

DIRECTAID

Dear Applicant:

Enclosed, please find your application for DirectAid.

DirectAid is an all-volunteer organization that provides one-time emergency interim financial assistance for rent and utilities to qualified applicants with AIDS. In addition, DirectAid provides referrals to organizations offering comprehensive AIDS services.

In order to receive financial assistance from DirectAid you must meet the following requirements:

1. You have been diagnosed with AIDS.
2. You are experiencing a financial emergency due to your health.
3. You have applied for or are receiving SSI/SSDI.
4. You have submitted a completed application along with required documentation.

I urge you to read the application carefully, answer all questions, and provide us with all of the documents on the checklist so that we may expedite your request for funds. Mail or drop off your application to:

DirectAid
3439 North Halsted Street, Lower Level
Chicago, IL 60657

Once your application is received, it will take 5-7 business days to process. DirectAid will notify you of any award, decline, or delay in processing. Awards will be made payable directly to the landlord and/or utility companies. Please refrain from calling to inquire as to the status of your application as it may further delay processing. DirectAid provides financial assistance to qualified applicants regardless of their gender, race, age, religion, national origin, marital status or sexual orientation.

If you have any questions about DirectAid or about your application, please do not hesitate to contact a volunteer at 773-296-4880.

Thank you for your interest in DirectAid. We look forward to assisting you.

Sincerely,

Jim Bissonnette
President

DIRECTAID

Application for Financial Assistance

PART I – APPLICANT INFORMATION

Answer every question on both sides of the application. Please print clearly.

FIRST NAME _____ LAST NAME _____ M.I. _____ APPLICATION DATE _____ / ____ / ____

ADDRESS _____ APT. # _____ CITY, STATE _____ ZIP _____

(____) _____ / ____ / ____ - ____ - ____
TELEPHONE _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ MOTHER'S MAIDEN NAME _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ TELEPHONE _____ (____)

LANDLORD NAME _____ ADDRESS _____ TELEPHONE _____ (____)

PHYSICIAN NAME _____ HOSPITAL AFFILIATION _____

PHYSICIAN ADDRESS _____ TELEPHONE _____ (____)

CASE MANAGER/SOCIAL WORKER NAME _____ HOSPITAL /ORGANIZATION AFFILIATION _____

CASE MANAGER ADDRESS _____ TELEPHONE _____ (____)

Are you enrolled in a pharmacy program? ____ No ____ Yes (Program Name: _____)
Are you enrolled in a food pantry/food delivery program? ____ No ____ Yes (Program Name: _____)

PRESENT OR PAST EMPLOYER _____ POSITION _____ FROM ____ / ____ / ____ TO ____ / ____ / ____
DATES WORKED _____

SUPERVISOR NAME _____ TELEPHONE _____ (____)

May we contact your last employer? ____ Yes ____ No

List all other household members

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>WORKING?</u>
1)			
2)			
3)			
4)			

Diagnosis: ____ HIV+ ____ ARC ____ AIDS

Important: You must include with your application a written letter from your physician confirming your diagnosis and diagnosis date.

How did you hear about DirectAid? _____
Comments or Additional information may be included on a separate sheet.

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PART II – EXPENSE WORKSHEET

MONTHLY INCOME		MONTHLY EXPENSES	
Part-time income	\$	Rent	\$
SSI/SSDI Income	\$	Electric	\$
Food Stamps	\$	Phone	\$
Employer Pension/ Retirement/Disability	\$	Food	\$
Child Support	\$	Medicine	\$
Rent Subsidies	\$	Transportation	\$
Other	\$	Entertainment	\$
		Other	\$
TOTAL INCOME	\$	TOTAL EXPENSES	\$

PART III – DOCUMENT CHECKLIST

Important: You must include photocopies of the following documents in order for your application to be processed. These documents cannot be returned.

_____ Completed Application	_____ Rental Agreement
_____ SSI/SSDI Award Letter	_____ Gas Bill
_____ Copy of Photo ID	_____ Electric Bill
_____ Medical Receipts	_____ Confirmation of Diagnosis From Applicants Physician

By signing this application, I attest that all of the information I have provided is true and complete to the best of my knowledge. My signature authorizes DirectAid to verify all information and documents presented within this application. I realize that misrepresentation or omission of information will remove me from consideration for financial assistance.

APPLICANT SIGNATURE

DATE

WITNESS SIGNATURE

DATE

WITNESS PRINT

Any information obtained by DirectAid will be used solely for the purpose for determining eligibility for financial assistance and will remain completely confidential. DirectAid provides financial assistance to qualified applicants regardless of gender, age, race, religion, or sexual orientation.