Application for Masonic "At-Home" Financial Assistance

THE OHIO MASONIC COMMUNITIES
RESOURCE CENTER

2655 West National Road, Springfield, OH 45504 | (877) 881-1623 | omcresourcecenter.org

Today. Tomorrow. Together.

Application for Masonic "At-Home" Financial Assistance

This application is used to gather information as part of the application for financial assistance. Please be assured that all information provided in this application will be held in strict confidence.

Fill out all items **completely and enclose copies of all supporting documentation**. Please send copies rather than original documents with this application. If a question is not applicable, please enter **"N/A."**

Any assistance granted will be in accordance with the Masonic "At-Home" Financial Assistance Agreement ("agreement"), and will be subject to the terms and conditions set forth in that agreement. Such assistance will be provided on a temporary basis as defined by the applicable dates in the agreement. Requests for additional assistance after termination of the original agreement require a new application.

Assistance granted by The Ohio Masonic Communities Resource Center ("OMCRC") is independent of any services provided by any other subsidiary of The Ohio Masonic Communities.

Please mail completed applications to:

The Ohio Masonic Communities Resource Center
2655 W. National Rd.
Springfield, OH 45504

Applicant Information

Applicant: _____

Address (note if co-applicant is different): _____

City/State/Zip: _____ Phone: (_____) _____

Alternate Phone: (_____) _____ Email: _____

Date of Birth: _____ U.S. Citizen? ☐ Yes ☐ No

Co-Applicant: _____

Date of Birth: _____ U.S. Citizen? ☐ Yes ☐ No

Do you have a Caregiver(s)? ☐ Yes ☐ No

Relationship to you: _____

Do you and your Caregiver live in the same household? ☐ Yes ☐ No

List income of other household members in addition to self: $ _____

Do you pay your caregiver for household tasks to be performed for you? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Have you applied for or are you eligible for Medicaid, Passport, or VA benefits? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Masonic Information:

Are you an active Ohio Master Mason, wife or widow of an Ohio Master Mason? ☐ Yes ☐ No

If a widow, was your husband a member in good standing at the time of his death? ☐ Yes ☐ No

Name of Ohio Master Mason: _____

Date of Birth _____

Lodge Name and Number: _____

Relationship to Applicant: _____

Are you an active Member of Ohio Order of the Eastern Star? ☐ Yes ☐ No
If yes, please provide copy of membership card.

Please provide a brief explanation regarding your request for financial assistance.

Financial Information:
Bank Accounts and Investments

Please provide information about all your current accounts or accounts in a living trust (CD's, Savings, Checking, Bonds including savings bonds, stocks, mutual funds, IRA's, Annuities, etc.)

The Net Current Value should be the market value of the account/investment (total value, not the share price).

Name of Financial Institution	Type of Account (CD, Checking, Saving, Stock, etc.)	Owner Name	Current Value of Account/Investment
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$

Real Estate

Please provide information for real estate you now own or owned or share(d) an interest in during the past 5 years. Regarding owner name for couples, enter "joint" if owned jointly; otherwise, record first name of owner.

Type	Address	Owner Name	Market or Appraised Value	Loans, Liens (Balances Owed)	Still Own? (Y/N)	Owned Jointly? (Y/N)
Primary Residence			$	$	☐ Yes ☐ No	☐ Yes ☐ No
			$	$	☐ Yes ☐ No	☐ Yes ☐ No
			$	$	☐ Yes ☐ No	☐ Yes ☐ No

Income

Please list all the monthly income that you and the people in your home receive such as earnings from employment, disability, retirement, worker's compensation, Social Security, Veteran's benefits, etc. Please also include any income provided by local or state organizations, including the Ohio Department of Jobs and Family Services.

Type of Income	Recipient	Amount	Frequency	Income for life? If not, what date does it end?
			☐ Monthly ☐ Quarterly ☐Annually	
			☐ Monthly ☐ Quarterly ☐Annually	
			☐ Monthly ☐ Quarterly ☐Annually	

Expenses

Please record your regular monthly expenses. All expenses should be recorded as **monthly** amounts, so if you have an annual expense, divide by 12 and record that amount. Attach additional sheet as needed.

Monthly Rent/Mortgage Payment	$
Property Insurance and Taxes (if not included in monthly payment)	$
Combined Utilities (Gas, Water, Electric, etc.)	$
Telephone/Cell Phone/Internet Expense	$
Average Monthly Groceries/Living Supplies	$
Personal Items and Clothing	$
Travel and Entertainment (including dining out)	$
Automobile Expenses (including Insurance, as applicable)	$
Health Insurance Premiums (including Rx Coverage)	$
Life Insurance Premiums	$
Out of Pocket Health Costs (Co-Pay, Deductible, OTC, etc.)	$
Out of Pocket Medication Costs (Rx not covered by insurance, OTC)	$
Monthly Payments Towards Debt	$
Gifts (Average amounts for holidays, birthdays, anniversary, etc.)	$
Other (Please Describe)	$
Other (Please Describe)	$
Total Monthly Personal Expenses	**$**

Current Debt and Liabilities

Please list any debt that you currently owe. This includes mortgages, loans, lines of credit, credit cards, outstanding medical bills, other bills, etc.

Party/Company Owed	Repayment terms? Balance in full, monthly payments, etc.)	Monthly Payment Due	Balance Due
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$

Health Insurance

Please list all existing health insurance coverage (including Medicare and Medicaid if applicable).

Please provide the amount of the monthly premium paid. Attach if more space needed.

Insurance Company	Policy Type (Primary, supplemental, Advantage, etc.)	Drug Coverage?	Monthly Premium
Medicare		☐ Yes ☐ No	$
		☐ Yes ☐ No	$
		☐ Yes ☐ No	$
		☐ Yes ☐ No	$

Do you have long-term care insurance? ☐ Yes ☐ No

If yes, does your insurance include an Assisted Living Clause? ☐ Yes ☐ No

***Please attach a copy of your policies with this application.**

Have you ever applied for Medicaid? ☐ Yes ☐ No

If Pending, Date Applied: _____

Office and Case worker: _____

If Denied, Reason: _____

Life Insurance

Please provide information for any life insurance policies. **Face Value** is the amount the policy would pay on death. **Cash Value i**s the amount you would receive if you cashed in the policy today. Please provide the *annual* Premium amount.

Insurance Company	Type of Policy (Term, Whole Life, AD&D, etc.)	Death Benefit	Cash Value (if any)	Annual Premium
		$	$	$
		$	$	$
		$	$	$

Acknowledgment and Consent

In consideration of The Ohio Masonic Communities Resource Center ("OMCRC") receiving and processing my Application for Financial Assistance, I hereby authorize OMCRC to review any and all available public records relating to me. This includes records that may be obtained from third parties including governmental authorities, credit reporting agencies, public depositories and computer databases. I affirm that I have provided full and complete disclosure of the information which is required for my Application for Financial Assistance and acknowledge that any material omission may result in denial of my Application for Financial Assistance.

Signature of applicant _____ Date _____

Signature of co-applicant _____ Date _____

Signature of POA _____ Date _____
(If Applicable)

Checklist of Required Information for Application

Category	Document(s)	Included
Identification	Copy of Valid Picture ID	☐
Estimate of Services	Pre-Authorization Form	☐
Verification/Masonic Eligibility (for OES)	Current Dues card or Letter from Chapter Secretary	☐
Financial statements (Banks, Investments, etc)	Copies of current statements for all accounts listed in application *(3 months)*	☐
Tax Returns	Copies of prior year Federal tax returns *Please note if not required to file taxes*	☐

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Please feel free to contact us with any questions:

Toll Free: 1-800-564-9016
Email: FAP@omcoh.org