NATIONAL PHILOPTOCHOS DEPARTMENT OF SOCIAL SERVICES

Please email, mail or fax this application to:

NATIONAL PHILOPTOCHOS • 126 EAST 37TH STREET • NEW YORK, NY 10016 Tel: 212.977.7770 • Confidential Tel: 212.977.7782

Email: socialwork@philoptochos.org

PLEASE ATTACH

CURRENT PHOTO OF APPLICANT

APPLICATION FOR ASSISTANCE

If you are seeking financial assistance, please review our policies and procedures on page 4.

DATE _____ **HOW DID YOU HEAR ABOUT US?** _____

NAME OF APPLICANT _____

ADDRESS _____ **APT** _____

_____ _____ _____

CITY/ STATE **ZIP CODE** **METROPOLIS**

HOME TEL: _____ **WORK:** _____ **CELL:** _____

EMAIL _____

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

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED **SPOUSE/ PARTNER'S DOB:** _____

NAME OF SPOUSE/ PARTNER: _____ **LIVES IN HOUSEHOLD:** ☐ YES ☐ NO

TYPE OF HOUSING: ☐ RENT ☐ OWN ☐ ROOMMATE ☐ OTHER **AMT. MORTGAGE/ RENT** PER MONTH

NAME/ ADDRESS LL: _____

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

_____ RELATIONSHIP _____

OTHERS IN THE 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 ☐ Permanent Resident/Green Card ☐Undocumented ☐Greek National ☐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: _____

_____

_____

PLEASE LIST HELP YOU HAVE RECEIVED OR CURRENTLY ARE RECEIVING FROM ANY OF THE FOLLOWING

☐ National Philoptochos	Help received	_____	Date(s)	_____
☐ Metropolis Philoptochos	Help received	_____	Date(s)	_____
☐ Local Philoptochos Chapter	Help received	_____	Date(s)	_____
☐ Other Church	Help received	_____	Date(s)	_____
☐ Social Service Agency	Help received	_____	Date(s)	_____
☐ Gov't./ Public Benefit(s)	Help received	_____	Date(s)	_____
☐ Other organization, family, friends	Help received	_____	Date(s)	_____

CONSENT FOR RELEASE OF INFORMATION: ☐ SIGNED ☐ MAILED ☐ VERBAL PERMISSION ☐ REFUSED

APPLICANTS HOUSEHOLD INCOME/ EMPLOYMENT INFORMATION:

Are You Currently Employed? ☐Yes ☐ No Name of Employer: _____

Dates Employed: (From)_____(To)_____ Type of Work You do: _____

Your Annual Income: _____ Can you submit recent pay stub or tax returns? ☐ Yes ☐ No

Are other in household currently working? ☐Yes ☐ No Their Monthly Income _____

TOTAL MONTHLY HOUSEHOLD INCOME AS OF DATE OF THIS APPLICATION: _____

If you are not currently employed: ☐Temp Layoff ☐ Permanent Layoff ☐ Seeking Employment

Have you filed for Unemployment Insurance Benefits (UIB)? ☐Yes ☐ No ☐ Not Eligible

If receiving UIB, amount of your weekly Benefit _____ Date UIB Ends _____

Are you receiving any other benefit? (Disability/Sick Leave/Other) ☐Yes ☐ No _____

Are you or any member of your immediate family suffering from stress/ depression or anxiety because of your current situation? ☐Yes ☐ No

If yes, would you like a referral to a mental health counselor? ☐Yes ☐ No ☐ Not Sure

IF APPLICANT IS SEEKING FINANCIAL ASSISTANCE FOR HEALTH/ HEALTHCARE RELATED COSTS PLEASE COMPLETE THIS SECTION:

NOTE: THE CONSENT FOR RELEASE OF INFORMATION MUST BE SIGNED

Name of Patient _____ **Date of birth** _____

Primary Diagnosis/ Disability, etc. _____

Primary Medical Provider (s):

Hospital _____

Doctor _____

Clinic/ Other _____

Is the patient covered by health insurance? ☐Yes ☐ No

Insurance Company: _____ Name of Policy Holder: _____

Amount of Current Unpaid Bills _____

Other Relevant Health Information _____

_____

For Greek Nationals

If Applicant is a Greek National, is s/he covered by Greek Health Insurance? ☐Yes ☐ No

If Yes, Name of Greek Insurance _____

What will the Greek Health Insurance cover in the United States? _____

TO BE COMPLETED BY ALL APPLICANTS

PUBLIC BENEFITS/ GOVERNMENT ENTITLEMENTS/ OTHER INCOME:

	NAME/RECIPIENT	AMOUNT/PERIOD
Public Assistance / TANF		
SNAP (Food Stamps) / WIC		
Supplemental Security Income (SSI)		
Social Security: Pension/ Retirement / Survivor Benefits		
Social Security: Dependent Benefits (for minor children)		
Social Security: Disability Benefits (SSD)		
Other Disability Benefits: State Disability/Emp. Benefit/Private Ins.		
Workers Compensation (WCB)		
Unemployment Insurance (UIB)		
Veteran Benefits		
Union Benefits _____		
Housing Subsidy: Section 8; Other _____		
HEAP / Utility Discount Program		
Medicaid/ACA Marketplace / Hospital Charity Care		
Medicare (Part ☐A ☐B ☐D)		
Private Health Insurance Coverage		
Child Support / Alimony		
Contributions from family / friends		
Other: _____		
Other: _____		

HOUSEHOLD EXPENSES (ALL):

ITEM	MONTHLY AMOUNT	PAID TO
Housing *(Rent/Mortgage)*		
Real Estate / Other Taxes		
Utilities *(Gas / Electric / Water / etc..)*		
Heat / Hot Water / Oil		
Telephone/Internet/Cell		
Food / Other *(e.g. Diapers)*		
Transportation / Auto Ins.		
Health Insurance Premiums / COBRA		
Life Insurance		
Child Support/Alimony		
Loans (Student / Other)		
Credit Card(s) Balances		
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 provided 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.*

- **Please describe specific help being requested from Philoptochos:**

_____

_____

_____

_____

- **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?**

_____

_____

_____

- **As 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***