

Grant Application

Applicants must complete this form to the best of their ability. ***It is essential that you provide current and accurate information. Any documentation that can support your claim would be helpful.*** Please keep a copy of the completed form for your records.

Completed applications should be submitted either:

via email to assistance@lathamcares.org or

via mail to: LathamCares C/O LATHAM & WATKINS
Attention: Wendy Atrokhov
555 Eleventh Street, NW
Washington, D.C. 20004

Questions? Please email: assistance@lathamcares.org.

COMPLETE SECTIONS 1 – 4. PLEASE PRINT CLEARLY.

Section 1 – Applicant Information

Name: _____

Address: _____

Telephone: _____

Alternate Number: _____

Email: _____

Manager's Name: _____

Have you applied to *LathamCares* before? Yes No

If so, did you receive assistance? Yes No

Date you applied: _____

Section 2 – Description of Hardship

Date of Disaster or Hardship: _____

Description of your loss/hardship:

Was it beyond your control? Yes No

Do you or any member of your household or family have other insurance coverage or any other financial resources to assist with the hardship/disaster? Yes No

If yes, please explain:

Section 3 – Amount of Assistance Requested

Please provide an itemized list of estimated costs included in your assistance request. Attach an additional sheet if necessary.

Description of Expense	Estimated Cost
Total Assistance Requested	

Section 4 – Your Financial Resources and Responsibilities

Please list all members of your household and their relationship to you:

Name	Relationship	Age

Combined Monthly Household Income:

Regular Wages _____
 Other Household Wages _____
 Child Support _____
 Social Security _____
 Other _____
 Total _____

Monthly Household Expenses

Rent/Mortgage _____
 Food _____
 Auto (Payments & Insurance) _____
 Gas _____
 Child Support _____
 Cable/Internet _____
 Home/Cell Phone _____
 Credit Card Debt _____
 Student Loan/Tuition _____
 Other Debt or Expenses _____
 Total _____

Financial Resources of Household

Checking Account Balance _____
 Savings Account Balance _____
 Other _____
 Total _____

Section 4 – Your Financial Resources and Responsibilities Continued...

Homeowner's/Renter's Insurance (complete if request is related to loss of primary residence)

Do you have Homeowner's/Renter's Insurance? Yes No

If yes, is this loss covered? Yes No

If yes, amount of deductible? _____

Auto Expenses (complete if request is automobile related)

Do you have auto insurance? Yes No

If yes, is this loss covered? Yes No

If yes, amount of deductible? _____

Will auto insurance cover medical expenses? Yes No

If yes, amount of coverage? _____

Will auto insurance cover lost wages? Yes No

If yes, amount of coverage? _____

If you are requesting temporary assistance to get to work or assistance with automobile repairs:

Is public transportation available? Yes No

Is there another car in your household? Yes No

How far is your commute to work? _____

Medical Expenses (complete if request is related to medical expenses)

Do you have medical insurance? Yes No

If yes, amount of annual deductible? _____

If yes, co-pay per visit? _____

If yes, annual out-of-pocket maximum? _____

If no, amount of anticipated government assistance? _____

Assistance with Funeral Expenses (complete if request is related to funeral expenses)

Is life insurance available? Yes No

If yes, how much? _____

Will funds be available from decedent's estate? Yes No

If yes, how much? _____

Total assistance family members can provide _____



Section 5 – Documentation

Please provide any photos or documentation that you believe will support your request. LathamCares retains the right to request additional documentation to substantiate all of the information contained in this application, including but not limited to pay stubs, financial records, and lease/loan documents. Failure to provide such documentation upon request may result in LathamCares' denial of your application.

Certification & Release

Under penalties of perjury, I certify that the information contained in this application is true, correct, and complete and that I am requesting assistance from LathamCares because of a severe financial hardship that is not covered by insurance or other sources.

Applicant Signature (or Delegate Signature)

Date

Delegate's Name and Relationship to Applicant (if applicable)