



Application for The HOPE Fund

Please complete this form to request support from The HOPE Fund. To be eligible, applicants must have resided in Sudbury for at least one year. For additional information, please contact the Sudbury Town Social Worker at 978-440-5476. An interview will be required.

Send completed form to: Sudbury Town Social Worker, 275 Old Lancaster Road, Sudbury, MA 01776.

Name: _____

Address: _____ Apt. # _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Current Marital Status: Single Married Separated Divorced Widowed

Date of Birth: ___/___/___ How many years have you lived in Sudbury? _____

1. Please list all other members of your household.

Name	Date of Birth	Relationship to Applicant	Occupation	Dependent?
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Please explain briefly why you are seeking financial assistance at this time.

Vendor Name (attach a copy of the bill(s)): _____

3. How did you originally hear about the HOPE Fund?

- | | | | |
|--|---|--|---|
| <input type="radio"/> Town Social Worker | <input type="radio"/> Other Social Worker | <input type="radio"/> Senior Center | <input type="radio"/> Housing Authority |
| <input type="radio"/> HOPEsudbury Telethon | <input type="radio"/> HOPEsudbury Website | <input type="radio"/> Church | <input type="radio"/> Food Pantry |
| <input type="radio"/> Apartment Management | <input type="radio"/> Family member | <input type="radio"/> Friend | <input type="radio"/> Neighbor |
| <input type="radio"/> School - Check one: | <input type="radio"/> Haynes <input type="radio"/> Loring <input type="radio"/> Nixon | <input type="radio"/> Noyes <input type="radio"/> Curtis | <input type="radio"/> LSRHS |
| <input type="radio"/> Other: | _____ | | |

Provide name/position of person who referred you: _____

4. Have you applied for (or are you receiving) any other financial assistance? If yes, please indicate which of the following resources you benefit from:

- | | | |
|---|---|---|
| <input type="checkbox"/> Food Pantry | <input type="checkbox"/> Senior Tax Relief | <input type="checkbox"/> St. Vincent dePaul |
| <input type="checkbox"/> Entitlement Assistance | <input type="checkbox"/> Mass Health/Medicare | <input type="checkbox"/> Other relief from religious org. |
| <input type="checkbox"/> Fuel Assistance | <input type="checkbox"/> Utility Assistance | <input type="checkbox"/> Elder dental program |
| <input type="checkbox"/> Housing subsidy | <input type="checkbox"/> SNAP/nutritional assistance. | <input type="checkbox"/> Bankruptcy/Other tax relief |
| <input type="checkbox"/> Veterans Benefits | <input type="checkbox"/> SSI/SSDI | <input type="checkbox"/> Clothing Exchange |

Please explain other types of assistance:

Have you completed the attached budget? (Must be completed thoroughly as part of the application process) Yes No

PREVIOUS APPLICANTS

Have you previously received assistance from The HOPE Fund? Yes No
If yes, provide the estimated date(s), amount received, and a brief description of how funds were used:

If yes, please list the steps you have taken to improve your financial situation since you last applied. What changes in your income or expenses have been made?

Note for those who have received assistance from The HOPE Fund two or more times in the past: You must have demonstrated that you have taken steps to improve your financial situation (i.e. followed through with previous referrals made for other sources of assistance, decreased spending, increased savings or completed an approved budgeting class) and/or have experienced a significant life event that has changed your financial circumstances so that you now have an emergency financial need and have no other resources available.

CERTIFICATION AND RELEASE OF INFORMATION

I certify to the best of my knowledge that the information provided is complete and accurate. I authorize The HOPE Fund committee to verify any of the information provided. I understand that information, names omitted, may be shared with committee and board members for the purpose of program review and planning.

Applicant's Signature: _____ Date: ___/___/___

<u>For Office Use</u> Date received: ___/___/___ Job #: _____ Client #: _____ Approved Amount: \$ _____ 1/17
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INCOME		AMOUNT per month
For salary, include full time, part time, and seasonal employment, temporary jobs, tips, and commissions. For self-employment, include income less cost-of-doing business expense and state average monthly income	Salary / Wages	
	Unemployment	
	SSI & SSDI	
	SNAP/WIC	
	Veteran's Benefits	
	Child Support/TANIF/EAEDC	
	Alimony	
	Other (explain)	
TOTAL		

ASSETS		VALUE
List all assets and their estimated value	Car	
	Home	
	Other	
	Other	
	TOTAL	

SAVINGS		
	Emergency Fund	
	Transfer to Savings	
	Education	
	401 K or Retirement Funds	
TOTAL		

BUDGET SUMMARY		
TOTAL INCOME		
TOTAL EXPENSES		
NET		

HOLIDAY, VACATION, & GIFT EXPENSES		PROJECTED
Airfare/Travel (gas, tolls, etc.)		
Accommodations (hotel, Air BnB...)		
Decorations		
Wrapping paper/gift bags		
Food (turkey, dessert, etc)		
Gifts (Name and Occasion)	Projected per gift	
TOTAL		

EXPENSE		AMOUNT per month	
If it is an annual payment, divide by 12 to get the monthly payment	HOME		
	Mortgage / Rent		
	Home/Renter's Insurance		
	Gas & Oil		
	Electric		
	Garbage, Sewer, & Water		
	Phone		
	Cable (Hulu/Netflix) & Internet		
	Other (explain)		
	TOTAL		
	TAXES		
	Excise Tax/ Property Tax		
	TRANSPORTATION		
	Gas & Maintenance		
	Public Transportation & Parking		
	Car Payment		
	Car Insurance		
	Repairs / Maintenance		
	DAILY LIVING		
	Groceries & Hygeine Products		
	Child Care		
	Dining Out		
	Pet Expenses		
	Clothing		
	Other (explain)		
	ENTERTAINMENT		
	Child's Extracurriculars		
Other (explain)			
TOTAL			
HEALTH			
Health Insurance			
Doctors / Dentist Visits			
Medicine / Prescriptions			
Other (explain)			
TOTAL			
DEBT		Monthly Payment	
Total Amount Owed	Credit Card Payment		
	Student Loan Payment		
	Other (explain)		
TOTAL			