

FLOOR COVERING INDUSTRY FOUNDATION FINANCIAL ASSISTANCE PROGRAM

Assisting Those in Our Industry Most in Need

Assistance Application

Please print or type all information. Any missing information will delay processing.

All information contained herein is strictly confidential, accessible only to the Floor Covering Industry Foundation leadership and assigned staff persons. **All documents submitted become the property of the FCIF.**

Eligibility standards are set by the Floor Covering Industry Foundation's Board of Directors. The FCIF Distribution Committee periodically reviews application summaries to decide each case, based on its own merit. It is our goal to assist all qualified applicants within the Foundation's funding limitations.

Should you have any questions regarding this application or the assistance program, please contact Foundation staff at 714.634.0302.

INFORMATION ABOUT THE APPLICANT

Applicant's Name _____

Address _____

City _____ State _____ Zip _____

Daytime Telephone _____ Evening Telephone _____

E-mail _____

Date of Birth _____ Social Security Number _____

Marital Status Single Married Widowed. If married, does your spouse work? Yes No

Spouse/Partner's Name _____

Please list the names, relationship to you, and ages of all your dependents:

Number of years employed in the floor covering industry? _____ years

Please provide company name, address, telephone number and name of HR representative.

Provide a brief description of primary duties while employed in the floor covering industry:

How did you learn of the Floor Covering Industry Foundation? _____

PATIENT STATEMENT OF NEED

To be completed by applicant, spouse, parent, or legal guardian. Describe in detail the need for which you are requesting a grant.

HEALTH PROFESSIONAL REVIEW

The applicant (1) may ask his or her diagnosing physician or primary medical provider to submit a statement outlining the applicant's medical condition and the necessary medical treatment(s), OR (2) may ask his or her diagnosing physician or primary medical provider to complete this portion of the application.

Physician's Name _____

Medical Field/Specialty _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

E-mail _____

Applicant's (patient's) name _____

Please describe the applicant's medical condition and the necessary medical treatment(s). Attach a separate sheet if necessary.

Physician's Signature _____ Date _____

MEDICAL BENEFITS REVIEW

1. Does the applicant have health insurance benefits? Yes No *If yes, list provider(s) and policy number(s).*

2. Does the applicant's spouse/partner have health insurance benefits? Yes No
If yes, is the applicant covered under the spouse/partner's plan(s)? Yes No *If yes, list provider(s) and policy number(s).*

3. Medicare benefits? Yes No *If yes, describe below.*

4. Other insurance? Yes No *If yes, describe below.*

5. Other supplemental insurance? Yes No *If yes, describe below.*

6. Have you applied for assistance from any other agency (governmental or private), union or foundation? Yes No
If yes, please list organization(s) and amount(s) requested, received, or pledged.

APPLICANT FINANCIAL INFORMATION

Please provide **MONTHLY** income and expense information for the applicant's household. **Please provide documentation for all items listed in Income and Expenses columns. Please provide copy of latest income tax return (including ALL applicable schedules).**

INCOME

Salary	\$
Retirement Income	
Social Security Income	
Social Security Disability	
SSI (Supplementary Sec.)	
State Disability	
Workers' Compensation	
Veteran's Benefits	
Spouse/Partner's Income	
Unemployment	
Residuals and Royalties	
General Relief	
Food Stamps	
Alimony	
Union Pension(s)	
Child Support	
Other Income: (Please list source)	\$

Relief Fund Grant(s): (Please list source)	\$

Bank Account Balances:	
Checking	\$
Savings	
Other	
Assets: (e.g., CD, IRA, stock, life ins., etc.)	\$

TOTAL INCOME	

EXPENSES

Mortgage	\$
Rent	
Home Insurance	
Maintenance/Homeowners fees	
Food	
Utilities:	
Gas	
Water	
Electric	
Telephone/Fax	
Cellular Telephone	
Pager	
Cable	
Transportation:	
Car Payment/Registration	
Car Insurance	
Gasoline/Repairs	
Public transit	
Medical:	
Health Insurance	
Medical Bills (e.g., doctor's visits, hospital stays/procedures, etc.)	
Prescriptions	
Dental Bills	
Vision Services	
Miscellaneous Expenses:	
Clothing (inc. dependents)	
Life Insurance	
Union Dues	
Credit Cards: (name and full balance)	\$

TOTAL EXPENSES	

FCIF ASSISTANCE INFORMATION REQUEST

Prior to this application, have you ever applied for FCIF assistance? Yes No

If yes, did you receive financial assistance from FCIF? Yes No

If yes, please specify the details of the financial assistance you received from the Foundation.

GRANT REQUEST

Total Amount Requested* \$ _____

*If your application is approved, this request information will assist the Distribution Committee in determining the grant amount.

CERTIFICATION AND AUTHORIZATION (SIGNATURE REQUIRED)

I hereby certify that I have answered the questions in this application to the best of my ability without any limitations whatsoever; the facts stated herein are true and I understand that any misrepresentation or false information will disqualify me (the applicant) for any assistance from the Foundation. I further agree to notify the Floor Covering Industry Foundation of any change in my financial situation from the time of my application to the time a grant is made to me.

I understand that the Distribution Committee requires me to provide a copy of my most recent tax return (including ALL applicable schedules).

I guarantee that all monies received from the Foundation will be used for expenses incurred as a result of my (the applicant's) medical needs.

Signature of Applicant _____ Date _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION (SIGNATURE REQUIRED)

I, _____
(PRINT NAME)

hereby authorize the release of my medical information to the **Floor Covering Industry Foundation**, including but not limited to, any and all hospital, clinic, medical, treatment, therapy and rehabilitation records, as well as copies of any x-ray or any other diagnostic imaging files. This authorization also allows any authorized agent employed or otherwise hired by the **Floor Covering Industry Foundation**, to directly contact any of my prior or currently treating physicians, chiropractors, acupuncturists, or any other health care providers, vocational rehabilitation providers, or mental health care providers for the purpose of discussing my diagnoses, treatment, progress and prognoses.

The information obtained pursuant to this authorization, shall be used for the limited purpose of evaluating whether I qualify for certain benefits or gifts to be granted to me by the **Floor Covering Industry Foundation**.

A photocopy of this release as signed by me may be used in lieu of the original, and any such photocopy shall have the same validity as if it were the original. I understand that I will be provided with a copy of my executed release upon my request.

Signature _____ Date _____

Please mail this completed application and related materials to:

**Connie Buda, Executive Administrator
Floor Covering Industry Foundation
2211 E. Howell Avenue
Anaheim, CA 92806**