



Healing Musicians in Need
2601 E. Chapman Ave, Suite 204
Fullerton, CA 92831
Phone: (714) 626-0447 • Fax: (714) 626-0473
E-Mail: info@sweetrelief.org

Application for Assistance
PLEASE PRINT ALL INFORMATION

Name Date of Application Date of birth

Home Address Home/Evening Phone

Home Address Continued Cell Phone/Fax/Other

E-Mail address Social Security Number Marital Status

I prefer to be contacted by (check one) Phone _____ E-mail _____ Ground Mail _____

Partner or Spouse's name, date of birth, and employer

Please list the names, relationship to you, and ages of your dependents: _____

How many people live in your household? What is the total and your share of the monthly rent/mortgage payment? # of people _____ Total pmt _____ Your share _____

Please describe why you need assistance (e.g. for outstanding medical or hospital bills, for future treatment, for living expenses if retired or unable to work, etc.) _____

Total Amount Requested: _____

How did you learn of Sweet Relief Musicians Fund? _____

Category	Recordings? (Y or N)	Length of Time Active	Approximate Number of Public Performances per year
Vocalist, Singer	_____	_____	_____
Songwriter, Composer, Arranger	_____	_____	_____
Instrumentalist, Musician	_____	_____	_____

Please attach copies of any items indicating musician status, i.e. a bio, discography, newspaper clippings, sheet music, records, contracts, guild/union membership card, dues notice, or verification from other members of the music industry.

What was your adjusted gross income for each of the last two years? (Note: You might be asked to supply your tax returns) 200__: \$_____ 200__: \$_____

Please list the total value of each of your assets:

Make/Model/Year _____ \$ _____

Assets, cont'd**Retirement Plans**

(IRA's, Pension Plans)

\$ _____

Cash Value of Life Insurance

\$ _____

Company Name _____

Other Personal Property (jewelry, artwork, musical instruments, studio equipment, etc.)

\$ _____

Other _____

\$ _____

Please list your liabilities below:**First Mortgage**

Lender _____

\$ _____

Second Mortgage

Lender _____

\$ _____

Home Equity Line of Credit

Lender _____

\$ _____

Automobile Loan

Lender _____

\$ _____

Credit Cards

Bank Name _____

Bank Name _____

Bank Name _____

Other Loan(s)

Lender _____

\$ _____

Loans Against Life Insurance

Company Name _____

\$ _____

Have you (or your spouse, if applicable) applied for assistance from any other charitable fund, agency (governmental or otherwise), union, or guild? If yes, please list organizations and amount(s) requested, received or pledged:

Sweet Relief Musicians Fund's policy is to make payments directly to doctors, hospitals, medical service providers, or other providers of necessities. Please indicate below any special circumstances that the Grant Committee should consider in deciding whether another payment method should be used in your case.

Please fill out the following section only if you are applying for assistance with medical costs OR assistance with living expenses if your medical condition prevents you from working. Otherwise, please skip to the Certification and Authorization.

Please attach copies of outstanding bills for which you are requesting assistance. Please be sure that the vendor's name, address, and phone number, and your account number, is on the bill.

If the attached bills do not indicate the nature of your medical condition, or you are requesting funds for future treatment or living expenses, please attach either a statement from a Medical Doctor (MD) or other medical or hospital bills containing a diagnosis.

Do you have other paid or unpaid medical bills for which you are not requesting assistance? Please explain. _____

If you are requesting funds for future treatment, please provide us a treatment plan and the name(s), phone number(s), and specialty, if any, of your health care provider(s).

If you are requesting funds for living expenses, please describe what you need help with (i.e. number of mos. rent at what amount, number of mos. utilities, etc. _____

If you or your spouse has medical insurance, please tell us the name of your insurance company and the policy number. _____

If you (or your spouse, if applicable) have other medical coverage, please indicate below:

Medicare A ____ B ____

Medicaid _____

Medi-Cal _____

Other _____

Certification and Authorization

I hereby certify that I have answered the questions in this application to the best of my ability without any limitations whatsoever; the facts stated herein are true and I understand that any misrepresentation or false information will disqualify me for any assistance from the Fund. I further agree to notify Sweet Relief Musicians Fund of any change in my financial situation from the time of my application to the time a grant is made to me.

I understand that the Grant Committee can require me to provide a copy of my first tax return filed after receiving a grant from the Fund and/or a summary of my total medical expenditures. (Any request for a summary of medical expenditures will be made within one year of the grant.) My signature below constitutes acceptance of this requirement.

I hereby authorize Sweet Relief Musicians Fund to communicate with other entertainment assistance organizations which might assist me and/or those people or organizations listed in this application, or later provided by me, regarding the information contained herein.

Signature of Applicant

Signature of Spouse

Monthly Budget Form

Note: Please make sure you divide annual, semi-annual, quarterly, or other types of payments into monthly sums.

<u>INCOME</u>	MONTHLY	<u>EXPENSES</u>	MONTHLY
Income from Work	_____	Rent	_____
Spouse/Partner's	_____	Mortgage	_____
Income	_____	Home Insurance	_____
Residuals/Royalties	_____	Maintenance/	_____
Social Security	_____	Homeowner's Fees	_____
Disability	_____	Food/Entertainment	_____
Supplemental	_____	Gas	_____
Security Income	_____	Water	_____
		Electric	_____
Social Security	_____	Telephone	_____
Income	_____	Fax	_____
Unemployment	_____	Cell phone/pager	_____
State Disability	_____	Cable television	_____
General Relief	_____	Car Payment(s)	_____
Food Stamps	_____		_____
Veteran's Benefit	_____	Car Insurance	_____
Alimony	_____	Gasoline	_____
Union Pension(s)	_____	Public Transit	_____
	_____	Health Insurance	_____
Child Support	_____	Medical Bills*	_____
Trust Fund/Interest	_____	Prescriptions	_____
Other (List source)	_____	Dental Bills	_____
_____	_____	Supplements	_____
_____	_____	Life Insurance	_____
Relief Fund Grants	_____	Union Dues	_____
_____	_____	Loan(s)	_____
_____	_____	Credit Card Payment	_____
		Laundry	_____
		Cleaning	_____
		Other (Describe)	_____
		_____	_____
		_____	_____
TOTAL INCOME	_____	TOTAL EXPENSES	_____

*Medical expenses include deductibles or costs not covered by insurance