NATIONAL PHILOPTOCHOS • DEPARTMENT OF SOCIAL WORK
Please email, mail or fax this application to:
NATIONAL PHILOPTOCHOS • 126 EAST 37TH STREET • NEW YORK, NY 10016
Main # 212.977.7770 • Confidential Social Work # 212.977.7782 • Fax 212.977.7784
Email: socialwork@philoptochos.org

PLEASE ATTACH CURRENT PHOTO

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**

TEL: HOME (_____) _____ WORK: (_____) _____ CELL: (_____)_____
EMAIL

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

NAME SPOUSE/PARTNER **LIVES IN** **SPOUSE/PARTNER'S**
MARITAL STATUS: _____ _____ **HOUSEHOLD** ___Y ___N **DOB:** _____

TYPE OF HOUSING **AMT. MORTGAGE**
*(Rent/Own/Roommate/Other*_____ **OR RENT**_____/**PER MONTH**

NAME / ADDRESS LL: _____

IF CLIENT IS UNDER 21, NAME OF CUSTODIAL PARENT OR GUARDIAN:
_____ **RELATIONSHIP**_____

OTHERS IN 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 **PERMANENT RESIDENT**
STATUS: ____**US CITIZEN** ____ / **GREEN CARD** ___ **UNDOCUMENTED** ___ **GREEK NAT'L.** _____**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 _____ TYPE / AMT. OF HELP RECEIVED_____ DATE(S)_____
METROPOLIS PHILOPTOCHOS _____ TYPE / AMT. OF HELP RECEIVED_____ DATE(S)_____
PHILOPTOCHOS CHAPTER_____ TYPE / AMT. OF HELP RECEIVED_____ DATE(S)_____
OTHER CHURCH _____ TYPE / AMT. OF HELP RECEIVED_____ DATE(S)_____
SOCIAL SERVICE AGENCY _____ TYPE / AMT. OF HELP RECEIVED_____ DATE(S)_____
GOV'T. / PUBLIC BENEFIT(S) _____ TYPE / AMT. OF HELP RECEIVED_____ DATE(S)_____
OTHER _____ TYPE / AMT. OF HELP RECEIVED_____ DATE(S)_____
OTHER _____ TYPE / AMT. OF HELP RECEIVED_____ DATE(S)_____

CONSENT FOR RELEASE OF INFORMATION: ____**SIGNED** ____**MAILED** ____**VERBAL PERMISSION** ____**REFUSED**

TO BE COMPLETED BY ALL APPLICANTS:
HOUSEHOLD INCOME / EMPLOYMENT INFORMATION:

IS APPLICANT CURRENTLY EMPLOYED? ___Y ___N IF YES, EMPLOYED BY: _____

DATES EMPLOYED: (FROM) _____ (TO)_____ IF NO LONGER EMPLOYED STATE REASON: _____

APPLICANT'S INCOME: _____ IS THIS AMOUNT: __ANNUAL __MONTHLY __WEEKLY

WAS INCOME TAX RETURN FILED LAST YEAR? _____Y _____N CAN YOU SEND US A COPY? ____Y ____N

SAVINGS / OTHER ASSETS: _____

OTHERS IN HOUSEHOLD WITH INCOME FROM ANY SOURCE:

NAME	*MONTHLY INCOME*	*AMOUNT CONTRIBUTED TO HOUSEHOLD*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL MONTHLY HOUSEHOLD INCOME: (ALL IN HOUSEHOLD) _____

IF APPLICANT IS SEEKING FINANCIAL ASSISTANCE FOR HEALTH / HEALTH CARE 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

NAME OF INSURANCE COMPANY: _____

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? _____
_____

NAME OF APPLICANT_____ **PAGE THREE / APPLICATION**

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 _____		

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***

(07.2019)