

SWIFT EAGLE CHARITABLE FOUNDATION

P.O. Box 1977 • Avon, Colorado 81620 • phone 970-845-7655 • 970-926-0330 • info@swift eagle.org

APPLICATION FOR ASSISTANCE

NO INCOMPLETE APPLICATIONS WILL BE ACCEPTED. (4 pages)

DATE: _____

Have you previously applied for assistance from Swift Eagle Charitable Foundation? YES NO When: _____

APPLICANT INFORMATION

NAME: _____ AGE: _____ DATE OF BIRTH: _____

PHYSICAL ADDRESS: _____ OWN RENT TYPE OF DWELLING: _____

MAILING ADDRESS: _____ YEARS AT CURRENT ADDRESS: _____

PREVIOUS ADDRESS: _____ YEARS AT PREVIOUS ADDRESS: _____

PHONE: _____ EMAIL: _____ YEARS IN EAGLE COUNTY: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

RESIDENCE STATUS: US CITIZEN LEGAL RESIDENT UNDOCUMENTED RESIDENT SSN# _____

If legal resident, type of Visa and Expiration Date: _____

PLEASE LIST 3 CHARACTER REFERENCES AND CONTACT INFORMATION:

1. _____ PHONE: _____

2. _____ PHONE: _____

3. _____ PHONE: _____

MAY WE CONTACT THESE REFERENCES? YES NO _____

APPLICANT EMPLOYMENT INFORMATION

EMPLOYER: _____ TYPE OF BUSINESS: _____

ADDRESS: _____

PHONE: _____ CONTACT PERSON: _____

POSITION HELD: _____ YEARS THERE: _____

PREVIOUS EMPLOYER: _____ YEARS THERE: _____

FAMILY MEMBERS LIVING WITH YOU (Please include parents, spouse, children, and any other close relatives)

NAME	AGE	RELATIONSHIP	OCCUPATION	US CITIZEN	LEGAL RESIDENT	UNDOCUMENTED RESIDENT
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL INSURANCE INFORMATION (if applicable)

DO YOU HAVE MEDICAL INSURANCE? YES NO NAME OF INSURANCE CARRIER _____

POLICY #: _____ CONTACT PERSON: _____ PHONE #: _____

DOES YOUR EMPLOYER OFFER MEDICAL INSURANCE? YES NO

PERSONAL FINANCIAL INFORMATION: PLEASE COMPLETE THE FOLLOWING

ASSETS	DEBTS/OBLIGATIONS	MO. PAYMENT
Cash in bank: \$ _____	Credit card balances:\$ _____	\$ _____
Stocks/bonds: \$ _____	Stock loans: \$ _____	\$ _____
Cash value of Life Insurance: \$ _____	Life insurance loans:\$ _____	\$ _____
Real Estate:		
Residence: \$ _____	Mortgage balance: \$ _____	\$ _____
Rentals: \$ _____	Mortgage balance: \$ _____	\$ _____
Other: \$ _____	Mortgage balance: \$ _____	\$ _____
Automobiles: (year/make)		
_____ : \$ _____	Auto loan/lease: \$ _____	\$ _____
_____ : \$ _____	Auto loan/lease: \$ _____	\$ _____
_____ : \$ _____	Auto loan/lease: \$ _____	\$ _____
Retirement accounts:		
IRAs: \$ _____	Loans against	
401K: \$ _____	Retirement funds: \$ _____	\$ _____
Pension: \$ _____		
Other: \$ _____		
Other assets: (describe)		
_____ : \$ _____	_____ \$ _____	\$ _____
_____ : \$ _____	_____ \$ _____	\$ _____
_____ : \$ _____	_____ \$ _____	\$ _____

GROSS MONTHLY INCOME

Salary of applicant: \$ _____

Salary of spouse: \$ _____

Salary of other relatives living with applicant: \$ _____

Other household income:
(describe)

_____ \$ _____

_____ \$ _____

_____ \$ _____

Alimony/child support or maintenance: \$ _____

MONTHLY EXPENSES

Mortgage or rent: \$ _____

Homeowners' dues: \$ _____

Utilities: \$ _____

Medical Insurance: \$ _____

Other insurance:
(describe)

_____ \$ _____

Food: \$ _____

Medical Bills: \$ _____

Prescriptions: \$ _____

Childcare: \$ _____

Alimony/child support or maintenance: \$ _____

