



Hope Fund Application

application number (office use only):

Date:

Send to: PO Box 224, East Machias, Maine 04630

fax: 207 835 4500

The purpose of the Hope Fund is to help providers from CCC partner agencies access resources to help their client/families accomplish established goals. Applications need to be submitted by staff providers and **all communication** is between the provider and the Hope Fund Committee.

## General Information

Provider Name: \_\_\_\_\_ Provider agency: \_\_\_\_\_

Provider Email: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Client / Family Name: \_\_\_\_\_

Client / Family Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Number of children : \_\_Ages of all household members (at least one child must be prenatal to age 8):

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## Request / Need Information

1. Brief family history and description of need or barrier:

2. What is the goal the family is working on?:

3. How does the Hope Fund support reaching this goal?:

4. Requested amount: \_\_\_\_\_



5. Resources already explored and outcomes:

General Assistance: \_\_\_\_\_ Shaw Fund: \_\_\_\_\_  
 DHHS Emergency Assistance: \_\_\_\_\_ Robbie Fund: \_\_\_\_\_  
 More Than Wheels: \_\_\_\_\_ Family: \_\_\_\_\_  
 Downeast Community Partners: \_\_\_\_\_ Other: \_\_\_\_\_

Please categorize your request according to the following areas:

- Addresses a safety issue
- Contributes to visitation or permanency outcomes
- Prevents a family crisis
- Supports child development
- Supports employment/career goals
- Increases access to services or opportunities
- Addresses unmet basic needs
- Other (please be specific)

\_\_\_\_\_  
 \_\_\_\_\_

\*Request Amount (one-time expenses, no past due bills) \$ \_\_\_\_\_

*\*Hope Fund award not to exceed \$1,000*



### Additional Documentation

- All requests must include invoice or estimate for repair, purchase, or services. (auto repair requests must include the cost of inspection)
- If combining Hope Fund with other resources to complete a purchase or project, you must fill out the **Combined Funding Budget** on page 3.
- If request commits family to future payments (e.g., security deposit or down payment) you must fill out the **Household Budget** on page 4.
- Supporting medical / dental / mental health information from health professional is required for medical requests.
- Other information the committee may need to make a determination: \_\_\_\_\_

### Payment Information

(must be completed)

Vendor / Landlord Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

### Permission to contact for follow-up interview

(optional)

\_\_\_ I do not wish to participate in a follow up interview

\_\_\_ I agree to participate in a follow-up interview to review my experience with the program. I understand that not participating will have **no** impact on the funding decision. I may change my mind about participating in the follow up interview at any time.

\_\_\_\_\_  
Client / Family Signature:

Date: \_\_\_\_\_

& Email Address: \_\_\_\_\_

\_\_\_\_\_  
Provider Signature:

Date: \_\_\_\_\_

*Thank you for your application*



## Combined Funding Budget

Use only if you are combining your request with funds from other sources. Only fill in the line items that apply to this request / need. Total costs must equal total funding. Do not fill this out if the Hope Fund is the only funding source for the request / need.

### Costs

- Materials \$ \_\_\_\_\_
- Equipment \$ \_\_\_\_\_
- Fees \$ \_\_\_\_\_
- Labor \$ \_\_\_\_\_
- Price of Auto \$ \_\_\_\_\_
  - Registration \$ \_\_\_\_\_
  - Insurance \$ \_\_\_\_\_
- Other \$ \_\_\_\_\_
- TOTAL COSTS** \$ \_\_\_\_\_

### Funding Sources

- Hope Fund Request \$ \_\_\_\_\_
- Other Agency Support \$ \_\_\_\_\_
- Savings \$ \_\_\_\_\_
- Family Contribution \$ \_\_\_\_\_
- Other \$ \_\_\_\_\_
- TOTAL FUNDING** \$ \_\_\_\_\_  
(must equal total costs)



# Monthly Household Budget

Use only if the request commits family to future payments. Use figures that do not include requested support.

## Current Monthly Income (take home or net monthly pay after taxes and deductions)

- Wages / Earnings \$ \_\_\_\_\_
  - Social Security and/or Veteran's Benefits \$ \_\_\_\_\_
  - TANF \$ \_\_\_\_\_
  - Child Support \$ \_\_\_\_\_
  - Unemployment Insurance \$ \_\_\_\_\_
  - Other \_\_\_\_\_ \$ \_\_\_\_\_
- TOTAL MONTHLY INCOME** \$ \_\_\_\_\_ **A**

## Current Monthly Expenses

- Rent or Mortgage (Include house insurance & property tax) \$ \_\_\_\_\_
  - Electricity \$ \_\_\_\_\_
  - Landline Phone/Cable/Internet \$ \_\_\_\_\_
  - Cell Phone \$ \_\_\_\_\_
  - Heat (annual expenses ÷ 12) \$ \_\_\_\_\_
  - Groceries (after WIC, SNAP or other food related resources) \$ \_\_\_\_\_
  - Current (not anticipated) Car Payment \$ \_\_\_\_\_
  - Gasoline & Maintenance \$ \_\_\_\_\_
  - Health Insurance & Medications \$ \_\_\_\_\_
  - Car Insurance \$ \_\_\_\_\_
  - child care expenses (monthly out-of-pocket expenses) \$ \_\_\_\_\_
  - School Loan(s) \$ \_\_\_\_\_
  - Credit Card Payment(s) \$ \_\_\_\_\_
  - Other Debt \$ \_\_\_\_\_
  - Child Support Payments \$ \_\_\_\_\_
  - Other \_\_\_\_\_ \$ \_\_\_\_\_
- TOTAL MONTHLY EXPENSES** \$ \_\_\_\_\_ **B**

**Monthly Income Less Expenses** \$ \_\_\_\_\_ **A minus B**

**Future monthly payment (rent, car payment, etc.) for requested item / need.** \$ \_\_\_\_\_