-profit purposes.

The Applicant(s) allow Swift Eagle to contact any individuals or entities to verify the validity of any representations made by the applicant(s).

The signature(s) serve to release Swift Eagle from any subsequent liability for gathering information heretofore confidential.

Dated:_______________________

Applicant Signature: ____

Printed name: ____

Applicant Signature: ____

Printed name: ____

FOR OFFICE USE ONLY

DATE & NOTES____

____

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____

DECISION____

INITIALS	Y	N	DATE
________	❑	❑	________
________	❑	❑	________
________	❑	❑	________
________	❑	❑	________
________	❑	❑	________
________	❑	❑	________