FLOOR COVERING INDUSTRY FOUNDATION

FINANCIAL ASSISTANCE PROGRAM
Assisting Those in Our Industry Most in Need

2017 Application

We provide financial assistance to help with medical care, prescriptions, medical equipment, home repairs, shelter, food, and utilities for families who have a catastrophic or life altering event.

GRANT REQUIREMENTS:

1. The applicant or immediate family member (spouse, children, or grandchildren living in the same household) must have derived primary income from employment in the floor covering business for at least five years. Eligible years do not have to be consecutive. Additional consideration will be given to applicants who have spent the majority of their career in the floor covering business.

2. The applicant or immediate family member must be diagnosed by a practicing, certified physician as having a life-altering hardship such as catastrophic medical crisis, injury, or disability, or mental illness.

3. The household must be in extreme financial need - other sources such as family assistance, medical insurance, and disability insurance depleted. The household's liquid assets (cash, checking, and savings accounts, money market accounts, stocks, certificates of deposit, bonds, and mutual funds) will be considered. Note: Liquid assets do not include primary car or house.

Please print or type all information. Any missing information will delay processing. All information contained herein is strictly confidential, accessible only to the Floor Covering Industry Foundation leadership and assigned staff persons. All documents submitted become the property of the FCIF.

Applicant Name: Social Security Number:

Address: City: State: Zip:

Daytime Telephone: Evening Telephone:

Employer: E-Mail: Date of Birth:

Marital Status: ◯ Married ◯ Single ◯ Widowed

If married, please complete this section.

Spouse's Name: Social Security Number:

Employer: E-Mail: Date of Birth:

List the name, age, and relationship to you of all your dependents:

HEALTH REVIEW:

You may either (1) ask your diagnosing physician or primary medical provider to submit a statement outlining the medical condition and the necessary medical treatment(s), OR (2) the diagnosing physician or primary medical provider can complete this portion of the application. The authorization for the release of medical information expires six (6) months after the application date.

Name of household member with medical needs:

Their Social Security Number:

Below box to be completed by your physician.

Patient's Name: Physician's Name:

Medical Field/Specialty:

Address: City: State: Zip:

Telephone: Fax: E-Mail:

Please describe the applicant's medical condition and the necessary medical treatment(s).
Attach a separate sheet if necessary.

▷ **PHYSICIAN'S SIGNATURE:** Date:

1, (PRINT NAME) hereby authorize the release of my medical information to the **Floor Covering Industry Foundation**, including but not limited to, any and all hospital, clinic, medical, treatment, therapy, and rehabilitation records, as well as copies of any x-ray or any other diagnostic imaging files. This authorization also allows any authorized agent employed or otherwise hired by the **Floor Covering Industry Foundation**, to directly contact any of my prior or currently treating physicians, chiropractors, or any other health care providers, vocational rehabilitation providers, or mental health care providers for the purpose of discussing my diagnoses, treatment, progress, and prognoses.

The information obtained pursuant to this authorization shall be used for the limited purpose of evaluating whether I qualify for certain benefits or gifts to be granted to me by the **Floor Covering Industry Foundation**. A photocopy of this release as signed by me may be used in lieu of the original, and any such photocopy shall have the same validity as if it were the original. I understand that I will be provided with a copy of my executed release upon my request. The applicant may revoke the authorization for the release of medical information and terminate the financial assistance application by writing to the **Floor Covering Industry Foundation,** 855 Abutment Rd Ste 1, Dalton, GA 30721.

Authorization for release of medical information (SIGNATURE REQUIRED)

▷ **APPLICANT SIGNATURE:** Date:

HEALTH INSURANCE

Please complete with any type health insurance, Medicare, Medicaid, supplementary insurance, or other medical benefits for each each family member who you are requesting medical assistance. Please attach the insurance card – front and back. *If you lost coverage, please send the termination or COBRA letter.*

Who is insured | Insurance Company:

ID #

Who is insured | Insurance Company:

ID #

Who is insured | Insurance Company:

ID #

Have you applied for assistance from any other agency (governmental or private), union or foundation? ◯ Yes ◯ No
If yes, please list the organization(s) and amounts received.

Prior to this application, have you ever applied for FCIF assistance? ◯ Yes ◯ No If yes, did you receive financial assistance from FCIF? ◯ Yes ◯ No If yes, please specify the details of the financial assistance you received from the Foundation.

FINANCIAL INFORMATION

Please provide income and expense information for the applicant's household. Please provide documentation for all items listed in income and expenses form with this application:

- A copy of the most recent tax return filed by everyone living in the applicant's household is required.
- Most recent statements checking, savings, 401(k) retirement accounts, life insurance, etc (all pages, front and back, not just the summary). Include both joint bank statements and individual bank statements for all individuals in the household.
- All pages of current rent/mortgage bill and utilities: gas, electric, water, waste, cell phone, telephone, cable, etc.
- All pages of current car payment(s), insurance(s), and registration(s).
- Most recent credit card statements - all pages, front and back, please include all credit cards within the household.
- Current insurance bills – medical, vision, dental, or supplemental (do not have to send if deducted on your paycheck)
- All outstanding medical bills. Should show how much insurance paid and what remains as the patient's responsibility. Must be dated in the past 30 days.
- If receiving payment from any of these please provide documentation: short-term and or long-term disability, unemployment, social security, food stamps, etc. If denied, please provide a denial letter.

RECURRING INCOME: Include documentation for each along with application.

SOURCE OF INCOME	PERSON RECEIVING	HOW OFTEN RECEIVED	AMOUNT
Salary Applicant			
Salary Spouse			
Salary Other Household Members			
Retirement Income			
Social Security Income			
Social Security Income Spouse			
Social Security Disability/SSI			
Short or Long-Term Disability			
Workers' Compensation			
Veteran's Benefits			
Spouse/Partner's Income			
Unemployment			
Residuals and Royalties			
Food Stamps			
Alimony			
Pension(s)			
Child Support			
Other recurring income			

ONE-TIME INCOME: Complete this section if you have received one-time payments from other sources in the past 6 months such as: church donations, Go Fund Me online fundraising contributions, one-time back payment for disability, grants from other foundations or non-profits, gifts from family members, relief funds, etc.

SOURCE OF ONE-TIME INCOME	PERSON RECEIVED	DATE RECEIVED	ONE-TIME AMOUNT

MONTHLY EXPENSES

TYPE	NAME OF COMPANY OWED	DATE ON BILL	AMOUNT
Rent/ Mortgage			
Home Insurance (if not escrowed)			
Property Tax (if not escrowed)			
Homeowners fees			
Utilities			
Gas			
Water			
Electric			
Telephone			
Pager			
Cable			
Fuel for Transportation (if more than $200 a month)			
Car Payment/Registration			
Car Insurance			
Car Repairs			
Public Transit			
Medical Insurance			
Prescriptions (monthly average)			
Dental / Vision Insurance			
Credit Cards: (list min. payment and total amount owed)			
Life Insurance			
Long or Short-Term Disability Insurance			
Other			
Other			

ONE-TIME EXPENSES: Complete this section if you have expenses that are not monthly, but are required for your health or basic living expenses.

TYPE	NAME OF COMPANY	DATE	AMOUNT
Medical Bills Outstanding (list individually)			
Maintenance/ Repair on house or car (list individually)			
Medical Equipment (list individually)			
Other			

EMPLOYMENT VERIFICATION

Name of family member who was employed in the floor covering industry for 5 or more years:

Relationship to applicant: Total # years employed in the industry?

Please list the floor covering companies and the years employed:

To verify years of service in the flooring industry please provide one of the following (check which option):

◯ HR Manager's Name: Company:

Phone: City: State:

◯ 5 years of tax returns

◯ A statement from Social Security

Provide a brief description of primary duties while employed in the floor covering industry:

How did you learn of the **Floor Covering Industry Foundation**?

GRANTS

Grants may be provided for emergency medical expenses, continuing healthcare expenses, or for basic necessities such as food, shelter, utilities, and prescription assistance. Financial aid is based on individual need. Grants may be awarded on a one-time, specific procedure basis, and/or may be awarded as a monthly stipend for 6 months. After 6 months, you may reapply. Grants are disbursed at the discretion of the Distribution Committee of the Foundation Board of Directors; all decisions by the body are final.

One-time outstanding medical bills request: $ A

One-time requested past due housing & living expense: $ B

Request housing & living expense each month for the next 6 months:

$ monthly x 6 = $ C

Total Grant Amount Requested (A + B + C): **$**

Statement of Need. Please describe in detail the need for which you are requesting a grant. What bills that you are requesting that we pay and if they are one time bills or monthly. We provide assistance for 6 months at a time.

ADDITIONAL INFORMATION

- Please complete all sections of the application. All information on the application will be taken into consideration in determining the urgency of need. Failure to complete all sections may result in a delay in reviewing the application.
- Each applicant must participate in an interview by a medical case manager, as certified by the Commission for Case Management.
- Eligibility standards are set by the Floor Covering Industry Foundation's Board of Directors. It is our goal to assist all qualified applicants within the Foundation's funding limitations.
- All grant beneficiaries are required to provide ongoing medical and financial reports and documents as required by the Foundation as a condition of continued funding.
- In the event of the death of a recipient the Foundation must be notified either in writing (FCIF, 855 Abutment Rd Ste. 1, Dalton, GA 30721) or by telephone (706-217-1183) within two weeks of the recipient's passing.
- All applicants, whether denied or approved, will receive notification in writing.

CERTIFICATION AND AUTHORIZATION

I hereby certify that I have answered the questions in this application to the best of my ability without any limitations whatsoever; the facts stated herein are true and I understand that any misrepresentation or false information will disqualify me (the applicant) for any assistance from the Foundation. I further agree to notify the Floor Covering Industry Foundation of any change in my financial situation from the time of my application to the time a grant is made to me. I understand that the Distribution Committee requires me to provide a copy of my most recent tax return (including ALL applicable schedules).

I guarantee that all monies received from the Foundation will be used for expenses incurred as a result of my (or my stated immediate family member's) medical needs.

SIGNATURE OF APPLICANT: Date:

Print Name of Applicant:

APPLICATIONS TAKE A MINIMUM OF 30 DAYS TO PROCESS ONCE ALL DOCUMENTATION IS RECEIVED. PLEASE TRY TO SEND ALL THE PAPERWORK AT ONE TIME TO DECREASE PROCESSING TIME.

COMPLETED APPLICATION AND DOCUMENTS CAN BE SENT TO:

FLOOR COVERING INDUSTRY FOUNDATION
855 ABUTMENT RD STE. 1, DALTON, GA 30721

FAX: 706-217-1165
SCAN AND EMAIL: INFO@FCIF.ORG
QUESTIONS? CALL 706.217.1183

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