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

- Completed applications and supporting documents are accepted by:
  - Online submission (www.thecarefund.org/apply)
  - Fax (480.223.6311)
  - Email (info@thecarefund.org)
  - Mail (16427 N. Scottsdale Road, Suite 145, Scottsdale, AZ 85254)
- Applicants must confirm eligibility based on the Care Fund Giving Guidelines, and if eligible, complete application in entirety to be considered. All information provided is subject to review and verification.
- The Medical Certification form (found at www.thecarefund.org/apply) must also be completed and provided by your social worker or child's physician before a submitted application will be considered. This may be submitted via any of the methods as listed above.
- Payment for approved applications will be submitted directly to the mortgage lender or the landlord/lessor.
- For approved applicants, the Care Fund does not expect repayment in any form.

Any questions?
Please email info@thecarefund.org.

Thank you!
Care Fund
16427 N. Scottsdale Road, Suite 145, Scottsdale, AZ 85254
480.305.8607 *phone* • 480.223.6311 *fax*
info@thecarefund.org
www.thecarefund.org
www.facebook.com/CareFundOrg





Giving Guidelines (Eligibility Requirements):

Care Fund represents the philanthropic needs of Arizona families, our community and committed valued partners. The Care Fund serves families of children with extended illness or injury and provides rent or mortgage payment support to qualified families.

The following Care Fund Giving Guidelines provide specific criteria to meet in order to receive available financial assistance. Guidelines are subject to change and approval is subject to available funds.

1. To be eligible, families with a child up to 18 years of age who are ill or injured with an extended illness must be certified by a medical care provider, social worker or hospital administrator (see Forms – "Care Fund Housing Expense Assistance & Authorization").
2. The applying family must provide evidence of financial hardship.
3. The parent or legal guardian must hold the mortgage of the home where the child resides, or be indicated as the primary leaseholder on the rental agreement/lease. All applications require the current year/month mortgage statement or current (un-expired only) lease agreement. Only primary residence qualifies.
4. Upon review of the application, the Care Fund will determine the length of time that rent or mortgage expenses will be covered on behalf of the applying family. The Care Fund may consider an additional grant if a child with a chronic illness has a significant change in health status.
5. Care Fund defines a housing expense payment as one of the following:
    a. One month's rent, as indicated on an executed lease agreement, inclusive of any applicable sales taxes, if listed on the provided rental agreement/lease.
    b. One monthly mortgage payment, inclusive of principal, interest, taxes, insurance or mortgage insurance, if included on the provided monthly mortgage statement.
6. Highest priority is given to applicants referred by Arizona hospital social workers or case workers if funds are limited.
7. All applications will be reviewed on a case-by-case basis, regardless of race, religion or gender.
8. All application information is subject to verification. Any application found to have false information will be denied.
9. The Care Fund Chairman of the Board, Co-Founder or Executive Director reserves the right to deviate from its established guidelines.
10. Applicant MUST reside in the state of Arizona.

All applicants MUST confirm that they meet all eligibility requirements as listed above before proceeding with this application.

☐ **I certify that I have read and meet all Care Fund Eligibility Guidelines.**

Signature: _____

Today's Date: _____

SECTION 1: FAMILY & MEDICAL INFORMATION

Name of Child Affected by Illness or Injury: _____

Birth Date of Child Affected by Illness or Injury: _____/_____/_____

Other Individuals Living In Your Home *(please include **ALL** adults and children)*:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

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

Family Information: The 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 certification verification is required to successfully complete your application. Your child's medical care provider or the hospital social worker must provide this directly to the Care Fund.

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: _____

SECTION 2: PERSONAL INFORMATION

All information for both P#1 and P#2 must be filled out whether or not married, divorced, separated or single.

Parent/Guardian #1

P#1 Name: _____

P#1 Date of Birth: _____/_____/_____

P#1 Social Security Number: _____

P#1 Phone Number: _____

P#1 Email Address: _____

P#1 Home Address: _____

_____

P#1 Length of Time at this Address: _____

P#1 Second Address (*if less than 2 years at current address*)**:**

_____

_____

P#1 I am the Child's:

☐ Parent ☐ Legal Guardian *(must provide legal documentation)*

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

P#1 Primary Language:

☐ English ☐ Spanish ☐ Other: _____

P#1 Ethnicity:

☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander

☐ Caucasian/White ☐ Hispanic/Latino ☐ Multi-ethnic

☐ Other:_____

P#1 Veteran?

☐ Yes, Active ☐ Yes, Retired ☐ No

Parent/Guardian #2

P#2 Name: _____

P#2 Date of Birth: _____/_____/_____

P#2 Social Security Number: _____

P#2 Phone Number: _____

P#2 Email Address: _____

P#2 Home Address: _____

_____

P#2 Length of Time at this Address: _____

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

_____

_____

P#2 I am the Child's:

☐ Parent ☐ Legal Guardian *(must provide legal documentation)*
☐ Grandparent ☐ Court Ordered Custodian *(must provide legal documentation)*

P#2 Primary Language:

☐ English ☐ Spanish ☐ Other: _____

P#2 Ethnicity:

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

P#2 Veteran?

☐ Yes, Active ☐ Yes, Retired ☐ No

<u>Additional Personal Information</u>

Marital Status of Parents/Guardians:

☐ Single ☐ Married ☐ Separated ☐ Divorced

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

Have you previously received assistance from the Care Fund?

☐ Yes (if yes, when and in what dollar amount?) ☐ No

When: _____ Amount: $_____

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

_____

SECTION 3: EMPLOYMENT & INCOME INFORMATION

*Please complete this section using your **current or most recent** employment and income information.*

Parent/Guardian #1

P#1 Are you currently employed?

☐ Yes ☐ No ☐ Part-time only ☐ Self-employed

P#1 Employer Name & Address *(current/most recent)*: _____

_____

_____

P#1 Business Phone Number *(current/most recent)*: _____

P#1 Position/Title *(current/most recent)*: _____

P#1 Length of Time on this Job *(current/most recent)*: _____

P#1 Years Employed in this Line of Work *(current/most recent)*: _____

P#1 Gross Monthly Income *(current/most recent)*: _____

P#1 Amount of Additional Overtime, Bonus or Commission Income Received *(current/most recent)*:

_____

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

P#1 Are you currently on leave?

☐ Yes, Paid Leave ☐ Yes, Unpaid Leave ☐ No

If yes, Leave Start Date: _____ Leave End 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:

P#1 Employer Name & Address *(previous/second)*: _____

_____

_____

P#1 Business Phone Number *(previous/second)*: _____

P#1 Position/Title *(previous/second)*: _____

P#1 Gross Monthly Income *(previous/second)*: _____

P#1 Amount of Additional Overtime, Bonus or Commission Income Received *(previous/second)*:

_____

Parent/Guardian #2

P#2 Are you currently employed?

☐ Yes ☐ No ☐ Part-time only ☐ Self-employed

P#2 Employer Name & Address *(current/most recent)*: _____

_____

_____

P#2 Business Phone Number *(current/most recent)*: _____

P#2 Position/Title *(current/most recent)*: _____

P#2 Length of Time on this Job *(current/most recent)*: _____

P#2 Years Employed in this Line of Work *(current/most recent)*: _____

P#2 Gross Monthly Income *(current/most recent)*: _____

P#2 Amount of Additional Overtime, Bonus or Commission Income Received *(current/most recent)*:

_____

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

P#2 Are you currently on leave?

☐ Yes, Paid Leave ☐ Yes, Unpaid Leave ☐ No

If yes, Leave Start Date: _____ Leave End 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:

P#2 Employer Name & Address *(previous/second)*: _____

_____

_____

P#2 Business Phone Number *(previous/second)*: _____

P#2 Position/Title *(previous/second)*: _____

P#2 Gross Monthly Income *(previous/second)*: _____

P#2 Amount of Additional Overtime, Bonus or Commission Income Received *(previous/second)*:

_____

SECTION 4: ADDITIONAL SOURCES OF HOUSEHOLD INCOME

*Please indicate the amount of **monthly** additional income received below:*

Social Security: _____

Child Support/Alimony: _____

Foster Care: _____

Pension/Retirement: _____

Food Stamps/EBT/SNAP/WIC: _____

Unemployment/Workers Compensation: _____

Other Public/Tribal Assistance: _____

Grants: _____

Disability: _____

Military Pension: _____

Other Assistance and/or Non-Profit Assistance You Have Received *(for example: GoFundMe, Salvation Army, Church Groups, etc.)* – please provide names and amount received for each source:

SECTION 5: HOUSEHOLD OBLIGATIONS & LIABILITIES

*Please list the **monthly** payment for all household obligations and liabilities below. **If none, enter 0.***

Mortgage Payment: _____

Rent Payment: _____

Car Payment(s): _____

Car Insurance: _____

Gas/Fuel: _____

Groceries: _____

Cable/Internet/Phone: _____

Cell Phone(s) : _____

Health Insurance: _____

Medication/Prescriptions: _____

Medical Co-Pays: _____

Dental/Vision: _____

Child Care: _____

Child Support/Alimony: _____

Other Out-of-Pocket Medical Expenses: _____

Student Loan(s): _____

Unreimbursed Business Expenses: _____

Credit Card Payments: _____

Utilities (Electric & Gas): _____

Utilities (Water/Sewer/Trash): _____

Entertainment: _____

Healthcare Related Travel: _____

Tuition: _____

Attorney/Legal: _____

Other: _____

Other: _____

SECTION 6: 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.

Mortgage Lender/Landlord Information:

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

_____

Payment Address: _____

_____

_____

Contact Name, Phone Number & Email Address:

_____

Monthly Payment Amount: _____

Account Number *(if applicable)*: _____

Name(s) on mortgage or lease: _____

2nd Mortgage Information (if applicable):

For a second mortgage, please provide the same information below, and ***attach a statement.***

Name of mortgage lender:

_____

Payment Address: _____

_____

_____

Contact Name, Phone Number & Email Address:

_____

Monthly Payment Amount: _____

Account Number *(if applicable)*: _____

Name(s) on mortgage: _____

Mortgage/Rent Payment Information:

Are you current on your mortgage or rent payments?

☐ Yes ☐ 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.

Signature: _____

Today's Date: _____

SECTION 7: ASSETS

Vehicle #1 Year/Make/Model: _____

Vehicle #1 Value: _____

Vehicle #2 Year/Make/Model: _____

Vehicle #2 Value: _____

Other Vehicle (Watercraft, RV, Motorcycle, etc.): _____

Primary Residence Address: _____

Primary Residence Value: _____

Other Real Estate Owned (Rentals/Vacation/Land): _____

Checking Account Balance: _____

Savings Account Balance: _____

Mutual Fund Balance: _____

Federal/State Retirement Account Balance: _____

401k/Retirement Account Balance: _____

Other Savings Balance: _____

Business Assets: _____

Stocks/Bonds/CDs/MM: _____

Other: _____

Work & Financial Impact: *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.

Signature: _____

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 section below)*

☐ Use our story, however please keep our family anonymous. *(please complete section below)*

☐ Do not use our story.

Signature: _____

Today's Date: _____

IF AUTHORIZING THE RELEASE, PLEASE COMPLETE SECTION BELOW:

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. 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.

Signature: _____

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 contacted our child's medical provider or hospital social worker, to complete the medical certification form.
- ☐ I/We understand that if documentation is not received in a timely manner, I may be required to submit a new application.

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. We will contact you if any information appears to be missing, as it may 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 (480.223.6311), email (info@thecarefund.org), or mail (16427 N. Scottsdale Road, Suite 145, Scottsdale, AZ 85254).
- Medical certification submitted or provided by your child's medical provider or hospital social worker.
- Two most recent paystubs for any income sources.
- Most current mortgage statement or lease agreement provided, with all pages.
- Two most recent bank statements for all accounts noted on application.

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.
- Verification of eligibility based on our current Giving Guidelines (see page 2).
- Verification of medical certification. This may be done verbally or in writing.
- Once all verifications are complete, our review committee will meet to determine whether assistance will be provided.
- 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 timeframe with you.

THANK YOU FROM THE CARE FUND TEAM!