

**SVECARES – PO BOX 405, SOUTH PITTSBURG, TN 37380  
APPLICATION FOR DONATION  
FOR INDIVIDUAL AND/OR FAMILY**

**\*\*The following information is necessary for consideration by the SVECares Board. Please fill out completely and return to the nearest SVEC office by no later than the last day of the month in order to be included in the next month's meeting.**

SVEC Account No: \_\_\_\_\_ Name on Account: \_\_\_\_\_  
**1. Applicant:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ Street Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone or number where you can be reached: \_\_\_\_\_

Employer or Source of Income: \_\_\_\_\_ Monthly Income: \$ \_\_\_\_\_  
 Employer's City and State: \_\_\_\_\_ Employer's Phone No: \_\_\_\_\_  
 Other income: \$ \_\_\_\_\_ Source of other Income: \_\_\_\_\_

**\*\*\*PROVIDE COPY OF PAYROLL CHECK, SOCIAL SECURITY CHECK, AND/OR BANK STATEMENT, IF APPLICABLE. IF NOT SUBMITTED, APPLICATION WILL NOT BE CONSIDERED. OTHER INCOME WOULD INCLUDE ASSISTANCE SUCH AS FAMILIES FIRST, CHILD SUPPORT & SUPPORTING DOCUMENTS.\***

**2. Other members in your household (including relatives and non-relatives; state relationship –wife, husband, child, parent, friend, etc)**

<u>NAME:</u>	<u>Social Security #</u>	<u>Date of Birth:</u>	<u>Relationship:</u>	<u>Source of Income:</u>	<u>Monthly Income:</u>
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

**3. Amount Requesting from SVECares? \$ \_\_\_\_\_**

Please itemize and provide necessary documents in support of your request (estimates, past due notice from landlord, eviction or foreclosure/past due notice from lending institution, doctor statements) must be attached, . YOUR APPLICATION CANNOT BE CONSIDERED WITHOUT ADEQUATE INFORMATION. ***IF REQUESTING DELINQUENT RENTAL OR MORTGAGE PAYMENTS, PLEASE PROVIDE PROOF FROM THE LANDLORD OR LENDING INSTITUTION OF THE DELINQUENT AMOUNT, WHICH CONTAINS THE ADDRESS AND PHONE NUMBER OF CONTACT PERSON.***

<u>Amount Needed</u>	<u>To Be Used For What Purpose?</u>	<u>Payable to Whom, along with address and phone number:</u>
\$ _____	_____	_____
\$ _____	_____	_____
\$ _____	_____	_____
\$ _____	_____	_____

**ITEMS NOT ELIGIBLE FOR GRANT:** UTILITIES SUCH AS ELECTRIC, WATER, PHONE, PROPANE/GAS; CAR PAYMENTS, CAR INSURANCE, HOMEOWNERS INSURANCE, LAND TAXES, MEDICAL BILLS, NOR PERSONAL LOANS.

**4. Please explain the circumstances that caused you to need funds from SVECares. (Attach a separate sheet if necessary)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Are you receiving any form of assistance or aid for the above stated request(s), such as donations, insurance, etc.)? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, from whom \_\_\_\_\_

6. Have you ever received funds from SVECare? Yes: \_\_\_\_\_ No: \_\_\_\_\_ If yes, when? \_\_\_\_\_

7. How or by whom did you hear about this program? \_\_\_\_\_

8. Please name three individuals who know your circumstances and can verify your need. (Must not be a relative or a member of the SVECare Board or employees of SVEC.)

1. _____	City & State: _____	Phone #: _____
2. _____	City & State: _____	Phone #: _____
3. _____	City & State: _____	Phone #: _____

9. Statement of Financial Condition as of \_\_\_\_\_ (Today's Date)

Cash on Hand: \$ \_\_\_\_\_  
Bank Accounts: \$ \_\_\_\_\_ Name of Bank: \_\_\_\_\_ Location: \_\_\_\_\_

Assets	Market Value:	Payoff:	Payable To:	Monthly Payment:
Home	\$ _____	\$ _____	_____	\$ _____
Other Real Estate	\$ _____	\$ _____	_____	\$ _____
Auto:				
_____	\$ _____	\$ _____	_____	\$ _____
_____	\$ _____	\$ _____	_____	\$ _____

10. Monthly Household Expenses:

Rent/Mortgage	\$ _____	(Payable to & Address: _____)
Water	\$ _____	Other Monthly Expenses (Specify) – Credit Cards Etc
Electricity	\$ _____	_____ \$ _____
Propane/Nat. Gas	\$ _____	_____ \$ _____
Telephone	\$ _____	_____ \$ _____
Cable TV/Satellite	\$ _____	_____ \$ _____
Groceries	\$ _____	_____ \$ _____
If you get food stamps – monthly amount:	\$ _____	
Health Insurance	\$ _____	Do you have health insurance? Yes _____ No: _____
Auto Insurance	\$ _____	If yes – what kind (TN Care, Medicare, etc _____)
Home Insurance	\$ _____	
Transportation	\$ _____	

11. Any other information you feel is important for the SVECare Board to consider in reviewing your request? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information contained in this statement is for the purpose of obtaining funding from SVECare on behalf of the undersigned. Each undersigned understands that the information provided herein is used in deciding to grant funding, and each undersigned represents and warrants that the information provided is true and complete and the SVECare Board of Directors may consider this statement as continuing to be true and correct until a written notice of change is provided. The SVECare Board of Directors is authorized to make all inquiries they deem necessary to verify the accuracy of the statements made herein. If false information is provided, this will bar applicant from any future grant requests.

Applicant(s) further gives SVECare permission to share this application and pertinent information with other organizations that may be able to assist in fulfilling this request.

Date: \_\_\_\_\_ Signature of Applicant/Recipient \_\_\_\_\_ Signature of Co-Applicant \_\_\_\_\_