Vail Valley Charitable Fund
Application for Assistance

The Vail Valley Charitable Fund (VVCF) provides assistance to individuals who live or work in the Vail Valley who are experiencing a financial hardship due to a medical crisis or a long-term illness that impacts the individual's ability to provide support for himself or his family.

- **To apply for a direct aid grant, applicants must: 1) be a *U.S. Citizen* or *Documented Resident* of the U.S.; 2) have lived and/or worked in the Vail Valley for a period of *at least one year*; 3) *currently* live and/or work full-time in the Vail Valley; and 4) document that hardship is due directly to a medical crisis or long-term illness.**

- Priority is given to individuals with catastrophic health care conditions, long-time locals, those who have taken initial steps to address their financial crisis, and those who have been involved in their community.

- Applicants should be 18 years of age or older. If a financial crisis is due to the illness or injury of a child, the "applicant" is the child's parent or legal guardian.

- Grant funds may not be used for funerals, burial expenses, or elective procedures.

- The VVCF's maximum direct aid grant is $5,000.

- The VVCF may fund all, part, or none of your request.

- The VVCF may, at its sole discretion, choose to pay applicant expenses directly.

- The VVCF provides one-time assistance only. Only in rare circumstances are exceptions made. If you have received a grant from the VVCF in the past, please contact us before submitting another application.

- Applications are reviewed by the VVCF Board of Directors monthly. This review typically (though not always) occurs on the first Thursday of each month.

- Applications are due the last day of the prior month for consideration. (i.e. Submit application by December 31st for review in January.)

- Please include physician documentation, paystubs, and relevant bills with application.

- ***Complete the entire application. If a question is not applicable to the applicant's situation, please write "n/a" in the space provided. Do not leave it blank. Incomplete applications will not be considered.***

Applicant Information

Today's Date: _____

Applicant Name: _____ Applicant Date of Birth: _____

MAILING Address: _____

Physical Address (If Different): _____

Number of Years You've Lived in Eagle County: _____

Home Phone Number: _____ Alternate Phone Number: _____

Email Address: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Residency Status: U.S. Citizen _____ Documented Resident _____ Undocumented _____

If you are a documented resident, please provide a photocopy of your residency documentation. Also specify the type of visa that you have and its expiration date: _____

If this application is being completed by someone other than the applicant, please provide that individual's name, mailing address, phone number, and relationship to the applicant: _____

_____

_____

Dollar Amount Requested* (A specific request must be listed.): $ _____

Describe what grant funds will be used for. Please be specific. _____

_____

_____

Employment Information

Are you currently employed? P/T _____ F/T _____ Seasonal _____ Unemployed _____

Employer: _____ Type of Business: _____

Position Held: _____ Years There: _____

Supervisor: _____ Contact Phone: _____

Previous Employer: _____ Years There: _____

If your condition has required a reduction in hours, describe. (Should be substantiated in physician note.)

If unemployed, how long have you been unemployed? _____

Is your unemployment health related? (Should be substantiated in physician note.) Yes ____ No ____

When can you return to work? (Should be substantiated in physician note.) _____

Is your spouse currently employed? P/T ____ F/T ____ Seasonal ____ Unemployed ____

Spouse's Employer: _____ Type of Business: _____

Position Held: _____ Years There: _____

Supervisor: _____ Contact Phone: _____

Previous Employer: _____ Years There: _____

If your current health condition has required a reduction in your *spouse's hours*, please describe.

Health Insurance Information

Do you have health insurance? Yes _____ No _____ Name of Carrier: _____

If employed, does your employer offer health insurance? Yes _____ No _____

If unemployed, are you/were you eligible for COBRA? Yes _____ No _____

If you have employer-sponsored or private insurance, what is your annual deductible? $_____

If you have employer-sponsored or private insurance, what is your annual max out-of-pocket? $_____

If you do not have medical insurance, or there is a limitation to it, please explain. _____

ASSETS & INCOME		DEBTS & EXPENSES		
			Balance	Pymt/Month
Cash in Bank	$	Credit Card Balance	$	$
Value - Stocks/Bonds	$	Stock Loans	$	$
Cash Value Life Insurance	$	Life Insurance Loan	$	$
Real Estate	Value	Retirement Loans	$	$
Primary Residence	$	Mortgage Balance	$	$
Other Residence	$	Mortgage Balance	$	$
Rental Property	$	Mortgage Balance	$	$
Land/Other	$	Mortgage Balance	$	$
Motor Vehicles (Yr/Make)	Value	Home Equity Loan		
	$	Vehicle Loan/Lease	$	$
	$	Vehicle Loan/Lease	$	$
	$	Vehicle Loan/Lease	$	$
	$	Vehicle Loan/Lease	$	$
Retirement Savings		Other Debts (Describe)		
IRAs	$		$	$
401K	$		$	$
Pension	$		$	$
Other	$		$	$
Other Assets (Describe)		Rent/Month		$
	$	Homeowner's Dues/Month		$
	$	Utilities/Month		$
	$	Food/Month		$
		Pymt/Month – Medical Bills		$
Gross Salary/Mo. Applicant*	$	Prescriptions/Month		$
Gross Salary/Mo. Spouse*	$	Childcare Costs/Month		$
Mo. Salary of Others in Home	$	Alimony *Paid*/Month		$
Income from Tips/Bonuses	$	Child Support *Paid*/Month		$
Rental Income	$	Auto Insurance		$
Alimony/Child Support *Rec'd*	$	Homeowner/Renters Insurance		$
Other Income (Describe)		Other Expenses (Describe)		
	$			$
	$			$
	$			$

*Two months of paystubs or annual tax returns required for documentation.

Household Information (Please list the other individuals living in your home.)

Name	Age	Relationship	Occupation

Family Members at Other Addresses (List children/immediate family living outside your home.)

Name	Age	Relationship to Applicant	Occupation (If Applicable)

If you live with individuals who are not part of your immediate family, please describe whether, and how, you share monthly household living expenses. Are the monthly expenses you have listed above your personal share, or the household's total?

Medical Expenses

Even though a VVCF grant is at most $5,000, it is helpful for the VVCF Board to fully understand the extent of the medical debt that you are facing. Please specify the health care providers that you owe along with the portion of your medical bills that you are personally responsible for. Please include a photocopy of these bills with your application. (For example, you may be responsible for $500 of a $10,000 emergency room visit and $25 of a $300 office visit.) Please note, if the VVCF is paying medical bills for you directly, we often call the provider and attempt to arrange a discount. We need your formal permission to talk to the provider about your account. Your signature, below, grants us the permission to make that initial contact. Your provider may require additional consent.

Health Care Provider (i.e. Vail Valley Medical Center)	**Amount Owed by Applicant** (i.e. $1,000)

Living Expenses

If you are requesting help with routine living expenses such as rent, mortgage, utilities, COBRA payment, etc., it is helpful to the VVCF Board to know the amount of your monthly payment, as well as any relevant names, addresses, and account numbers that we might need in order to cover these bills. Please list them below.

Item	Pay To	Reference or Account #	Mailing Address

Involvement in Community: Please describe how you have been involved in your community.

Attempts to Address Financial Need

There are many ways that applicants can attempt to address their financial crisis before they contact the VVCF. Examples include contacting medical providers to request a discount or payment plan; contacting Eagle County Health & Human Services to determine whether you are eligible for Medicaid or CHP+, contacting the State of Colorado if your illness or injury might qualify you for disability insurance; pursuing insurance payouts if your injury is the result of an auto accident; ensuring worker's compensation paperwork is in place if you were injured at work; contacting your bank lender to discuss a line of credit on your home; selling an unused vehicle or second home/property; cashing in investments; taking in a roommate for rental income, or taking a loan out against a retirement or life insurance policy. Please describe in detail the efforts you have made to address your financial crisis:

Please ask your primary treating physician to complete this form. Your physician should verify your injury or diagnosis, required treatment, and prognosis. If your injury or illness prevents you from working, your physician should provide an *estimated date* at which you can return to work and in what capacity. If your physician has this information in an existing dictation or office note, he/she may submit that to us in lieu of this form. If your care was provided outside this region, a letter from a local physician who is familiar with your situation is acceptable.

Submit this form with your application. Or your provider may fax it to the VVCF at: 970.524.1480.

Patient/Applicant's Name: _____

Physician/Provider's Name: _____

Physician Comments: _____

Background Information

Please use the space below to describe the circumstances leading to your present situation. Include relevant dates, diagnoses, treatments, description of injuries, prognosis, etc. If your illness or injury has resulted in the loss of wages or employment, please describe. Also describe the impact that your illness or injury has had on your overall family income and ability to meet routine expenses. Please tell the VVCF how a grant from us will meet your needs. If your financial need surpasses the amount of funds the VVCF can allocate, please share with us your plan for addressing your remaining financial needs.

I, _____ affirm that the foregoing is true and accurate.
(Print Name)

By my signature, below, I give my permission for the Vail Valley Charitable Fund, Inc. (VVCF) to contact my employer, persons with whom I may have accounts, my medical providers, and the accounting departments of my medical providers. I understand that, on my behalf, the VVCF may try to arrange discounts and/or payment plans. I further understand that the VVCF is not providing legal, tax, or accounting advice or services for me and will assume no legal responsibility or obligation for any of my affairs, liabilities, or accounts. I also authorize the VVCF to use my name for promotional purposes should I receive assistance from the VVCF.

_____ _____
Signature Date

Please return completed application form and all requested attachments to:

Michelle Maloney, Executive Director
Vail Valley Charitable Fund
PO Box 2307
Edwards, CO 81632
Ph: 970.524-1480 Fx: 970.524-1489
www.vvcf.org info@vvcf.org