SYEMC Members Round Up Fund, Inc.

(CATASTROPHIC ILLNESS APPLICATION)

CONTACT INFO
Address: PO Box 305, Dobson, NC 27017
Telephone Number: 336-356-8241 or 1-800-682-5903
Fax Number: 336-356-9744
Email Questions or Comments to: RoundUp@syemc.com

Funding Criteria

Funds donated by the members of Surry-Yadkin EMC shall be disbursed by the SYEMC Members Round Up Fund Inc., Board of Directors to individuals who have had a house fire or individuals who are suffering from a catastrophic illness.

Privacy Policy

The information obtained in this application is solely for the purpose of determining qualification for assistance from the SYEMC Members Round Up Fund, Inc., and will be kept in strictest confidence.

The person signing this application warrants that the information provided is true and complete. SYEMC Members Round Up Fund Inc. is authorized to make all inquires deemed necessary to verify the accuracy of the statements made herein. Any deliberate falsehoods detected will be strong grounds to deny the assistance application.

To ensure confidentiality, decisions made by the SYEMC Members Round Up Fund, Inc., Board of Directors will NOT be discussed with anyone. Whether a request for funds is denied or granted, reasons for Board decisions will NOT be given to anyone, including the applicant.

Submitting a Grant Request

Grant applications are to be completed and returned to the Member Services Department at Surry-Yadkin EMC in Dobson or mailed to:

SYEMC Members Round Up Fund, Inc.
Attention: Rhonda Hill or Wendy Wood
PO Box 305
Dobson, NC 27017

Incomplete Applications will NOT be reviewed!!!

It is imperative that ALL information requested be supplied on the application along with supporting documents.

Name of Applicant: _____

Age: _____ County in which you reside: _____

Social Security Number: _____

Mailing Address: _____

Physical Address (if different from above):_____

Home Phone: _____ Alternate (Cell #):_____

Employer of Applicant: _____

Name of Supervisor: _____ Work Number:_____

List ALL other people living with applicant (use back of page if necessary)

Name	Relationship	Age	SS#	Employment
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

Assistance Requested

Give as many details as possible. **MUST** include specific amount requested. If no amount is listed, request will be considered incomplete. Include any supporting documents you may have. We need as much information as you can provide to show the nature of the assistance you need!

Amount Requested: $_____

Why do you need assistance? (If you need additional space, write on the back of this page).

Total monthly family income (include ALL INCOME of everyone living in the home)

Salaries	**$** **$** **$**	Persons Earning Income _____ _____ _____
Disability	**$**	
Retirement	**$**	
Child Support	**$**	
Food Stamps	**$**	
Work First	**$**	
SSI	**$**	
AFDC	**$**	
Unemployment or Workman's Comp	**$**	
Pell or Education Grants	**$**	
Any other misc. income	**$**	

Total Monthly Family Income $_____
Total Cash on hand (Checking, Savings, etc.) $_____

Monthly Expenses	**Current/Typical** (what you pay out per month)	**Past Due Balances**	**Total Due to reach zero balance**
Home: Rent ( ) Mortgage ( )			
Electric Bill			
Telephone Bill			
Cell Phone Bill			
Water/Sewer			
Cable TV/Satelite			
Gas/Oil (for heating)			
Groceries			
Car Payments			
Car Insurance (if monthly)			
Home Insurance (if monthly)			
Medical Insurance per mo.			
Medical Bills			
Your cost for prescription medicines			
Credit Card			
Other loans, debts			

Total Monthly Expenses: _____

Total Past Due Expenses: _____

Personal Property

Amount of Property Owned (Lot/Acreage):_____

Year, Make & Model of all vehicles (Including Boats, R.V.'s, etc.):

_____

Financial Assistance

Is individual or family receiving any other form of assistance or aid for the stated grant requested (donations from churches or local organizations, family, etc?)

YES ____ NO____

If ***YES***, please indicate sources and amount of assistance:

_____

Specific Payment Information

If you are requesting assistance paying a specific bill, please include a copy of that bill as well as complete the information below.

Name of Company _____

Address _____

Contact name and number_____

Account # (if applicable): _____

References – Only one can be a family member!!!

Name	Address	Daytime Telephone Number

Name	Address	Daytime Telephone Number

Name	Address	Daytime Telephone Number

Check list of important information we need to review your application!

- Copy of bill that you are requesting assistance for
- Pay stubs for anyone in the home that is working.
- A Statement of Eligibility for SSI or Food Stamps.
- A letter from your doctor stating your current health diagnosis. This needs to be a current letter, on doctor's letterhead, dated in the month you apply for our assistance.
- Bank Statement

"The information provided in the application to the SYEMC Members Round Up Fund, Inc., is true and complete. The Fund agents are authorized to contact my references, doctors, employer and others to verify the information provided. I understand any deliberate falsehoods or efforts to mislead the Round Up Fund Board of Directors will be strong grounds to deny the requested application."

_____

Signature of Applicant Date

_____

Name of person filling out application if other than named applicant Date