SONS OF CHARITY INC.

San Diego, California
CONFIDENTIAL

REQUEST FOR ASSISTANCE - APPLICATION

Instructions: Please PRINT OUT and complete the attached form and FAX or mail documents to the address listed below. ALL INFORMATION PROVIDED IS CONSIDERED CONFIDENTIAL AND FOR SOC, INC BOARD OF DIRECTORS REVIEW ONLY, to determine Grant eligibility.

APPLICANT INFORMATION

Name: ______________________________ DOB: __________

Last *First* *M.I.*

Current Address: ______________________________

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: __________________ Email (or Guardian email) __________________

Please consider sending a photograph of the Applicant with this application or by email to sonsofcharityinc@gmail.com with full name and date of birth. A media release will be provided to you, prior to publication of the Applicants image.

PRIMARY PARENT/GUARDIAN INFORMATION (If Applicant is Minor Child)

Name(s): ______________________________ DOB: __________

Last (Circle MOTHER-STEPMOTHER) *First* *M.I.*

______________________________ DOB: __________

Last (Circle FATHER-STEPFATHER) *First* *M.I.*

______________________________ DOB: __________

Last (Circle LEGAL GUARDIAN)) *First* *M.I.*

Phone: (Cell) __________________ Email __________________

Is address same as Applicant? YES ■ NO ■

If no, provide address: ______________________________

Marital Status of Parents/Guardians:

■ Married ■ Single ■ Divorced ■ Cohabitants ■ Widowed ■ Separated ■ Other __________

If divorced, who is the primary custodial guardian of the Applicant/child? __________________

Do guardians speak English? YES ■ NO ■ If no, primary language:

Other Children in the Household & their ages: ______________________________

Please note – consent of both parents and/or custodial guardian(s) is required to process this Application.

Assistance Requested

Please indicate which type(s) of assistance you may need. Please include a copy of bill(s) you request be paid on your behalf .

■ Mortgage ■ Rent ■ Utility Payment ■ Child Care ■ Health Insurance Premiums/COBRA

■ Car Expenses ■ Treatment Expenses/TravelCost ■ Other (Please explain)____

Please describe how this assistance will help your household: ____

____

____

HOUSEHOLD INCOME

Total annual Household income, all sources, NET: $____

Household income sources (check all that apply):

■ Wages ■ SSI ■ Child Support ■ TANF ■ CHARITABLE Gift ■ Other ____________________________________

Parent/Guardian's Employer (Name/Contact) ____

Is Parent/Guardian on unpaid leave?

YES ■ NO ■

Parent/Guardian's Employer (Name/Contact) ____

Is Parent/Guardian on unpaid leave?

YES ■ NO ■

How much has the household collected in monetary donations? ____

If you have an active donation site, please list URL here: ____

MEDICAL INFORMATION

Referring Hospital: ____

Social Worker/Advocate: ____

Diagnosis: ____

Stage or Grade: ______________________________ Date of Diagnosis: ____________________________________

# of relapses: ______________________________

Date(s) of relapse (mm/dd/yyyy) ____

INSURANCE INFORMATION

Does Applicant have
Medical Insurance?   YES ■ NO ■

If yes, please indicate what type of insurance (check all that apply):

■ Private ■ Medicaid ■ Medicare ■ Other

Does Applicant have catastrophic medical benefits or access to pledged medical benefits?

DOCUMENTS TO INCLUDE

1. **Letter from a doctor or hospital showing the Applicant's diagnosis;**
2. **Copies of the Household bill(s) requested to be paid, and how related to treatments, if applicable;**
3. **Family financial information – copy of most recent tax return; and**
4. **A personal statement of request for financial assistance, including information about how the cost of the bill(s) and other expenses related to the Applicant's treatment, will/does impact the Household, and it's current and future financial situation(s). (i.e. rent/mortgage, any relevant information about the Primary employment of caregiver and any Applicant sibling(s), any other Household material costs unrelated to treatment, etc.)**

****Please note this Application will not be processed until all documents are received. Thank You.***

FUNDING PROCEDURES

A Board member of Sons of Charity, Inc. will contact you by phone to verify the application has been received and when processed, to determine if you have been approved for a grant. Assistance is based on Household's eligibility for funds, and other need based criteria. You may apply for assistance one time per calendar year. To reapply, you must continue to meet the eligibility guidelines; and complete a new application for assistance.

Applicant's HOH (Head of household) will be required to complete a W-9 listing all Grant amounts received from SOC Inc. If you have any questions about completing this application, please email your inquiries to the address shown.

APPLICANT Signature______________________________ DATE:__________

For Minor Applicants:
PARENT Signature______________________________ DATE:__________

PARENT Signature______________________________ DATE:__________

If Applicable:
GUARDIAN Signature______________________________ DATE:__________

GUARDIAN Signature______________________________ DATE:__________

Return completed application via EMAIL: sonsofcharityinc@gmail.com

or FAX TO: 866-457-2540

or MAIL TO: SOC, Inc. 235 Middlebush Dr, San Diego, CA 92114

Sons of Charity Inc is a federally recognized 501c3
Charity, in the state of California.