SWIFT EAGLE CHARITABLE FOUNDATION

P.O. Box 1977 • Avon, Colorado 81620 • phone 970-401-4820 • 970-300-2652 • info@swifteagle.org

APPLICATION FOR ASSISTANCE

DATE: _____

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

Are you able to do the interview in English? ❏ YES ❏ NO

APPLICANT INFORMATION

NAME:_____ AGE:_____ DATE OF BIRTH: _____

PHYSICAL ADDRESS:_____ ❏ OWN ❏ RENT TYPE OF DWELLING: _____

MAILING ADDRESS:_____ YEARS AT CURRENT ADDRESS:_____

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

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED _____SEPARATED _____WIDOWED

LANDLORD'S NAME:_____ PHONE :_____ MAILING ADDRESS:_____

PLEASE LIST 3 NON-FAMILY CHARACTER REFERENCES THAT WE MAY CONTACT AND THEIR CONTACT INFORMATION:

1. _____ PHONE:_____

2. _____ PHONE: _____

3. _____ PHONE: _____

APPLICANT EMPLOYMENT INFORMATION

MOST RECENT EMPLOYER:_____ TYPE OF BUSINESS: _____

CONTACT PERSON:_____ PHONE:_____

POSITION HELD:_____ SALARY:_____ YEARS THERE: _____

PREVIOUS EMPLOYER:_____ YEARS THERE: _____

IF NECESSARY, MAY WE CONTACT YOUR CURRENT AND PREVIOUS EMPLOYERS? ❏ YES ❏ NO

SPOUSE EMPLOYMENT INFORMATION

MOST RECENT EMPLOYER:_____ TYPE OF BUSINESS: _____

CONTACT PERSON:_____ PHONE:_____

POSITION HELD:_____ SALARY:_____ YEARS THERE: _____

PREVIOUS EMPLOYER:_____ YEARS THERE: _____

IF NECESSARY, MAY WE CONTACT YOUR CURRENT AND PREVIOUS EMPLOYERS? ❏ YES ❏ NO

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

NAME	AGE	RELATIONSHIP	OCCUPATION
MENTED			
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

MEDICAL INSURANCE INFORMATION (if applicable)

DO YOU HAVE MEDICAL INSURANCE? _____YES _____NO   NAME OF INSURANCE CARRIER_____

DOES YOUR EMPLOYER OFFER MEDICAL INSURANCE? _____YES _____NO

IS THERE A PROBLEM WITH YOUR CURRENT POLICY, PLEASE EXPLAIN:_____

_____

_____

SPECIFIC ASSISTANCE REQUESTED

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

_____

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

HAVE YOU CONTACTED EAGLE COUNTY HEALTH & HUMAN SERVICES? _____970-328-8840

WHAT OTHER ORGANIZATIONS HAVE HELPED YOU? WHEN AND HOW MUCH WERE YOU GRANTED?_____

_____

_____

MAY WE CONTACT THESE ORGANIZATIONS FOR INFORMATION? ❏ YES ❏ NO   _____

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 IMMEDIATE STEPS CAN YOU TAKE TO IMPROVE YOUR FINANCIAL SITUATION? 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: $ _____	$
List Retirement accounts and amount in each:		
IRAs: $ _____	Loans against	
401K: $ _____	Retirement funds: $ _____	$
Pension: $ _____		
Other: $ _____		

GROSS MONTHLY INCOME

Salary of applicant: $ _____

Salary of spouse: $ _____

Social Security payments: $ _____

Portion of rent paid
  by others $ _____

Other household income:
  (describe)

_____ $ _____

_____ $ _____

_____ $ _____

Alimony/child support
  or maintenance: $ _____

MONTHLY EXPENSES

Mortgage or rent:

Homeowners' dues:

Medical Insurance: $_____

Other insurance:
  (describe)

_____ $_____

Food: $_____

Medical Bills: $_____

Prescriptions: $_____

Childcare: $_____

REQUESTED PAPERWORK

❑ Please include a copy of your lease

❑ Please include two months checking account bank statements

❑ Please include any other applicable bills for which you are requesting assistance

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: _____