



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

- | | | | |
|--|---------------|-------|---------------|
| <input type="checkbox"/> National Philoptochos | Help received | _____ | Date(s) _____ |
| <input type="checkbox"/> Metropolis Philoptochos | Help received | _____ | Date(s) _____ |
| <input type="checkbox"/> Local Philoptochos Chapter | Help received | _____ | Date(s) _____ |
| <input type="checkbox"/> Other Church | Help received | _____ | Date(s) _____ |
| <input type="checkbox"/> Social Service Agency | Help received | _____ | Date(s) _____ |
| <input type="checkbox"/> Gov't./ Public Benefit(s) | Help received | _____ | Date(s) _____ |
| <input type="checkbox"/> 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)		
<u>Social Security:</u> Pension/ Retirement / Survivor Benefits		
<u>Social Security:</u> Dependent Benefits (for minor children)		
<u>Social Security:</u> Disability Benefits (SSD)		
<u>Other Disability Benefits:</u> 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 <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D)		
Private Health Insurance Coverage		
Child Support / Alimony		
Contributions from family / friends		
Other: _____		
Other: _____		

HOUSEHOLD EXPENSES (ALL):

ITEM	MONTHLY AMOUNT	PAID TO
Housing (<i>Rent/Mortgage</i>)		
Real Estate / Other Taxes		
Utilities (<i>Gas / Electric / Water / etc.</i>)		
Heat / Hot Water / Oil		
Telephone/Internet/Cell		
Food / Other (<i>e.g. Diapers</i>)		
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