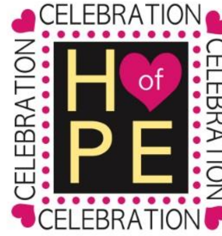
OFFICE USE ONLY

DATE RECEIVED	DATE APPROVED
________________	________________
AMOUNT REQUESTED:	**AMOUNT APPROVED:**
$________________	$________________



Celebration of Hope

Application for Assistance

Applicant Information:

First Name: ___________________________ Last Name: ____________________________________

Street Address: _________________________________ City/Zip ______________________________

County: __________________________

E-mail Address: ____

*Email is our primary means of communicating with you.

Please provide a phone number where you can *always* be reached.

Phone: (Home/Cell) ______________________________ (Work) ______________________________

Legal Guardian/Caregiver Information (if applicable):

First Name: __________________________ Last Name: __________________________________

Telephone Number: ____________________________

Email (If different than Applicant's): ____

How did you hear about Celebration of Hope?

____

Who referred you to Celebration of Hope?

____

Have you, other family, or anyone listed above ever been helped by Celebration of Hope?: YES NO

If yes, when? ____

Please describe why you are in need of assistance (attach additional sheets of paper if needed):

____

____

____

We may be able to help you with essentials such as rent/mortgage, food, utilities, transportation, and medical equipment:

❑ Housing $____________________

❑ Food $____________________

❑ Utilities $____________________

❑ Transportation $____________________

❑ Medical Equipment $____________________

Other – Explain below $____________________

____

____

What is your illness / injury / situation? ____

____

____

____

If your application is approved and we meet with you, you will need to provide copies of any of the above you are requesting assistance with. You may also be given a specific form you will need to complete. For example, Notice of Rent Due form.

What is the total amount being requested? $_________________

When do you need it? _________________

HEALTH INSURANCE INFORMATION

Are you currently on Medicare or Medicaid or any other supplemental government program?

Yes ________________ No ___________________

If yes, which one? _________________________________ County _____________________________

If Medicaid, name of Case Worker: ____

Medical Insurance? YES ______________ No _______________

What is your co-pay? $________________ What is your out-of-pocket limit? ______________

If you have applied for assistance for this need with another agency or church, please list below:

____

____

____

ONLINE FUNDRAISER AVAILABLE – GO TO WWW.CELEBRATIONOFHOPEINC.ORG

TERMS AND CONDITIONS

By completing and signing this form, you acknowledge and agree as follows:

1. The funds you receive will be used for the purpose stated above.
2. Celebration of Hope, Inc. is a Christian non-profit organization who provides financial assistance and fundraising opportunities to individuals in need.
3. You will be notified by telephone, email, or mail within 30 days as to whether or not your application has been approved.
4. Funds are limited and based upon availability and applicant's need, and are in no way based upon race, creed, sex, religion, age or disability.
5. Assistance may be in the form of a payment directly to a creditor, a gift certificate for staple items, or the like. Forms of assistance will be decided on a case by case basis by the Board of Directors.
6. You agree to set up **ONE** mandatory meeting with a representative from Celebration of Hope before disbursement of the funds.
7. Approval of this request grants a one-time assistance payment and does not necessarily promise future financial assistance.
8. You are a Wisconsin resident and reside in Outagamie, Winnebago, Calumet, Fond du Lac or Waupaca County.

If funding is granted I give consent to Celebration of Hope, Inc. to share my story.
The recipient of funds from Celebration of Hope hereby irrevocably and unconditionally agrees, to the fullest extent permitted by law, to defend, indemnify and hold harmless Celebration of Hope, Inc., their respective officers, directors, trustees, employees and agents from and against any and all claims, liabilities, losses and expenses (including reasonable attorney fees) directly or indirectly, wholly, or partially arising from or in connection in any way with this application, the funds awarded or use of the funds by recipient. This paragraph shall survive the termination of this agreement.

I hereby agree that everything I have stated in this application is true and accurate to the best of my knowledge and that the Celebration of Hope, Inc. is relying on this application to make its decision to support proposed funding. I understand that this application can be rejected for incomplete information. Furthermore, I understand that the Celebration of Hope, Inc. is not obligated to accept me as the recipient of the proposed funding.

Applicant Signature: ____ Date: __________

If under 18 years old, both parents must sign, if applicable.

1. Parent Signature: ____ Date: __________

Parent Printed Name: ____________________________________

2. Parent Signature: ____ Date: __________

Parent Printed Name: ____________________________________

Information requested on this form is for the private use of the Board of Directors of Celebration of Hope, Inc. All information will be kept confidential.

The mission of Celebration of Hope, Inc. is a Christian charity with a mission of providing financial assistance and fundraising opportunities to any individual in need, lending a hand of support by sharing the burden and offering hope.

APPLICATION FOR ASSISTANCE WILL BE REVIEWED WITHIN 30 DAYS AND YOU WILL BE CONTACTED WITHIN ONE MONTH.

Applicant – DO NOT write below this line. Office use only.

Evaluation:

Date	Reviewer's Name	Recommendation