FLOOR COVERING INDUSTRY FOUNDATION

2018 APPLICATION FOR FINANCIAL ASSISTANCE
Helping Those in Our Industry Most in Need

We provide financial assistance to help with medical care, prescriptions, medical equipment, home repairs, shelter, food, utilities, and other basic needs for families who have a life-altering medical event.

GRANT ELIGIBILITY:

1. The applicant or immediate family member (spouse, children, or grandchildren living in the same household) must have derived primary income from employment in the floor covering business for at least five years. Eligible years do not have to be consecutive.

2. The applicant or immediate family member must be diagnosed by a practicing, certified physician as having a life-altering hardship such as catastrophic medical crisis, injury, or disability, or mental illness.

3. The household must be in extreme financial need. The household's liquid assets (cash, checking and savings accounts, money market accounts, stocks, certificates of deposit, bonds, and mutual funds) will be considered.

Applicant Name: Social Security Number:

Address: City: State: Zip:

Home Phone: Cell Phone:

E-Mail: Date of Birth:

I need translation services: ◯ Yes ◯ No If yes, what language?

Living Arrangements: ◯ Married ◯ Separated/Divorced ◯ Widowed ◯ Single ◯ Cohabitating

If married or cohabitating, please complete this section:

Spouse/Significant Other's Name: Social Security Number:

Employer: Phone: Date of Birth:

List the name, age, and relationship to you of all your household members:

How did you learn about the **Floor Covering Industry Foundation**?

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

GRANT INFORMATION

- 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.
- Each applicant must participate in an interview by a medical case manager, as certified by the Commission for Case Management.
- Eligibility standards are set by the Floor Covering Industry Foundation's Board of Directors. It is our goal to assist all qualified applicants within the Foundation's funding limitations. All decisions are final.
- All grant beneficiaries are required to provide ongoing medical and financial reports and documents as required by the Foundation as a condition of continued funding.
- In the event of the death of a recipient the Foundation must be notified either in writing (FCIF, 855 Abutment Rd, Ste. 2, Dalton, GA 30721) or by telephone (706-217-1183) within two weeks of the recipient's passing.
- In the event we find that funds have been misused, we would cease payments.

HOUSEHOLD INCOME: Sources of income can include (but is not limited to): wages, Social Security income, Social Security Disability/SSI, short or long-term disability, Workers' Compensation, veteran's benefits, unemployment, food stamps, alimony, pension(s), child support, etc. **Include documentation for each source of income along with application.**

	PERSON'S NAME RECEIVING	SOURCE OF INCOME	MONTHLY AMOUNT (AFTER TAX & DEDUCTIONS)
Applicant Income			
Spouse/Significant Other Income			
Other Household Members Income			

ONE-TIME INCOME: Complete this section if you have received one-time payments from other sources in the past six months such as: church donations, Go Fund Me online fundraising contributions, one-time back payment for disability, grants from other foundations or non-profits, gifts from family members, relief funds, etc.

SOURCE OF INCOME	PERSON RECEIVING	DATE RECEIVED	ONE-TIME AMOUNT

	PERSON'S NAME ON ACCOUNT	BANK/OTHER INSTITUTION	CURRENT BALANCE
Checking & Savings Accounts			
(Send the past two months statements for everyone in the household)			
Retirement Account(s)			
Other (stocks, property, investment, business ownership, etc.)			

HOUSEHOLD EXPENSES: Please submit documentation dated in the past 60 days for each expense.

TYPE	NAME OF COMPANY OWED	DATE ON BILL	MONTHLY AMOUNT
Rent/ Mortgage			
Home Insurance (if not escrowed)			
Property Tax (if not escrowed)			
Gas			
Water			
Electric			
Waste			
Telephone/Cellphone			
Internet			
Cable			
Car Payment			
Car Insurance			
Medical Insurance (if not payroll deducted)			
Prescriptions (monthly average)			
Dental / Vision Insurance			
Credit Cards: (list min. payment and total amount owed)			
Repairs (house, car, etc.): attach a quote of costs			
Loans			
Medical Bills (list individually)			
(Attach additional sheets if needed)			
Other			

EMPLOYMENT

Please list flooring jobs of all household members who have 5 or more years service to the floor covering industry. The years of employment can be from more than one company.

Job #1

Employee Name: Social Security Number:

Company: Dates Employed:

Job Title(s):

City: State: Company Phone:

Job #2

Employee Name: Social Security Number:

Company: Dates Employed:

Job Title(s):

City: State: Company Phone:

Job #3

Employee Name: Social Security Number:

Company: Dates Employed:

Job Title(s):

City: State: Company Phone:

I hereby authorize the employers listed above to release information concerning my employment status:

▷ Signature: Date:

Please list the date ranges that your medical condition has kept you or your family member out of work. Please provide a doctor's note specifying your work limitations and the expected date your doctor will release you back to work.

MEDICAL RECORDS RELEASE

The **Floor Covering Industry Foundation** provides financial grants to individuals who have life-altering medical conditions, worked in the floor covering industry for 5 or more years, and financial need.

Household Member with Medical Needs: _____ SSN: _____

Physician's Name: _____ Medical Field/Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

(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, or any other health care providers, vocational rehabilitation providers, or mntal 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. The applicant may revoke the authorization for the release of medical information and terminate the financial assistance application by writing to the **Floor Covering Industry Foundation**, 855 Abutment Rd. Ste. 1, Dalton, GA 30721.

I authorize the **Floor Covering Industry Foundation** release of medical information (SIGNATURE REQUIRED)

▷ **APPLICANT SIGNATURE:** _____ Date: _____

GRANT REQUEST

Grants may be provided for emergency medical expenses, continuing healthcare expenses, or for basic necessities such as food, shelter, utilities, and prescriptions. Financial aid is based on individual need. Grants may be awarded on a one-time, specific procedure basis, and/or may be awarded as a monthly stipend for six months. After six months, you may reapply. Please describe in detail the need for which you are requesting a grant. We provide assistance for six months at a time. Please note if additional household members have medical needs. **Please describe your medical condition and your financial needs with which you are requesting assistance.**

One-time request for procedure, surgery, equipment, repairs, or past due housing & living expenses: $ _____

Requested housing, living, & medical expenses each month: $ _____

Do you have health insurance? ◯ Yes ◯ No Please provide a copy of the front and back of your insurance card.

Insurance Company: _____

DOCUMENTS TO INCLUDE WITH APPLICATION

Please provide income and expense information for each member living in the applicant's household. Please send statements that are no more than 60 days old.

- ☐ Medical records from the past six months for the applicant and any other household members who have a medical condition.
- ☐ A copy of the most recent tax return filed by everyone living in the household. If the member of the household who has worked for the floor covering industry is/was self-employed, please provide five years of tax returns that include a Schedule C (do not have to be consecutive years).
- ☐ Paycheck stubs from the past 60 days for each member of the household who is working. If a member of the household is over the age of 21 and not working, please provide a statement about why he or she is not working.
- ☐ If receiving payment from any of these, please provide a copy of the award letter: short-term or long-term disability, unemployment, Social Security, food stamps, etc. If denied, please provide a denial letter.
- ☐ Most recent checking and savings account statements (all pages, front and back). Include both joint bank statements and individual bank statements for all individuals in the household.
- ☐ All pages of 401(k) or retirement accounts.
- ☐ All pages of current rent/mortgage bill. If renting, please include a copy of the lease agreement.
- ☐ All pages of recent bills for utilities: gas, electric, water, waste, cellphone, telephone, cable, etc.
- ☐ All pages of current car payment(s), insurance(s), and registration(s).
- ☐ Most recent credit card statements (all pages, front and back).
- ☐ Copies of medical insurance cards (front and back) for all household members who have a serious medical condition.
- ☐ Current insurance bills – medical, vision, dental, or supplemental (no need to send if deducted on your paycheck).
- ☐ All outstanding medical bills. "Statement date" should be within past 60 days, even if "date of service" is older.
- ☐ A summary of the cost of prescriptions from the past 2 months. You can get this summary at your pharmacy.
- ☐ Quotes for any repairs that need to be done to your house, cars, etc.
- ☐ Copies of award/denial letters where you have applied for financial assistance through a hospital to help with your medical bills.

CERTIFICATION AND AUTHORIZATION:

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 guarantee that all monies received from the Foundation will be used for expenses as stated in the award letter. I also authorize the Foundation to be able to discuss my application with other non-profits or agencies that may be able to provide assistance to me.

The following people are authorized to communicate with the **Floor Covering Industry Foundation** about my application:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

▷ **SIGNATURE OF APPLICANT:** _____ Date: _____

Print Name of Applicant: _____

APPLICATIONS TAKE A MINIMUM OF 30 DAYS TO PROCESS ONCE ALL DOCUMENTATION IS RECEIVED.
PLEASE TRY TO SEND ALL THE PAPERWORK AT ONE TIME TO DECREASE PROCESSING TIME.

Completed application and documents can be sent to:

Floor Covering Industry Foundation • 855 Abutment Rd. Ste. 2, Dalton, Ga 30721

FAX: 706-217-1165 • Scan and Email: info@fcif.org • Questions? Call 706.217.1183

Print