THE ERIE COUNTY
BAR FOUNDATION

APPLICATION TO THE
ERIE COUNTY BAR FOUNDATION, INC.

Dated: _____

PLEASE NOTE: ***The information supplied on this application will be used solely by the Officers and Directors of the Erie County Bar Foundation, Inc. in considering your application for a loan/grant and will be kept in strict confidence. See protections afforded by the Judiciary Law Section 499, Disciplinary Rule 1-102 and HIPAA.***

I. PERSONAL DATA

Applicant Name _____

Business Address _____

_____

Business Tel. No. _____ Cell Phone No. _____

Business or home Email _____

Home Address _____

_____

Own or Rent. *Please circle.*

Home Tele. No. _____

Date of Birth _____ Marital Status _____

Names and Ages of Dependents _____

_____

Names of those with whom you reside _____

_____

_____

Have you received assistance from the Bar Foundation in the past? _____ Yes _____ No

Please explain your need(s) for assistance and/or ways in which the Foundation might help.

_____

_____

_____

_____

_____

II. PROFESSIONAL INFORMATION

A. Year of Admission to Practice: _____

Bar Association of Erie County membership? _____ Yes _____ No

B. EMPLOYMENT DATA (current and/or recent).

_____

_____

Annual income for the last 12 months _____

C. ADDITIONAL EMPLOYMENT INFORMATION.

If you are *not* presently employed, specify employment-related issues or concerns and list any relevant employment experience and job skills.

_____

_____

D. INFORMATION REGARDING EMPLOYMENT OF SPOUSE.

EMPLOYER:

Name _____ Job Title _____

(If self-employed, so state)

Address _____

_____

Length of Employment _____

Annual income for the last 12 months _____

E. ATTORNEY TRUST ACCOUNT INFORMATION.

Bank Name _____ Account Title _____

Account Number _____

F. Last year for which you filed federal/state income tax returns _____

G. Last year of payment of biennial attorney registration fee to Office of Court Administration _____

III. PUBLIC BENEFITS INFORMATION

Have you applied for social service assistance? If so, please list current payments (i.e. Food Stamps, Medicaid, Home Relief, SSI, etc.)

_____

_____

IV. GRIEVANCE INFORMATION

Are you now, or have you been, a subject to any disciplinary proceedings before the Grievance Committee? If yes, briefly give details including any claim involving *misuse* or *co-mingling* of client funds:_____

_____

If represented by an attorney in connection with grievance(s), give name of counsel:

_____

V. SUMMARY STATEMENT OF FINANCES

ASSETS:	***PERSONAL***	***BUSINESS***
Real Estate (*Market Value)*	$	$
Cash on Hand	$	$
Bank Account and Loans *Receivable*	$	$
Stocks and Bonds	$	$
Cash Value Life Insurance (*Net of Loans)*	$	
Autos, Boats & Other Vehicles	$	$
Business Accounts *Receivable*		$
Other Assets - Itemize:		
_____	$	$
_____	$	$
_____	$	$
TOTAL ASSETS:	$	$

LIABILITIES:	***PERSONAL***	***BUSINESS***
Real Estate Mortgages	$	$
Notes Payable (*Secured)*	$	$
Notes Payable *(Unsecured)*	$	$
Accounts and Bills Due	$	$
Unpaid Income Taxes	$	
Unpaid Real Estate Taxes	$	$
Unpaid Employee Taxes		$

DEBTS (ITEMIZE):	***PERSONAL***	***BUSINESS***
_____	$	$
_____	$	$
_____	$	$
_____	$	$
_____	$	$
_____	$	$
_____	$	$
TOTAL LIABILITIES:	$	$
NET WORTH (*Total Assets Minus Total Liabilities)*	$	

VI. STATEMENT OF INCOME AND EXPENSES ON A MONTHLY BASIS:
(*Average for the last three months)*

A.	***CURRENT MONTHLY INCOME***	***APPLICANT***	***SPOUSE***
	Gross Salary or Receipts	$	$
	Dividends and Interest	$	$
	Real Estate Income	$	$
	Other: _____	$	$
	_____	$	$
	TOTAL MONTHLY INCOME:	$	$
B.	***CURRENT MONTHLY EXPENSES***	***PERSONAL***	***BUSINESS***
	Rent	$	$
	Mortgage	$	$
	Total Taxes (Realty/Income/Payroll)	$	$
	Insurance		
	• *Life*	$	
	• *Medical*	$	$
	• *Property*	$	$
	• *Auto*	$	
	• *Professional Liability/Disability*	$	$
	Food	$	
	Utilities (including telephone)	$	$
	Clothing	$	
	Transportation (oil/gas/tolls)	$	$
	Medical and Dental (uninsured)	$	$
	Repairs and Maintenance	$	$
	Installment Obligations:		
	• *Auto Payment*	$	$
	• *Credit Card(s)*	$	$
	• *Other* _____	$	$
	_____	$	$
	Miscellaneous (Itemize)		
	• *Tuition*	$	
	• *Maintenance/Child Support*	$	
	• *Other* _____	$	
	Secretarial		$
	Office Supplies and Equipment/Postage		$
	Professional Dues and Fees		$
	Other Offices Expenses		$
TOTAL MONTHLY EXPENSES:		$	$
NET MONTHLY INCOME:		$	

VII. INFORMATION REGARDING APPLICANT HEALTH

A. Are you presently under the care of a physician, therapist or program? _____ Yes _____ No

If yes, name of therapist or program _____

Please detail your health situation _____

_____

B. What prescribed medications are you currently taking? For what conditions? Name of pharmacy?

_____

_____

C. If hospitalized within the last two years, indicate name of hospital(s), date(s) of admission and *reasons* for admission.

_____

_____

_____

D. Limitations on your ability to earn income. _____

_____

E. Do you have medical insurance? _____ Yes _____ No

Name of Carrier: _____

Type of Plan (individual, family, major medical, etc.): _____

Amount of quarterly premium: _____

Premium paid for by applicant/employer/spouse: _____

F. Do you have disability insurance: _____ Yes _____ No

Name of Carrier: _____

Waiting period and amount of coverage: _____

Amount of quarterly premium: _____

Premium paid for by applicant/employer/spouse: _____

VIII. STATEMENT OF FOUNDATION POLICY

The Foundation's mission is to aid attorneys and, in certain circumstances attorneys' families, who are experiencing financial hardship as a result of illness, incapacitation, or sudden unemployment. Assistance from the Foundation may consist of financial support, provision of counseling assistance, and/or vocational counseling and evaluation in the event vocational rehabilitation appears necessary, or a combination of such forms of assistance.

Applicant agrees to an immediate personal interview with the Resource Counselor working with the Foundation if requested to do so. Applicant also understands his/her application will be assigned to an attorney board member of the Foundation and understands cooperation with the reasonable requests of such attorney board member is necessary to ensure proper handling of this application.

Upon receipt of an application, an immediate assessment is made of the applicant's needs in the context of his/her existing financial and life circumstances and of the Foundation's resources and mission. Each applicant should understand that any aid the Foundation provides is intended to be short term in nature and unavailable for long-term, chronic difficulties. Each applicant is expected to make his/her best efforts to return to work as an attorney, participate in vocational counseling, and/or arrange for whatever long term financial and living assistance is available from other sources. The Foundation may be able to provide direction as to accessing such long-term assistance.

Financial aid from the Foundation is intended to be temporary and is designed to help an applicant through his/her emergency time in a caring and considered manner and as a bridge to a more permanent resolution of an applicant's difficulties. Under no circumstances are Foundation monies available to pay income or other business taxes or to aid an applicant for misappropriation or theft of client funds.

The Foundation meets monthly to review new applications and all pending cases. Communication and cooperation with reasonable requests of the Board or its agents to the best of an applicant's ability is required and vital to a proper response to an application and the continuation of assistance.

The Applicant certifies that the information contained in this application is accurate and affirms his/her understanding of the terms and conditions of assistance from the Foundation.

Applicant Signature_____ Date_____

IX. CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION IN ACCORDANCE WITH HIPAA REQUIREMENTS

I, _____, authorize _____
(Name) (Name of designation of medical/program/person disclosing)

at _____ to disclose
(address of medical/program/person disclosing)

to _____
(Name of person or organization to which disclosure is made)

mental health/medical/addiction information including diagnosis, prognosis, treatment plan, medication and/or other non-medical information pertaining to applicant.

(Nature and amount of information is be as limited as possible.)

The purpose of the disclosure authorized is to provide information to the Erie County Bar Foundation so that it may most appropriately assist applicants.

I understand that my records are protected under the Federal regulations governing Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164; Confidentiality and Drug Abuse Patient Record, 42 C.F.R. Pt. 2, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year or when applicant no longer requires assistance.

Dated:_____ _____
Signature of Applicant

_____
or Signature of Authorized Representative

STATE OF NEW YORK)
COUNTY OF ERIE) SS:
CITY OF BUFFALO)

On this _____ day of _____, 201___ before me, the undersigned, a notary public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acts, executed the instrument.

_____
Notary Public

X. CONSENT FOR RELEASE OF CREDIT HISTORY INFORMATION

I hereby authorize the Erie County Bar Foundation, its Board members and authorized employees, to investigate my creditworthiness and communicate with third parties relative to my credit history with them. Any information will be used solely in connection with my request for assistance, and shall not be disseminated to third parties unrelated to any such request.

_____
Signature

_____
Print Name

_____
Date