Gwendolyn And Joseph Straus Charitable Fund, Inc.

Request Form for Assistance

INFORMATION QUESTIONNAIRE:

I. General Information

Name of Applicant/Recipient: ____

Home Address: ____

(Street) (City)

____

(State or Provence) (Country) (Zip or Postal Code)

Telephone Number(s): ____

(Weekdays) (Nights/Weekends)

Name of Recipient (if not Applicant) / Recipient's Relationship to Applicant:

____

Diagnosis: ____

Name of Treating Doctor: ____

Primary Hospital: ____

Recipient's Employer: ____

Work Address: ____

(Street) (City)

____

(State or Provence) (Country) (Zip or Postal Code)

Recipient's Occupation/Title: ____

Recipient's relationship to any officers, trustees, or key employees of the Fund or substantial contributors to the Fund ____

Annual Gross Household Income Prior to Diagnosis:____

Annual Gross Household Income Following Diagnosis:____

Number of Dependents (excluding Recipient): _________; Ages of Dependents: ____________________________

If any amounts requested are covered by insurance, indicate reason that additional assistance is warranted:

____

____

REQUEST FOR GRANT [1]

Name of Recipient: ____

Amount of Grant Request: ____

What is your monthly mortgage or rental payment? ____________________________________

What is your monthly car payment? ____

What are your other monthly expenses (e.g. food, utilities, telephone)?

____

____

____

Are you requesting additional assistance (e.g. payments for medical care or counseling services, tuition assistance, temporary housing, etc.)? If so, please specify type and amount.

____

____

____

Date(s) When Grant Required: ____

Please indicate if any of the above amounts are reimbursable by insurance, to the extent you have this information:

____

____

Note: If any of the assistance requested is for payment of third party invoice(s) received by Recipient, please attach a copy of the invoice(s).

Date: ______________________

II. Additional Information – Complete Only if Long-Term Assistance is Requested*

1 These questions are intended to serve as an example and may be modified as necessary.

** Please provide the additional information indicated in this Part II if the assistance requested consists of long-term assistance (such as long-term health care costs, long-term housing assistance, future college tuition expenses, etc.)*

Additional sources and amounts of assistance expected to be received by Recipient in connection with disaster (including insurance proceeds and assistance from other disaster assistance organizations):

____

____

Value of Liquid Assets Owned by Recipient(s):

Bank Accounts: ____

Other: ____

____

____

____

____

____

____

I certify that the information provided in this application is true and accurate.

__________________________________ ________________________________

Printed Name Signature

Date:

Please submit the completed application along with a copy of your most recent tax return to Ben Grannick at bgrannick@care-one.com.