The CARE Fund

APPLICATION FOR GRANT

Date_____

Name_____ Phone (all)_____

Address_____

City_____ State_____ Zip_____

Email_____ Fax_____ Date of Birth_____

Domicile_____ File#_____ SW Seniority Date_____ Co Seniority Date_____

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Domestic Partnership_____
Common-law_____ Roommate_____
If you are involved in a domestic-partnership, do you have an affidavit on file with UAL? Yes_____ No_____
Number of Dependents_____ Names and Ages of Dependents_____

_____

Brief description of illness or circumstance necessitating financial assistance: _____

_____

_____ Work Related? Yes_____ No_____

Health Insurance: BC/BS_____ (name)_____ Other (name)_____

If unable to work, last day worked?_____ If known, an approximate return date_____

Have you or are you applying for other assistance/grants? (e.g., CAUSE™, UAL Employee Relief Fund, Pegasus™, church, insurance, etc.) Yes___ No___ If yes, name and results_____

Have you applied for Disability Benefits?_____ If yes, results_____

Do you plan to transfer to another domicile within the next three (3) months? Yes_____ No_____

Have you or a household member previously applied for a CARE Fund grant? Yes____No_____ Date_____

Have you declared bankruptcy in the past 24 months? _____ **Grant Amount Requested:** $_____

I, the undersigned, certify that all of the statements and representation within this application constitute a true and accurate account of my illness/circumstance and financial condition as of the date below. I have attached, in support of this application, requested documentation. Fraudulent use of *CARE* Funds will cause of forfeiture of all future benefits and may result in criminal and/or civil litigation and prosecution. Additionally, *The CARE Fund* will investigate all possible avenues of recouping monies obtained under false pretenses.

I, the undersigned, on my behalf or as guardian of another, authorize *The CARE Fund* to release information to its Review and Oversight Committee, and AFA Officers as necessary with regard to my grant application. I give the above authorization with the recognition of my privacy rights under the Health Insurance Portability and Accountability Act and the Final Rule promulgated under HIPAA, 45CFR Parts 160 and 164.

_____ _____

Applicant's Signature Date