TRI-COUNTY HEALTH NETWORK

Fund #_____ □ Approved □ Denied
Application received___/___/_____
Referred by _____
Total grant awarded $_____
Completed by: _____

EMERGENCY FUND APPLICATION

For the Good Neighbor Fund (GNF) or Ouray County Response Fund (OCRF)

Name:_____ Date of Birth: _____
Last First Middle DD/MM/YYYY

Are you married or living with a significant other? □ Yes □ No

If yes, spouse/partner's name: _____
Last First Middle

Number of children living in the household?_____ Ages: _____

Physical Address: _____
Street City State Zip

Mailing Address:_____ ☐ Same as Physical Address

Phone:_____ Email:_____
Home Mobile

Length of time living or working in San Miguel County, West end of Montrose, or Ouray County_____
Years/Months

Do you plan to stay in the area once this crisis is over? □ Yes □ No

Race: □ White □ Black or African American □ American Indian or Alaskan Native □ Asian
□ Native Hawaiian or other Pacific Islander □ Other (please specify): _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Gender: □ Male □ Female □ Transgender Male □ Transgender Female □ Gender non-conforming □ Nonbinary
□ Other gender identity

Requested Amount: $_____

What are you requesting funds for?

Please describe <u>in detail</u> why you are in this crisis:

Have you (or your spouse/partner) applied to GNF or OCRF in the past? □ Yes □ No
If YES, please provide the date(s) and amount of request_____/_____/_____$_____

<u>Employment information:</u>

Are you currently employed? □ Yes □ No

If you are <u>unemployed or on leave</u>, what date did unemployment begin:____/____/___

If you are <u>unemployed or on leave</u>, have you applied for unemployment benefits? □ Yes □ No

Date you submitted unemployment application:_____/____/____

Were you approved for unemployment benefits? □ Yes □ No

Date your unemployment benefits started or will start:_____/____/____

Amount of unemployment benefits you were approved to receive each month: **$**_____

Most Recent Employer: _____
Name of Company City State

Manager Name and Phone Number: _____

Do you plan to return to this employer? □ Yes □ No Date:____/____/___

Is a medical release required for your return? □ Yes □ No

What is the anticipated date of the medical release?____/____/___

Do you have a new job lined up? □ Yes □ No Anticipated start date:_____/_____/_____

New Employer: _____
Name of company Address City State Zip

New Manager Name and Phone Number _____

*What are your sources of **monthly** income? Check all that apply.* Monthly Amount

- ☐ Employment (salaries, tips, bonuses, etc.)
  - ☐ Former Monthly Employment***** (salaries, tips, bonuses, etc.)....$_____
  - ☐ Current Monthly Employment***** (salaries, tips, bonuses, etc.) ....$_____
- ☐ Alimony/Child Support ....$_____
- ☐ Social Security/Retirement/Disability***** **....** $_____
- ☐ Welfare/TANF/Food Assistance(SNAP)....$_____
- ☐ Severance Pay… ....$_____
- ☐ Trust Funds/Annuities/Interest….....$_____
- ☐ Lottery Winnings/Insurance Settlements, etc....$_____

**** Proof of income sources required***

*What are your **monthly expenses**? Please provide documentation of these expenses when you submit your application.*

- ☐ Rent/Mortgage… ....$ _____
- ☐ Utilities (electric, water/sewer, gas)....$ _____
- ☐ Cell Phone/Phone….....$ _____
- ☐ Food… ....$ _____
- ☐ Health and Medical Bills (insurance, prescriptions). ....$ _____
- ☐ Car-Related Payments (car insurance, gas, car payment)....$ _____
- ☐ Childcare… ....$ _____
- ☐ Child Support/Alimony… ....$ _____
- ☐ Other… ....$ _____

***What other resources have you pursued? You must provide an answer for each** (approved, terminated, denied etc.)*

APPLIED?

Housing Authority
Section 8 Rental Assistance/HUD/etc… …☐ Yes- Status:_____☐ No- Reason:_____

Social Security/Disability/etc… ....☐ Yes- Status:_____☐ No- Reason:_____

Social Services
TANF… ....☐ Yes- Status:_____☐ No- Reason:_____

Food Stamps/SNAP… ....☐ Yes- Status:_____☐ No- Reason:_____

Medicaid/CHP+ ....☐ Yes- Status:_____☐ No- Reason:_____

Emergency Funds….....☐ Yes- Status:_____☐ No- Reason:_____

Misc COVID-19 Funds.....☐ Yes- Status:_____☐ No- Reason:_____

Health Insurance….....☐ Yes- Status:_____☐ No- Reason:_____

Private Charities… ....☐ Yes- Status:_____☐ No- Reason:_____

Family/Friends….....☐ Yes- Status:_____☐ No- Reason:_____

Victim's Compensation….....☐ Yes- Status:_____☐ No- Reason:_____

Other:_____☐ Yes- Status:_____☐ No- Reason:_____

How much cash do you have on-hand (including checking/savings accounts*)? $_____
*****_Proof of account balance required_

Please explain how you have exhausted all your other resources:

If you are reapplying to GNF or OCRF, elaborate on what steps and actions you have taken to become financially stable since you last received funding.

Please provide us with any other information that you feel would help in determining your eligibility for funds

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Social Determinants of Health Questionnaire:

1. *What is your living situation?*
   - ☐ I have a steady place to live.
   - ☐ I have a place to live, but I am worried about losing it in the future.
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, a bench, in a car, abandoned building, bus or train station, or in a park.
2. *Think about the place you live. Do you have problems with any of the following? (select all that apply).*
   - ☐ Pests such as bugs, ants or mice
   - ☐ Smoke detectors missing or not working
   - ☐ Oven or stove not working
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ None of the above

3. *Within the past 12 months, you worried that your food would run out before you got money to buy more:*

   ☐ Often true
   ☐ Sometimes true
   ☐ Never true

4. *Within the past 12 months, the food you bought just didn't last and you didn't have money to get more:*

   ☐ Often true
   ☐ Sometimes true
   ☐ Never true

5. *In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living (food, job interview, child care)?*
   ☐ Yes
   ☐ No
   ☐ I choose not to answer

6. *In the past 12 months has the electric, gas, oil, or water company threatened to shut of services in your home of where you live?*
   ☐ Yes
   ☐ No
   ☐ Already shut off
   ☐ I choose not to answer

7. *Do problems getting child care make it difficult for you to work or study?*
   ☐ Yes
   ☐ No
   ☐ I choose not to answer

8. *How many times have you received care in an emergency room (ER) over the last 12 months?*
   ☐ 0 times
   ☐ 1 time
   ☐ 2 or more times

9. *In the last 12 months, have you needed to see a medical provider (doctor, dentist, mental health, optometrist, specialist), but could not because of how much it cost?*
   ☐ Yes
   ☐ No
   ☐ I choose not to answer

10. *How often do you have a problem understanding what is told to you by a medical provider about your health or medical condition?*
    ☐ Never
    ☐ Rarely
    ☐ Sometimes
    ☐ Fairly often
    ☐ Frequently

11. *How confident are you in filling out medical forms by yourself?*
    ☐ Extremely confident
    ☐ Somewhat confident
    ☐ A little bit confident
    ☐ Not at all confident
    ☐

12. *How often does anyone, including family and friends, insult or talk down to you?*
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

13. *How often does anyone, including family and friends, scream or curse at you?*
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

14. *How often does anyone, including family and friends, threaten you with harm?*
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

15. *How often does anyone, including family and friends, physically hurt you?*
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

16. *In the past 12 months, how often do you participate in group activities like going to church, volunteering, attending a meeting or an organized group (book club, Rotary, veterans 'group)?*
    - ☐ Never
    - ☐ About one or twice a year
    - ☐ Several times a year
    - ☐ About once a month
    - ☐ Every week
    - ☐ Several times a week

17. *If your family suddenly had a crisis or needed money for an unexpected expense, like a car repair or serious illness, would you have someone you could count on for help?*
    - ☐ Yes
    - ☐ No
    - ☐ I choose not to answer

18. *How often do you feel lonely or isolated from those around you?*
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

19. *Stress is when someone feels tense, nervous, anxious or can't sleep at night because their mind is troubled. How stressed are you?*
    - ☐ Not at all
    - ☐ Slightly stressed
    - ☐ Moderately stressed
    - ☐ Very stressed
20. *Do you have concerns about immigration for you or your family members?*
    - ☐ Yes
    - ☐ No
    - ☐ I choose not to answer

Attestation:
I certify that the information given on this application is accurate and complete to the best of my knowledge and belief. I also understand that false statements or information are grounds for denial of assistance and/or prosecution of fraud, as allowed by Colorado law.

Release of Information Consent
By signing this application, I understand that my information may include protected health information. I authorize the release of my information to any person or agency necessary to meet my service needs, including, but not limited to, vendors and partner agencies. This information will be used solely for the purpose of assessing, arranging, and meeting my individual service needs.

I release Tri-County Health Network and its partners from any liability related to the sharing of this information.

Applicant Signature: _____ _____/_____/_____
Date

Co-applicant Signature: _____ _____/_____/_____
Date

Please submit this application, along with proof of the following,
- ✓ **Proof of current or most recent employment (e.g., paystubs, offer letter, etc.)**
- ✓ **Proof of social security, retirement, and/or disability payments (if applicable)**
- ✓ **Copies of all financial bills (car, electricity, insurance, etc.)**
- ✓ **Copy of lease agreement or mortgage statement**
- ✓ **Proof of checking and savings account balances**

Submit To:

Tri-County Health Network
Mail: PO Box 4178 Telluride, CO 81435
By fax: 720-712-9100
By email: GNF@tchnetwork.org
Any questions, call TCHNetwork: 970-708-7967