Cain Cares Grant Application

Email to give@caincares.com

Criteria

Cain Cares grants provide a measure of financial assistance to support Cain Team clients and their families, including qualified domestic partners, with hardship caused by a sudden emergency. "Hardship" is defined as a difficult circumstance that a person or family cannot handle without outside help. Cain Cares grants provide assistance for expenses incurred, and cannot provide assistance for projected expenses.

Eligibility

The Cain Team past and current clients and their families are eligible to apply.

Grants

Grant applications are evaluated on a case-by-case basis after verification of the applicant's need. Cain Cares grants are made subject to approval of the Cain Cares board of directors.

Application

Prior to submission to Cain Cares, the application must be reviewed and signed by the President and Secretary. If the need is medically related, a signed physician's statement must also be submitted.

Cover Letter

Please submit with the application a cover letter summarizing (1) the applicant's circumstances and how these circumstances necessitate a need for assistance; (2) the amount of the actual monetary need; (3) the amount of the monetary request; (4) an indication of the amount of financial and other assistance the applicant's community has provided in the spirit of family helping family.

Documentation Required

1. Most recent (two years) signed federal income tax returns in their entirety with 1099s/ W-2s.
2. Most recent bill or statement for all line items completed on pages 3 and 4 of the application.
3. Signed physician's statement, if this need for the grant is a result of a medical emergency.
4. If the applicant does not have medical insurance, copies of bills for medical (or other) expenses that have been incurred as a result of the situation.
5. If the applicant has medical insurance, Medicaid or Medicare, please submit only a summary of all claims for the range of dates for which medical treatment was needed. The summary should show the amount of medical expense paid by the insurance provider and the amount of the medical expense for which the patient is responsible. The summary can be obtained from the medical insurance provider, usually online.
6. If the applicant has homeowner's insurance, please submit documentation for limits of coverage and deductibles, if applicable to the situation.

The Cain Cares board reserves the right to request other pertinent information. Completed application and attachments should be emailed to Cain Cares at give@caincares.com. Any questions should also be directed to give@caincares.com.

Process

Cain Cares will review the application and secure any additional needed information from the applicant prior to submission to the Cain Cares board for approval. Within 30 days of the receipt of the application and all required documentation, the applicant will receive notification of approval and the amount of the grant, or notification of regret. Although this application might meet the grant criteria set forth by Cain Cares, this does not necessarily mean the request will be approved.

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Total Amount Needed $_____

Total Amount Requested $_____

Certification by Applicant

I have reviewed the Cain Cares grant criteria (see page 1) and the information submitted is accurate. I hereby give permission to Cain Cares to obtain any additional information needed to complete the grant approval process..

Signed: _____ Date: _____

Print Name: _____ Tel: _____

Email: _____

Certification by Family Member of Applicant

I have reviewed this Cain Cares grant application. To the best of my knowledge, the information submitted is accurate, a financial need exists as represented and the applicant meets the criteria (see page 1) for a Cain Cares grant.

Signed: _____ Date: _____

Print Name: _____ Tel: _____

Relationship to Applicant: _____

Email: _____

*****For Cain Cares Use Only*****

Date Application Received _____

Date Additional Supporting Documents Received _____

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Personal Balance Sheet

Statement of Financial Condition as of _____ 20____

Assets - Attach a copy of the most recent statement for each line item completed.

Cash		
Checking Account(s)		
Savings Account(s)		
Certificates of Deposit		
Investment Securities (stocks, bonds, annuities, etc.)		
401(k), 403(b) etc.		
IRA(s)		
Pension(s)		
Residence – Fair Market Value		
Investment or Other Real Estate – Fair Market Value		
Investment or Other Real Estate – Fair Market Value		
Personal Property		
Whole Life Insurance Cash Values		
Business Ownership		
Loans Owed to You		
Other Assets		
Total Assets	**A**	

Liabilities - Attach a copy of the most recent bill or statement for each line item completed.

Residence – Mortgage Loan Balance(s)		
Real Estate Mortgage – Investment or Other Property		
Real Estate Mortgage – Investment or Other Property		
Second Trust(s)		
Home Equity Loan(s)		
Line of Credit		
Credit Card/Charge Account Bills		
Vehicle Loans		
Other Loans		
Education Loans		
Unpaid Federal Income Tax/Interest/Penalties		
Unpaid State Income Tax/Interest/Penalties		
Other Unpaid Taxes/Interest/Penalties		
Other Debts (please list)		
Total Liabilities	**B**	
Net Worth (A – B = C)	**C**	

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Monthly Income – Attach a copy of the most recent statement for each line item completed.

Average monthly household earned income from all jobs. Provide most recent 1099s/W-2s and most recent pay statement	Gross	Net
Dividends and Interest		
IRA Disbursements		
401(k) or 403(b) Disbursements		
Annuity Payments		
Social Security Disability or Retirement Income		
Alimony/Child Support		
Rental Property Income (please itemize if more than one)		
Total		

Monthly Expenses - Attach a copy of the most recent bill or statement for each line item completed.

Mortgage or Rent Payments	
Home Equity Loan(s)	
Second Mortgage(s)	
Homeowners Insurance (if not included in escrow)	
Car Loan(s)	
Car Insurance	
Fuel for Car(s)	
Medical/Dental/Vision Insurance	
Life Insurance	
Disability/Long Term Care Insurance	
Utilities: electric, gas, water and sewer, waste disposal	
Phone (cell and land lines)	
Internet and Cable/Satellite	
Credit and Charge Cards	
Rental/Investment Property Expenses	
Real Estate Business Expenses	
Child Care	
Alimony/Child Support	
Food	
Maintenance/Repairs/HOA fees	
Other (please provide details)	
Total	

Health Insurance? Yes _____ No _____

Medicare? Yes _____ No _____

Medicaid? Yes _____ No _____

Prescription Drug Insurance? Yes _____ No _____

Patient Release of Information

I consent and agree to authorize Cain Cares to obtain and discuss information related to my grant application with my physician and/or insurance company and/or pharmacy.

_____ _____

Print Name Date

_____

Signature

Physician's Statement

Dear Physician:

Your patient has applied to Cain Cares, a 501(c)(3) charity, for financial assistance. In order to process this application, we must verify the following information, and may contact you for additional information if needed. Please contact Cain Cares with any questions you may have. Thank you.

This completed form should be mailed or emailed to:

Cain Cares
1801 S. Mopac Expwy.
Suite 100
Austin, TX 78746
give@caincares.com

Patient's Section (Patient, please fill out this section)

Print Patient Name: _____ Last Four Digits of Patient's SSN: _____

Physician's Section

Print Name: _____ License Number: _____

Address: _____

Phone: _____ Fax: _____

Patient Diagnosis: _____

Diagnosis Date: _____

Patient Prognosis: _____

Other Pertinent Information: _____

Physician's Signature: _____ Date: _____