

Applicant Name: \_\_\_\_\_

**Vail Valley Charitable Fund, Inc.  
Application for Expanded Assistance**

If you are completing this application, the following criteria must apply:

1. You have completed the VVCF's Application for Assistance.
2. You are undergoing treatment for and/or recovering from a medical crisis or long-term illness.
3. You can reasonably itemize the upcoming expenses you will face during treatment/recovery.
4. You estimate that you will need in excess of the VVCF's maximum direct aid grant of \$5,000.
5. You would like to apply for Expanded Assistance from the VVCF.
6. You have reviewed Community-Based Fundraising Overview and Community-Based Fundraising FAQ.
7. Your friends, colleagues, or relatives wish to work with the VVCF on Community-Based Fundraising.

Estimated Duration of Treatment/Recovery: \_\_\_\_\_

Estimated Time out of Work (If Applicable): \_\_\_\_\_

Estimated\* Loss of Income/Wages (Please Explain): \$ \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Estimated\* Increase in Expenditures (Provide Detail):

• Deductible/s \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_

• Co-Payments \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_

• Out-of-Pocket Med Exp. \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_

• Transportation \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_

• Lodging \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_

• Child Care \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_

• Home Health Care \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_

• Other (Specify) \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*We understand that much of this information may be unknown to you at this time. You may of course provide updated information to the VVCF as unforeseen circumstances arise. Please attach additional pages if necessary.

