

Society of St. Vincent de Paul, St. Victor Conference
 PO Box 178, 501 1st Ave.
 Monroe, WI 53566
 608-329-7837, Ext 223
 iac@stvincentmonroe.org

REQUEST FOR ASSISTANCE INSTRUCTIONS

PAGE	YOU NEED TO	CHECK WHEN COMPLETED
2	Read and Sign "Notice to Applicants for Assistance"	
3	Read and Sign "Authorization to Release Information"	
4	Complete all of the information on page 4	
5	Tell us why you need assistance and fill out the remainder	
6	Complete all of the requested Financial Information	
7	Furnish the information or indicate if you don't wish to share	

ADDITIONAL THINGS NEEDED	CHECK WHEN COMPLETED
Please include COPIES of your last four payroll stubs	
IF you are requesting rental assistance have your landlord complete the "Verification of Residence" form	
IF you are requesting utility assistance, include a COPY of the bill and/or disconnection notice	
IF you are receiving benefits from Green County include a COPY of the "Notice of Decision for Eligibility" for each program you use	

Once the application is completed, call 608-329-7837, dial 0, and ask for the Intake and Assistance Coordinator to schedule an interview. Once the interview is completed, you may be asked for further information, referred to other resources or your request will be forwarded to members of our Vincentian Team. Our team will contact you for an interview.

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NOTICE TO APPLICANTS FOR ASSISTANCE

The Society of St. Vincent de Paul is a worldwide Christian community. The vocation of the Society's members is to follow Christ through service to those in need. Members show their commitment through person-to-person contact. The Society serves those in need regardless of creed, ethnic or social background, health, gender, or political opinion. No work of charity is foreign to the Society (Taken from Part I of the Rule of the International Confederation of the Society of St. Vincent de Paul).

When you apply for assistance from the Society of St. Vincent de Paul, St. Victor Conference (SVdP), there is no guarantee that you will receive any or all of the assistance that you request. The members of the Board of Officers, the individual Conference members, the store management team and individual store employees cannot personally guarantee or promise you or anyone else SVdP assistance.

There are many variables thoughtfully considered in the decision making process to determine the assistance granted to our applicants by SVdP. A decision on each individual application is made after careful evaluation by Conference members who insure confidentiality and fairness in the application process. I understand that Conference members might visit me in my home at a mutually agreeable time if it is appropriate. The SVdP Conference is committed to doing all it can with its limited resources to continue helping those in our communities who are in need.

By signing below you are indicating that:

- * I have read and understood this notice.
- * I have had all of my questions about the assistance decision making process answered to my satisfaction.
- * I understand that assistance from SVdP is a one time occurrence unless highly unusual circumstances arise.

_____ Applicant's Signature

_____ SVdP Authorized Representative

Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I, _____, of _____ do hereby consent and authorize all hospitals, clinics nursing homes, long term care facilities, physicians, health care providers, psychologists, psychiatrists, counselors, social workers, therapists and pharmacists who have custody or control of any medical or counseling information or business records, tenant records, employment records, banking records, credit reports, utility records, social security records, probation information or other records pertaining to ME, MYSELF to disclose such information to the Society of St. Vincent de Paul of Monroe, Wisconsin.

DESCRIPTION OF INFORMATION DISCLOSED

TYPE OF INFORMATION TO BE RELEASED: _____ VERBAL _____ WRITTEN

____ Information related to my request for assistance, e.g. communication with Green County Wisconsin Human Services, landlord, utility or heat providers, pharmacy, clinic, or other businesses.

____ Other: _____

PURPOSE OF THE DISCLOSURE:

The purpose of this disclosure is to assist in the evaluation of available services that can be provided to me by The Society of St. Vincent de Paul of Monroe, Wisconsin. Assistance may not be conditioned on obtaining the individual's authorization.

REVOCAION EXPIRATION, INSPECTION, REDISCLOSURE:

I understand that I may revoke this consent at any time by giving written notice to The Society of St. Vincent de Paul, St. Victor Conference, Monroe, WI, authorized to make disclosures in writing except to the extent that the program which is to make the disclosure in writing has already taken action in reliance on it. If not previously revoked, this consent will expire one year from the date of the signing of this authorization form. This consent allows the inspection and copying of records which are generated or produced after the date this consent is signed. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

I have read this authorization. I understand that I have the right to inspect and receive (at the expense of the undersigned) copies of and material disclosed by this release as required under Wis. Admin. Code ch. HSS 92.05 and 92.06. This release does not authorize The Society of St. Vincent de Paul of Monroe, Wisconsin, to re-release such records, (42 C.F.R. Part 2) This medical/psychological information release complies with the provisions of 51.30 Wis. Stats., and Admin. Code ch. HSS 92. This authorization is issued in accordance with 146.81 and 51.30 Wis. Stats., 45 CFR 164.508 (HIPPA) and Public Law 92.282.

A COPY OR FAX COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

_____ The Society of St. Vincent De Paul, Monroe, WI
Signature Date

_____ By: _____
Date of Birth Authorized Representative

ASSISTANCE APPLICATION "WHY I NEED ASSISTANCE"

(Add another sheet if necessary)

PLEASE GIVE A DETAILED DESCRIPTION OF YOUR REASONS FOR REQUESTING ASSISTANCE

How many adults live in your household? _____ What are their ages? _____ How many are employed? _____ How many children do you have? _____ What are their ages? _____ How many live with you full time? _____ Part time? _____ Some other place? _____ Who referred you to us? _____

ASSISTANCE APPLICATION FINANCIAL INFORMATION
Tell us about any previous assistance you have received from us

DATE	TYPE OF ASSISTANCE	AMOUNT

List benefits received from Human Services Caseworker: _____

TYPE	AMOUNT	TYPE	AMOUNT

Monthly Income

Source	Amount	Source	Amount
		TOTAL MONTHLY INCOME	

Monthly Expenses

Payment	Amount	Payment	Amount	Payment	Amount
Rent/Mortgage		Cable		Insurance	
Electricity		Food		Credit Cards	
Heat		Vehicle		Loans	
Water/Sewer		Gasoline		Other	
Phone		Medical		MONTHLY TOTAL	

Credit Card Balances	Loan Balances	Mortgage Balance	Other Balance

Total Monthly Income	Subtract: Total Monthly Expenses	End of Month Balance

