The Community Caring Collaborative	**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. Please remember that families have a $1,000 cap in a program year (3 terms) which begins on October 1st.

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 lease one child must be prenatal to age 8):

_____

_____

_____

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: $ _____ *(Hope Fund award not to exceed $1,000)*

Requests for services already rendered or goods already purchased will be denied

5. Resources already explored and outcomes: Please indicate below which resources have already been considered or pursued and whether the results were "n/a," "denied," "granted in part," etc.

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)

_____

_____

Justification for this specific item/need and consequences for the family if this request is denied:

_____

_____

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.

_____ Date: _____

Client / Family Signature:

& Email Address: _____

_____ Date: _____

Provider Signature:

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 **$** 0.00

Funding Sources

- Hope Fund Request $_____
- Other Agency Support $_____
- Savings $_____
- Family Contribution $_____
- Other $_____

TOTAL FUNDING **$** 0.00
(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 $ 0.00 **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 $ 0.00 **B**

Monthly Income Less Expenses $_____ **A minus B**

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