Human Connexus FOUNDATION

Connecting people with needs with people with means

Recipient Application

Date: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City:_____ State:_____ Zip:_____

Home Phone Number:_____ Cell Phone Number: _____

Email Address: _____

SS#:_____

Gender: ❑ Male ❑ Female Birth date: MM/DD/YR _____

Number of children: _____

U.S. Citizen or Permanent Resident: ❑ YES ❑ NO

All information will remain confidential with Human Connexus Foundation.

1. **Please check the Support Category that applies to your situation (more than one category may apply)**

❑ **Healthcare:**	provide financial support associated with an unexpected illness
❑ **Education:**	assist with educational expenses & basic living needs while an individual pursues their educational goals
❑ **Basic Living:**	support for basic living costs for those who are trying to improve their lives by taking on challenges
❑ **Natural Disaster:**	provide financial support for those impacted by natural disaster resulting in financial hardship
❑ **Military Service:**	provide financial support to individual families who commitment to the military resulting in financial hardship

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For the questions below, please attach a separate document with the explanation for each question along with any supporting documents.

2. **Provide a brief description of your background and your current living situation.**

3. **Explain the reason for applying for financial support.**

4. **Describe your short & long goals you want to achieve that this funding would help support.**

   Short term - what is possible in the next 6-12 months.
   Long term - what is possible in the next 1-3 years.

5. **Complete the attached worksheet that outlines your income and assets. The following support documents need to be included with the application:**

   - Tax returns or W2s for the past two (2) consecutive years
   - Bank account information (savings & checking account numbers and balances)
   - List of assets (house, car, trusts, etc.)
   - Other sources of income

6. **Complete the attached worksheet that outlines your monthly expenses. Indicate those expenses you want HCN to cover by check marking the appropriate box.**

Applicant's Signature _____ **Date:** _____

I agree that all information contained in this document and any supplemental material is accurate. Failure to provide accurate information will automatically forfeit funding.

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DATE: _____

NAME: _____

INCOME	SOURCE	MONTHLY AMOUNT	ANNUALIZED
Salary			
Child support			
Alimony			
Grants			
Disability			
Workman's Compensation			
State Assistance			
Federal Assistance			
Food Stamps			
Relatives/Friends			
Other			

ASSETS	BALANCE /VALUE	ACCOUNT INFORMATION
Checking Account #1		
Checking Account #2		
Savings Account #1		
Savings Account #2		
Car		
Home		
IRA		
401K		
Trust		
Other		

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DATE: _____

NAME: _____

EXPENSE	VENDOR	MONTHLY AMOUNT	BALANCE REMAINING	HCN FUNDED (CHECK MARK)
LIVING EXPENSES				
Rent/Mortgage				
Electricity				
Water				
Telephone				
Cell Phone				
Internet				
Cable/Satellite				
Car Payment				
Renter Insurance				
Homeowner Insurance				
Car Insurance				
Other				
INCIDENTAL EXPENSES				
Food				
Gasoline				
Baby supplies				
School supplies				
Gym memberships				
Post Office Box				
DMV Registration				
Other				
DEBT				
Credit card 1				
Credit card 2				
Credit card 3				
Credit card 4				
School loans				
Medical bills				
Other				