CARE FUND

We care for your home, while you care for your family

OUR MISSION:

To financially and resourcefully support Arizona families who endure financial hardship while experiencing extended illness or injury of their children. The Care Fund provides mortgage or rent support during a child's extended health crisis.

Housing Rent/Mortgage Assistance Application

Important Notes:

- Completed applications & supporting documents are accepted by email (info@thecarefund.org), fax (480.223.6311), mail or via on-line submission (www.thecarefund.org/we-care/apply).
- All information provided is subject to review and verification.
- A Medical Verification Form must be completed and provided by your social worker or child's physician before a submitted application will be considered and can be sent in as listed above.
- For questions, please contact the Care Fund office by phone (480.305.8607) or by email (info@thecarefund.org).
- For approved applicants, Care Fund does not expect repayment in any form.
- Payment for approved applications will be submitted directly to the mortgage lender or the landlord/lessor.

Care Fund Contact Information:

- *Address*: 16427 N. Scottsdale Road, Suite 145, Scottsdale, AZ 85254
- *Phone*: 480.305.8607
- *Fax*: 480.223.6311
- *Web*: www.thecarefund.org
- *Facebook*: www.facebook.com/CareFundOrg



FAMILY & MEDICAL INFORMATION

Child's Name*: _____ **Child's Birth Date*:** _____
(effected by illness or injury)

Names & ages of all other individuals living in your home.* Please include adults and children.

We are residents in the State of Arizona*: ☐ Yes ☐ No

Do you have pets in your home? How many? Cats_____ Dogs_____
Other_____

Family Information: Care Fund would like to know more about you and your family! Please utilize this section to tell us more about each member of your family; include interests, hobbies, accolades, awards and activities. If you'd like to attach photos or memorable moments captured on video, please feel free to include those when submitting your application.

Child's Medical Situation*: Please write a description of your child's medical situation to include:

1. Type of illness or injury 2. Diagnoses 3. Length of hospitalization 4. Type of treatment
5. Number of surgeries 6. Other supporting medical information.

Please remember that a medical verification is required to successfully complete your application. Your child's medical care provider or the hospital social worker must complete and submit.

Please provide the dates of your child's hospitalization, home care and/or treatment(s)*:

Child has had *(check all that apply)*:

☐ Inpatient hospital care ☐ Rehabilitation ☐ Hospice Care
☐ Full time home care ☐ Extended Treatment

Doctor's Name*:

Doctor's Office or Hospital*:

Doctor's Email:

Doctor's Phone Number:

Insurance or medical coverage *:

PERSONAL INFORMATION

Parent/Guardian*#1

Name*

Date of Birth*

Social Security Number*

Email Address*

Phone Number*

Home Address:

Length of time at this address*

Second address (*if less than 2 years at current address*):

Parent/Guardian #2

Name:

Date of Birth

Social Security Number

Email Address:

Phone Number

Home Address*

Length of time at this address:

Second address (*if less than 2 years at current address*):

Is this the same address that the ill/injured child resides at?*

☐ Yes ☐ No

I am the child's*:

☐ Parent ☐ Legal Guardian (must provide legal documentation)

☐ Grandparent ☐ Court Ordered Custodian (must provide legal documentation)

Primary Language*:

☐ English

☐ Spanish

☐ Other: _____

Primary Language*:

☐ English

☐ Spanish

☐ Other:_____

How would you classify yourself?*:

- ☐ African American/Black
- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Caucasian/White
- ☐ Hispanic/Latino
- ☐ Multi-ethnic
- ☐ Other:_____

☐ **Veteran** ☐ Active ☐ Retired

How would you classify yourself?*:

- ☐ African American/Black
- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Caucasian/White
- ☐ Hispanic/Latino
- ☐ Multi-ethnic
- ☐ Other:_____

☐ **Veteran** ☐ Active ☐ Retired

ADDITIONAL PERSONAL INFORMATION

Marital Status of Parents/Guardians*:

☐ Single ☐ Married ☐ Divorced

If parents are divorced or separated, who has custody of the child?

Have you previously received housing assistance from the Care Fund or any other donation site or source (for example, GoFundMe)? If YES, when, from whom and how much?

Please tell us how you heard about the Care Fund, or indicate who referred you to us*:

EMPLOYMENT & INCOME INFORMATION

Parent/Guardian #1

Are you currently employed fulltime?

☐ Yes ☐ No ☐ Part-time only

Employer Name and Address* – most current

Business Phone Number*

Parent/Guardian #2

Are you currently employed fulltime?

☐ Yes ☐ No ☐ Part-time only

Employer Name and Address* – most current

Business Phone Number

Position/Title*

Length of time on this job*

Years employed in this line of work*

Gross Monthly Income*

Total of Add'l Overtime, Bonus or Commission

Position/Title

Length of time on this job

Years employed in this line of work

Gross Monthly Income

Total of Add'l Overtime, Bonus or Commission

Please provide a copy of your **current or most recent 2 pay stubs** for anyone working in the home over 18.

Are you currently on unpaid leave?*

☐ Yes ☐ No

If yes, leave start date? _____

Are you currently on unpaid leave?*

☐ Yes ☐ No

If Yes, leave start date?_____

If employed in current or most recent position for less than 2 years or if currently employed in more than one position, please complete the following:

Employer Name and Address* – previous/2nd

Business Phone Number

Employer Name and Address* – previous/2nd

Business Phone Number

ADDITIONAL SOURCES OF HOUSEHOLD INCOME

Please indicate the amount of monthly additional income received below:

Social Security/Social Security Disability

Child Support/Alimony

Foster Care

Pension/Retirement

Food Stamps

Unemployment/Workers Compensation

Other Public Assistance

Grants

Other Non-Profit Organizations *(name and amount received)*

Other

HOUSEHOLD OBLIGATIONS & LIABILITIES

Please list the monthly payment for all household obligations and liabilities below:

Mortgage Payment

Rent Payment

Car Payment/Payments

Car Insurance

Gas/Fuel

Groceries

Cable/Internet/Phone

Cell Phone(s)

Health Insurance

Medication/Prescriptions

Medical Co-Pays

Dental/Vision

Other Out-of-Pocket Medical Expenses

Child Care

Child Support/Alimony

Student Loan(s)

Healthcare Related Travel

Credit Card Payments

Utilities (Power)

Utilities (Gas)

Utilities (Water/Sewer/Trash)

Other

Utilities and Auto Insurance Providers: *Please circle all that apply*

Utilities

APS SRP Southwest Gas TEP Cox CenturyLink Other _____

Insurance

State Farm Farmers Allstate American Family Ins Geico Travelers Progressive

Other _____

HOUSING EXPENSE INFORMATION

Please include a copy of your most recent mortgage statement, verifying your account number, property address and mortgage payment OR a copy of your current lease agreement and landlord contact information. **Please note that for approved applications, payment will be submitted directly to the mortgage lender or the landlord/lessor.*

Name of primary mortgage lender OR landlord/property manager/lessor*

Payment Address

Contact Name, Phone Number & Email Address (if available)

Monthly Payment Amount*

Account Number*(if applicable) **Name(s) on mortgage or lease**

For a second mortgage, please provide the same information below & attach a statement:

Are you current on your mortgage or rent payments?*

☐ YES ☐ No If no, how far behind are you?

Are your mortgage or rent payments automatically withdrawn from your bank account?

☐ YES ☐ No

HOUSING EXPENSE AUTHORIZATION

I/We hereby authorize the mortgage lender or landlord listed above to provide the status of my/our mortgage loan (loan number stated above) or my/our lease to the Care Fund or their designated representative. Signing below signifies my/our authorization. *

Please enter your name(s) as your electronic signature*:

Please enter today's date*:

ASSETS

Vehicle (Year/Make/Model)

Vehicle Value

Primary Residence Value

Bank Account Balance

Bank Account Balance

401k/Retirement Account Balance

Vehicle (Year/Make/Model)

Vehicle Value

Add'l Residence Value

Bank Account Balance

Bank Account Balance

Stocks/Bonds/CD's/Other

Change of Circumstance*: Please use this space to provide details regarding the financial hardship experienced by your family. Please make sure to describe your experienced loss of income or assets (due to unpaid leave from work, decreased work hours, loss of job, etc) as a result of your child's hospitalization, injury, medical treatment or home care. Please also describe details of additional expenses incurred (mileage, meals, parking, gas, lodging, travel expenses, etc) and increased out-of-pocket insurance payments, prescription costs or other medical expenses.

APPLICATION AUTHORIZATION

I/We affirm and agree that:

- I/We have read the guidelines and understand them.
- I/We attest this information is true to the best of my/our ability.
- I/We authorize my/our child's medical care provider to discuss my/our child's medical information pertinent to this case with the Care Fund or their designated representatives.
- I/We understand that if approved for assistance, the Care Fund does not expect repayment in any form.
- I/We grant permission to the Care Fund to obtain and verify all necessary information in order to process this application. This information includes, but is not limited to, my/our past and present consumer credit record, mortgage or rental record, income or employment, expenses, dependents, etc.
- I/We understand that if approved for assistance, mortgage or rental payments may be made on our behalf directly to the mortgage lender or landlord/lessor.

Please enter your name(s) as your electronic signature*: _____

Please enter today's date*: _____

RELEASE

The Care Fund hopes to help as many families in our community as possible. By sharing your story, we will be able to expand our reach within our community. We promise to share your story with the highest integrity, with your permission only. We may request photos, testimonials and/or appearances

Please select from below:

- ☐ I/We give the Care Fund consent to use our family. *(Please complete both sections below)*
- ☐ Use our story, however please keep our family anonymous. *(Please complete both sections below)*
- ☐ Do not use our story.

Please enter your name(s) as your electronic signature*: _____

Please enter today's date*: _____

IF AUTHORIZING THE RELEASE, PLEASE COMPLETE BOTH SECTIONS BELOW:

1. I/We understand that neither my child nor I/us will receive any compensation as a result of the use of our information and photos, testimonials or appearances as described in this release. I waive any rights of privacy and/or approval of the materials in which our name and/or likeness may be used. This signifies my/our agreement and acknowledgement of the above statement.

Please enter your name(s) as your electronic signature*: _____

Please enter today's date*: _____

I/We hereby grant the Care Fund permission without restriction to use in all media my child's name and photo, and my/our name and photo, as well as the story of my child's illness, injury and/or treatment, to promote the purposes of the Care Fund and to solicit funds to help other children. This signifies my/our agreement and acknowledgement of the above statement.

Please enter your name(s) as your electronic signature*: _____

Please enter today's date*: _____

APPLICATION CHECKLIST

_____Most recent mortgage statement or lease agreement provided.
_____ I/We have signed off on all parts of the application.
_____I/We have provided our most recent 2 paystubs from any income sources.
_____I/We have provided our 2 most recent bank statements
_____I/We have requested our child's medical provider or hospital social worker to submit the Medical Verification Form.

WHAT'S NEXT?

Our team will begin to review and verify the information provided in your application as soon as we receive:

- Completed application, with all pertinent information provided. Any missing information will impact or delay our decision-making process.
- Providing the requested information in a timely fashion will help to expedite our process.
- Please send supporting documents by fax (480-383-6257), email (info@thecarefund.org) or mail.
- Medical Verification form provided by your child's medical provider or hospital social worker.
- Most recent 2 paystubs for any income sources.
- Most recent mortgage statement or lease agreement provided, with all pages.
- Most recent bank statements for all accounts.

Our review process consists of the following steps:

- Verification of all information provided in your application. This may be done verbally or in writing. This may include, but is not limited to: employment and/or income verification, mortgage or rent verification, past and present consumer credit record, etc.
- Verification of eligibility based on our current giving guidelines. Guidelines can be found at www.thecarefund.org/we-care/eligibility
- Medical Verification Form from the signer.
- Once all information is complete, our review committee will determine whether assistance will be provided and approved.
- Approval of an application is made at the sole discretion of the Care Fund. Approval is made on a case-by-case basis, based on available funds.
- You will be contacted by a member of our team, to inform you of the review committee determination. If you are awarded assistance, they will also review the parameters and time frame with you.

THANK YOU!

From the team at the Care Fund