



Fund # _____ <input type="checkbox"/> Approved <input type="checkbox"/> Denied Application received ____/____/_____ Referred by _____ Total grant awarded \$ _____ Completed by: _____
--

EMERGENCY FUND APPLICATION

For the Good Neighbor Fund (GNF) or Ouray County Response Fund (OCRF)

Name: _____ Date of Birth: _____
 Last First Middle DD/MM/YYYY

Are you married or living with a significant other? Yes No

If yes, spouse/partner's name: _____
 Last First Middle

Number of children living in the household? _____ Ages: _____

Physical Address: _____
 Street City State Zip

Mailing Address: _____ Same as Physical Address

Phone: _____ Email: _____
 Home Mobile

Length of time living or working in San Miguel County, West end of Montrose, or Ouray County _____
 Years/Months

Do you plan to stay in the area once this crisis is over? Yes No

Race: White Black or African American American Indian or Alaskan Native Asian
 Native Hawaiian or other Pacific Islander Other (please specify): _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Gender: Male Female Transgender Male Transgender Female Gender non-conforming Nonbinary
 Other gender identity

Requested Amount: \$ _____

What are you requesting funds for?

Please describe in detail why you are in this crisis:

Have you (or your spouse/partner) applied to GNF or OCRF in the past? Yes No

If YES, please provide the date(s) and amount of request ____/____/____ \$_____

Employment information:

Are you currently employed? Yes No

If you are unemployed or on leave, what date did unemployment begin: ____/____/____

If you are unemployed or on leave, have you applied for unemployment benefits? Yes No

Date you submitted unemployment application: ____/____/____

Were you approved for unemployment benefits? Yes No

Date your unemployment benefits started or will start: ____/____/____

Amount of unemployment benefits you were approved to receive each month: \$_____

Most Recent Employer: _____
Name of Company City State

Manager Name and Phone Number: _____

Do you plan to return to this employer? Yes No Date: ____/____/____

Is a medical release required for your return? Yes No

What is the anticipated date of the medical release? ____/____/____

Do you have a new job lined up? Yes No Anticipated start date: ____/____/____

New Employer: _____
Name of company Address City State Zip

New Manager Name and Phone Number _____

*What are your sources of **monthly** income? Check all that apply.*

Monthly Amount

- Employment (salaries, tips, bonuses, etc.)
 - Former Monthly Employment* (salaries, tips, bonuses, etc.).....\$ _____
 - Current Monthly Employment* (salaries, tips, bonuses, etc.)\$ _____
- Alimony/Child Support\$ _____
- Social Security/Retirement/Disability*\$ _____
- Welfare/TANF/Food Assistance(SNAP).....\$ _____
- Severance Pay...\$ _____
- Trust Funds/Annuities/Interest.....\$ _____
- Lottery Winnings/Insurance Settlements, etc.....\$ _____

*** Proof of income sources required**

*What are your **monthly** expenses? Please provide documentation of these expenses when you submit your application.*

- Rent/Mortgage...\$ _____
- Utilities (electric, water/sewer, gas).....\$ _____
- Cell Phone/Phone.....\$ _____
- Food...\$ _____
- Health and Medical Bills (insurance, prescriptions).....\$ _____
- Car-Related Payments (car insurance, gas, car payment).....\$ _____
- Childcare...\$ _____
- Child Support/Alimony...\$ _____
- Other...\$ _____

What other resources have you pursued? You must provide an answer for each (approved, terminated, denied etc.)

APPLIED?

- Housing Authority
 - Section 8 Rental Assistance/HUD/etc... . . . Yes- Status: _____ No- Reason: _____
- Social Security/Disability/etc... . . . Yes- Status: _____ No- Reason: _____
- Social Services
 - TANF... . . . Yes- Status: _____ No- Reason: _____
 - Food Stamps/SNAP... . . . Yes- Status: _____ No- Reason: _____
 - Medicaid/CHP+ Yes- Status: _____ No- Reason: _____
 - Emergency Funds... Yes- Status: _____ No- Reason: _____
- Misc COVID-19 Funds..... Yes- Status: _____ No- Reason: _____
- Health Insurance... Yes- Status: _____ No- Reason: _____
- Private Charities... Yes- Status: _____ No- Reason: _____
- Family/Friends... Yes- Status: _____ No- Reason: _____
- Victim's Compensation... Yes- Status: _____ No- Reason: _____
- Other: _____ Yes- Status: _____ No- Reason: _____

How much cash do you have on-hand (including checking/savings accounts*)? \$ _____

**Proof of account balance required*

Please explain how you have exhausted all your other resources:

If you are reapplying to GNF or OCRF, elaborate on what steps and actions you have taken to become financially stable since you last received funding.

Please provide us with any other information that you feel would help in determining your eligibility for funds

Social Determinants of Health Questionnaire:

1. *What is your living situation?*

- I have a steady place to live.
- I have a place to live, but I am worried about losing it in the future.
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, a bench, in a car, abandoned building, bus or train station, or in a park.

2. *Think about the place you live. Do you have problems with any of the following? (select all that apply).*

- Pests such as bugs, ants or mice
- Smoke detectors missing or not working
- Oven or stove not working
- Mold
- Lead paint or pipes
- Lack of heat
- None of the above

3. *Within the past 12 months, you worried that your food would run out before you got money to buy more:*
- Often true
 - Sometimes true
 - Never true
4. *Within the past 12 months, the food you bought just didn't last and you didn't have money to get more:*
- Often true
 - Sometimes true
 - Never true
5. *In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living (food, job interview, child care)?*
- Yes
 - No
 - I choose not to answer
6. *In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home of where you live?*
- Yes
 - No
 - Already shut off
 - I choose not to answer
7. *Do problems getting child care make it difficult for you to work or study?*
- Yes
 - No
 - I choose not to answer
8. *How many times have you received care in an emergency room (ER) over the last 12 months?*
- 0 times
 - 1 time
 - 2 or more times
9. *In the last 12 months, have you needed to see a medical provider (doctor, dentist, mental health, optometrist, specialist), but could not because of how much it cost?*
- Yes
 - No
 - I choose not to answer
10. *How often do you have a problem understanding what is told to you by a medical provider about your health or medical condition?*
- Never
 - Rarely
 - Sometimes
 - Fairly often
 - Frequently
11. *How confident are you in filling out medical forms by yourself?*
- Extremely confident
 - Somewhat confident
 - A little bit confident
 - Not at all confident
 -

12. *How often does anyone, including family and friends, insult or talk down to you?*

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

13. *How often does anyone, including family and friends, scream or curse at you?*

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

14. *How often does anyone, including family and friends, threaten you with harm?*

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

15. *How often does anyone, including family and friends, physically hurt you?*

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

16. *In the past 12 months, how often do you participate in group activities like going to church, volunteering, attending a meeting or an organized group (book club, Rotary, veterans 'group)?*

- Never
- About one or twice a year
- Several times a year
- About once a month
- Every week
- Several times a week

17. *If your family suddenly had a crisis or needed money for an unexpected expense, like a car repair or serious illness, would you have someone you could count on for help?*

- Yes
- No
- I choose not to answer

18. *How often do you feel lonely or isolated from those around you?*

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

19. *Stress is when someone feels tense, nervous, anxious or can't sleep at night because their mind is troubled.*

How stressed are you?

- Not at all
- Slightly stressed
- Moderately stressed
- Very stressed

20. *Do you have concerns about immigration for you or your family members?*

- Yes
- No
- I choose not to answer

Attestation:

I certify that the information given on this application is accurate and complete to the best of my knowledge and belief. I also understand that false statements or information are grounds for denial of assistance and/or prosecution of fraud, as allowed by Colorado law.

Applicant Signature: _____

_____/_____/_____
Date

Co-applicant Signature: _____

_____/_____/_____
Date

Please submit this application, along with proof of the following,

- ✓ Proof of current or most recent employment (e.g., paystubs, offer letter, etc.)
- ✓ Proof of social security, retirement, and/or disability payments (if applicable)
- ✓ Copies of all financial bills (car, electricity, insurance, etc.)
- ✓ Copy of lease agreement or mortgage statement
- ✓ Proof of checking and savings account balances

Submit To:

Tri-County Health Network

Mail: PO Box 4178 Telluride, CO 81435

By fax: 720-712-9100

By email: GNF@tchnetwork.org

Any questions, call TCHNetwork: 970-708-7967