The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 86
Chicopee, MA 01014

Emergency Financial Assistance (EmFAR) Application Form

Case Manager / Applicant Checklist

The following is a checklist to assist the Case Manager/Applicant with submitting a COMPLETE application for emergency financial assistance. Documentation of ALL HOUSEHOLD income and expenses is mandatory to support your request to The AIDS Foundation of Western Massachusetts (AFWM) EmFAR Committee. **All applications are due to the AFWM office by 12pm Friday in order to be considered for review the following Monday. Applications that are received after 12pm will be reviewed the following week.**

_____ Complete all pages included in the grant application that pertain to your request. **If applications are incomplete you will be notified by email, and the application will be withdrawn. It will then have to be resubmitted in its entirety with the information that was originally missing.**

_____ Include documentation of income (i.e., wages, SSI, SSDI, TAFDC, unemployment benefits, etc.) **for ALL members of the household**.

_____ Include copies of ALL documentation of expenses. (i.e., electric, gas and phone bills, car payments and all other receipts that support expenses listed on page 6 of application)

_____ Proof of Emergency Fuel Assistance (EFA) Denial if seeking money for fuel

_____ Proof of ownership such as registration or title when claiming expenses for vehicle

NOTE: Incomplete applications will be returned to the case manager if one is listed, or to the applicant if not.

I, _____, representing _____, understand that this application requires the above documentation, and I give the AFWM's Emergency Financial Assistance Review Committee permission to review this application as being complete.

Please send this checklist with the completed application. If you have questions or concerns, you can contact the AFWM office at (413) 592-5444 or fax at (413) 592-5440.

REMEMBER: Your PRINTED OR TYPED narrative tells your or your client's entire story. Please be clear and concise when explaining to the EmFAR Committee how your client came into this situation, what the nature of the emergency is, and what preventative steps are being taken to prevent a repeat of the emergency.

APPLICANT'S CONSENT TO RELEASE OF INFORMATION

I, _____ am applying for a grant from the AIDS Foundation of Western Massachusetts, Inc., and I recognize and understand that as a part of the EmFAR process, members of the Review Committee and the Board of Trustees of the AIDS Foundation of Western Massachusetts, Inc., will have access to information regarding my HIV Status.

I understand that my EmFAR application, which may include information about my HIV status, and I hereby expressly authorize the Review Committee of the AFWM and the Board of Trustees of the AIDS Foundation of Western Massachusetts, Inc., to discuss my HIV status on an as needed basis as it pertains to the grant review process.

I acknowledge that any assistance given to me by the AFWM is at the sole discretion and option of the AFWM and the dollar assistance levels and criteria for awards are subject to change without notice to me and are further subject to the availability of funds. I affirm that the information submitted in this application is true and submitted in good faith.

Applicant's Signature _____ Date _____

Applicant's Printed Name _____

POLICY CONCERNING MINOR APPLICANTS

The AIDS Foundation of Western Massachusetts, Inc. will process applications of people with HIV/AIDS regardless of age. If the applicant is a minor, the application must be submitted by the parent/guardian or legal representative for the child. If, in the sole discretion of the Review Committee, special circumstances exist, a child may be entitled to a one-time award of up to $500.00 during their minority. The child may apply on his/her own behalf, upon reaching age 18, for an additional lifetime award of up to $2,000.00 subject to the discretion of the Review Committee. The applicant must not have received assistance in the two-year period prior to reaching their majority. I acknowledge that any assistance given to any minor by the AFWM is at the sole discretion and option of the AFWM and the dollar assistance levels and criteria for awards are subject to change without notice to me and are further subject to the availability of funds. I affirm that the information submitted in this application on behalf of a minor is true and submitted in good faith.

Parent's (Legal Guardian or Representative) Signature _____

Parent's (Legal Guardian or Representative) PRINT _____ _____

Witness's Signature _____

Witness (PRINT) _____

ON THIS PART OF THE APPLICATION PLEASE WRITE VERY CLEARLY OR TYPE ON A SEPARATE SHEET OF PAPER

What is the nature of the Emergency that leads to the need for AFWM's assistance? Please explain what circumstances led to these financial difficulties. Please list any and all steps taken to prevent the recurrence of similar circumstances, if applicable. Narratives that do not address all three of these points will be considered incomplete. If you show a substantial amount of disposable income or overage in your monthly expenses, please provide an explanation here.

Please send copies of all bills that apply to your application. List all bills in the order of priority.

1. **Business or Payee**_____
   Address_____
   City_____State_____Zip_____
   Amount $_____

2. **Business or Payee**_____
   Address_____
   City_____State_____Zip_____
   Amount $_____

APPLICANT INFORMATION

Applicant Name: Last _____ First _____ Middle Initial _____

Sex (circle one) Male Female Transgender

Current Address: _____

Street Apt. # City Zip County

Mailing Address if different from above:

_____

Street Apt.# City Zip County

Email: _____

Home Phone ( ) _____-_____ Cell Phone ( ) _____-_____

Social Security # _____ - _____ - _____ Age _____ Date of Birth _____/ _____ / _____

Month Day Year

Case Manager Info.

Case Manager's Name (Print) _____ Title _____

Agency Name _____

Street _____Suite #_____

City _____ Zip Code _____ County _____

Work Phone _____ Work Fax _____

Work Email_____

Have you previously applied for assistance? Yes _____ No _____ if yes, date _____

If yes, was the application: Granted _____ Denied _____ Amount Requested _____

What was the reason for the request?

_____

Residence (check one): Own Home _____ **Rent (Subsidized) ____** **Rent (Non-subsidized) _____**

Homeless _____ Other (explain)_____

_____

_____

Household Information:

List all of the people who live in your home, starting with applicant and provide the following information.
If more than one person lives in the home, their income and expenses must be reflected on page 6.

1. Full Name: _____ Relationship: ___Self____ age: _____ SS# _____-___-_____
2. Full Name: _____ Relationship: _____ age: _____ SS# _____-___-_____
3. Full Name: _____ Relationship: _____ age: _____ SS# _____-___-_____
4. Full Name: _____ Relationship: _____ age: _____ SS# _____-___-_____
5. Full Name: _____ Relationship: _____ age: _____ SS# _____-___-_____

** If there are more than five people living in household please attach a separate sheet to application.

Total Number of persons with HIV in the household (including applicant) _____

Employment (check one): Full-Time _____ Part-Time _____ Unemployed _____

Employer (if applicable):

_____

Medical Coverage (check all that apply):

Medicaid _____ Medicare _____ HMO _____ VA _____ **HDAP _____**

Other (explain): _____

CURRENT MONTHLY INCOME AND EXPENDITURES OF APPLICANT*

(ALL INCOME AND EXPENSES REQUIRE SUPPORTED DOCUMENTATION)

INCOME:

Wages …… $_____

Housing Assistance…… $_____

Fuel Assistance…… $_____

Social Security Benefits:

Disability Benefits (Adult)…… $_____

Disability Benefits (Child)…… $_____

Supplemental Security Income (Adult)…… $_____

Supplemental Security Income (Child)…… $_____

Government Assistance:

Dept. of Transitional Assistance - SNAP Benefits (Food Stamps)..... $_____

Dept. of Transitional Assistance - Cash Assistance…… $_____

Unemployment Benefits…… $_____

Child Support…… $_____

Other Monthly Income (Specify)…… $_____

TOTAL MONTHLY HOUSEHOLD INCOME…….. $_____

EXPENDITURES:

Rent…… $_____

Utilities: **If utilities are included in the rent or phone lines are free, please make a note to this effect**

Electricity…… $_____

Gas…… $_____

Telephone (Landline)…… $_____

Telephone (Mobile)…… $_____

Cable…… $_____

Bundle Package (Phone, Cable, Internet)…… $_____

Food…… $_____

Clothing **(this includes only new clothing purchased every month)**…… $_____

Medical, Vision and Oral Health Services…… $_____

Transportation (not including car payments) …… $_____

Car Fuel…… $_____

Insurance:

Medicare …… $_____

Medicare Part D…… $_____

Health (Specify)…… $_____

Auto…… $_____

Other (Specify)…… $_____

Installment Payments: **(Credit cards, bill arrears, etc.)**

Auto…… $_____

Other (Specify)…… $_____

Hygiene Products (Specify)…… $_____

Household Products (Specify)…… $_____

Other (Specify)…… $_____

TOTAL MONTHLY EXPENSES…… $_____

TOTAL MONTHLY DISPOSABLE INCOME +/-…….. $_____

Please take a moment to double check your math.

Section A*

TENANCY VERIFICATION

Date_____

This letter confirms that _____has arranged to rent an apartment from me at the following address**:**

Address_____**Apt.#**_____
City_____**State**_____**Zip**_____

This tenancy will begin on: **Date**_____

Amount required to move in: **First Month's Rent**** **$**_____

Last Month's Rent **$**_____

Property Manager's Signature_____
**** If applicable please attach documentation of lease agreement and paid receipts.**

Section B*

OWNER'S AGREEMENT NOT TO EVICT

Date_____

I, _____, owner of the unit at_____,
Which is currently occupied, by _____, certify that the tenant owes $_____in back rent to date. I agree to accept **$_____(maximum of $500)** from your agency, which will be applied towards this tenant's back rent.

By accepting these funds, I agree that I will not commence eviction proceedings against this tenant based upon back rent or use and occupancy fee I claim is owed to this date; or, if there are eviction proceedings in process I agree to dismiss any such proceedings already in process.

Property Manager's Signature_____

Property Manager (Please Print)_____
Address_____
City _____State_____Zip_____
*Both Section A and Section B may need not apply; please complete Section B if applicable.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient (Last –First-M.I.)_____

Street _____Apt. #_____

City_____State_____Zip_____D.O.B._____

I give consent to _____(Name of Physician) to release information from the medical record regarding my HIV status and condition maintained while a patient in your care to:

The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 30092
Springfield, MA 01103

I understand that this consent is subject to revocation at any time unless action based on this release has already been taken. I understand that further disclosure of the information to be released may not be made without my written consent or as otherwise restricted by federal regulations. This authorization is valid for 90 days after the date it is signed. A photo static copy is as valid as an original.

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Patient's Signature_____Date_____

Witness's Signature_____Date_____

Patient's (Last – First – M.I.)_____:

Has applied for a grant from The AIDS Foundation of Western Massachusetts, Inc. To assist the Patient/Client we need documentation from you verifying his/her HIV seropositivity and confirmation that the Patient/Client would be classified as having HIV/AIDS.

Date tested HIV positive_____
CD4 Count_____Date_____
Physician's Signature_____
Physician (Please Print)_____
Board Certification Number_____Date_____

Above you will find consent for release of information authorizing you to share this information with The AIDS Foundation of Western Massachusetts, Inc.