



METROPOLIS OF BOSTON PHILOPTOCHOS • DEPARTMENT OF SOCIAL WORK

Please email, mail or fax this application to:

METROPOLIS OF BOSTON PHILOPTOCHOS • 162 GODDARD AVENUE • BROOKLINE, MA 02445
Main # 617-277-4742 • Fax # 617-739-9229 Email: mob.philoptochos.service@gmail.com

APPLICATION FOR ASSISTANCE

If you are seeking financial assistance, please review our policies and procedures on page 3.

**PLEASE ATTACH
CURRENT PHOTO**

DATE ____ / ____ / ____ HOW DID YOU HEAR ABOUT US? _____

NAME OF APPLICANT _____

ADDRESS _____ Apt _____

CITY _____ STATE _____ ZIP CODE _____
TEL: HOME (____) _____ WORK: (____) _____ CELL: (____) _____

DATE OF BIRTH (DOB): _____ EMAIL: _____

NAME OF YOUR PARISH: _____ NAME OF YOUR PRIEST: _____

NAME SPOUSE: _____ LIVES IN _____ SPOUSE _____

MARITAL STATUS: _____ HOUSEHOLD ___ Y ___ N DOB: _____

TYPE OF HOUSING _____ AMT. MORTGAGE _____
(Rent/Own/Roommate/Other) _____ OR RENT _____ /PER MONTH

NAME / ADDRESS LL: _____

IF CLIENT IS UNDER 21, NAME OF CUSTODIAL PARENT OR GUARDIAN: _____
RELATIONSHIP _____

OTHERS IN HOUSEHOLD: NAME RELATIONSHIP DATE OF BIRTH

SOLELY SO WE CAN DETERMINE IF YOU MAY BE ELIGIBLE FOR PUBLIC BENEFITS OR OTHER ENTITLEMENTS, PLEASE PROVIDE:

CITIZENSHIP PERMANENT RESIDENT
STATUS: ___ US CITIZEN ___ /GREEN CARD ___ UNDOCUMENTED ___ GREEK NAT'L. ___ OTHER

IS THERE A PERSONAL OR FAMILY HISTORY OF ALCOHOL OR DRUG ABUSE/ADDICTION? ___ Yes ___ No

IS THERE A PERSONAL OR FAMILY HISTORY OF MENTAL ILLNESS? ___ Yes ___ No

ARE THERE FIREARMS IN HOUSEHOLD? ___ Yes ___ No IF YES, HOW ARE THEY SECURED? _____

SPECIFIC ASSISTANCE BEING REQUESTED: _____

PLEASE LIST HELP YOU HAVE RECEIVED OR CURRENTLY ARE RECEIVING FROM ANY OF THE FOLLOWING

NATIONAL PHILOPTOCHOS _____	TYPE / AMT. OF HELP RECEIVED _____	DATE(S) _____
METROPOLIS PHILOPTOCHOS _____	TYPE / AMT. OF HELP RECEIVED _____	DATE(S) _____
PHILOPTOCHOS CHAPTER _____	TYPE / AMT. OF HELP RECEIVED _____	DATE(S) _____
OTHER CHURCH _____	TYPE / AMT. OF HELP RECEIVED _____	DATE(S) _____
SOCIAL SERVICE AGENCY _____	TYPE / AMT. OF HELP RECEIVED _____	DATE(S) _____
GOV'T. / PUBLIC BENEFIT(S) _____	TYPE / AMT. OF HELP RECEIVED _____	DATE(S) _____
OTHER _____	TYPE / AMT. OF HELP RECEIVED _____	DATE(S) _____
OTHER _____	TYPE / AMT. OF HELP RECEIVED _____	DATE(S) _____

CONSENT FOR RELEASE OF INFORMATION: ___ SIGNED ___ MAILED ___ VERBAL PERMISSION ___ REFUSED

NAME OF APPLICANT _____

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TO BE COMPLETED BY ALL APPLICANTS:
HOUSEHOLD INCOME / EMPLOYMENT INFORMATION:

IS APPLICANT CURRENTLY EMPLOYED? Y N If YES, EMPLOYED BY: _____

DATES EMPLOYED: (FROM) _____ (TO) _____ IF NO LONGER EMPLOYED STATE REASON: _____

OTHERS IN HOUSEHOLD WITH INCOME FROM ANY SOURCE:

NAME

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF APPLICANT IS SEEKING FINANCIAL ASSISTANCE FOR HEALTH / HEALTH CARE RELATED COSTS
PLEASE COMPLETE THIS SECTION:

NOTE: THE CONSENT FOR RELEASE OF INFORMATION MUST BE SIGNED

NAME OF PATIENT _____ DATE OF BIRTH _____

PRIMARY DIAGNOSIS / DISABILITY, ETC: _____

PRIMARY MEDICAL PROVIDER(S):

HOSPITAL _____

DOCTOR _____

CLINIC / OTHER _____

IS THE PATIENT COVERED BY HEALTH INSURANCE: YES NO

NAME OF INSURANCE COMPANY: _____

AMOUNT of CURRENT UNPAID BILLS _____

OTHER RELEVANT HEALTH INFORMATION _____

FOR GREEK NATIONALS:

IF APPLICANT IS A GREEK NATIONAL, IS S/HE COVERED BY GREEK HEALTH INSURANCE? YES NO

IF YES,

NAME OF GREEK INSURANCE _____

WHAT WILL THE GREEK HEALTH INSURANCE COVER IN THE UNITED STATES? _____

PLEASE NOTE OUR POLICIES and PROCEDURES REGARDING FINANCIAL ASSISTANCE:

- *Our financial assistance is limited to Orthodox Christian individuals and families, regardless of immigration status provided the bills / expenses you are asking us to consider are from vendors within the United States of America.*
- *Each case is evaluated individually based on its merits, documented need and abilities of those involved.*
- *Cases seeking financial assistance are reviewed for approval or denial by designated members of the National Board of Philoptochos.*
- *All information provided is confidential and will not be shared with sources outside those named above without your permission.*
- *As a nonprofit organization, we are accountable to our donors. As a result, you will be required to submit current documentation of household income and expenses to verify your request, e.g. employment pay stubs; tax filing(s); government benefit award or denial letter(s); income from others in household; confirmation of contributions received from family / friends; copy of your lease, mortgage statement; copy of eviction / foreclosure notice, utility bills / shut-off notice; documentation of medical diagnosis; copies of uncovered medical expenses and other medical bills, etc.*
- *As our resources are limited in amount and scope, we are unable to provide ongoing financial assistance. When necessary, information about and/or referrals and/or assistance to apply for continuing help may be made to government agencies, local nonprofits, other levels of Philoptochos.*
- *Should your request be approved, please note that we do not provide direct cash assistance to applicant(s). Our policy is to pay the provider of service directly, such as the landlord, mortgage holder, utility company, medical provider, hospital, funeral home, etc.*

• Please describe specific help being requested from Philoptochos:

• Was there an event or events that caused you to seek our help and contact us at this time?

• How have you managed until now?

• As Philoptochos cannot provide ongoing assistance, how do you plan to manage in the future?

• Additional information that may help us determine how best to help you:

CERTIFICATION:

I certify that the information included on this form is true and complete to the best of my knowledge.

Signature of Applicant (or parent or legal guardian if applicant is a minor)

Date