



CFLAA SUPPORT FUND

PLAN "A"

LONG TERM MEDICAL APPLICATION FOR ASSISTANCE

Please be assured that all information provided in this application will be handled in a confidential manner. If you have any questions or concerns or need assistance completing this application please contact: Leo Ezerins, Executive Director CFLAA, supportfund@cflaa.ca or call 1-902-488-8734.

Whether you are applying for assistance yourself, or on behalf of a friend or loved one, complete this application to the best of your knowledge and ability. The application form will provide the CFLAA Support Fund with the information needed to understand your request for assistance, and where to consider directing any approved funding.

To forward this application for consideration, printout, scan, complete and email to:

supportfund@cflaa.ca

or mail

CFLAA
PO Box 33
Porters Lake STN Main, NS, B3E 1M1



OFFICE USE: DATE RECEIVED:

CFLAASF Plan "A"
LONG TERM MEDICAL APPLICATION FOR ASSISTANCE

All information provided by you in this application is strictly confidential and will be used by the CFL Alumni Support Fund (the "CFLASF") for the sole purpose of determining eligibility to receive support from the CFLASF,

1. PLEASE PROVIDE THE FOLLOWING ELIGIBILITY INFORMATION (PLEASE TYPE OR PRINT LEGIBLY)

How did you hear about the CFL ALUMNI SUPPORT FUND?

2. CFL PLAYER'S NAME ASSOCIATED WITH THIS REQUEST FOR ASSISTANCE:

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

3. CFL AFFILIATION / CREDITED SEASONS (use more space if necessary)

TEAM 1 _____ CREDITED SEASONS _____ TO _____

TEAM 2 _____ CREDITED SEASONS _____ TO _____

TEAM 3 _____ CREDITED SEASONS _____ TO _____

4. IS THIS REQUEST FOR DIRECTLY ASSISTING AN ALUMNI? _____ YES _____ NO

IF NO, PLEASE EXPLAIN THE RELATIONSHIP TO ALUMNI: _____

5. REQUEST TO TALK DIRECTLY TO SOMEONE ABOUT _____

Contact: _____ Phone # _____ Best time of day to call _____

Name of Applicant _____ Date _____

6. REQUIRE LONG TERM FINANCIAL ASSISTANCE

What is the amount of your request? As well, please provide any background info which you feel will support your request.

PRESCRIPTION DRUGS _____

ASSISTED LIVING EXPENSES _____

MEDICAL EQUIPMENT/SUPPLIES (I.E. WHEELCHAIR) _____

QUALITY OF LIFE _____

REHABILITATION/THERAPY _____

OTHER (SPECIFY) _____

7. CURRENT MARITAL STATUS:

SINGLE _____ MARRIED _____ COMMON-LAW _____ SEPARATED _____

Partner's name _____

NUMBER OF DEPENDENTS _____

NUMBER RESIDING IN HOUSEHOLD _____

8. CURRENT ADDRESS:

own _____ rent _____

STREET _____ UNIT / APT # _____

CITY _____ PROV _____ POSTAL CODE _____

PHONE (HOME) _____ (CELL) _____

(WORK) _____ Email address _____

DRIVERS LICENSE # _____

If you have not lived at your current address continuously for the past two years, please list ALL other addresses at which you resided during that period.

Name of Applicant _____ Date _____

9. EMPLOYMENT APPLICANT'S CURRENT EMPLOYER

EMPLOYER / COMPANY NAME AND ADDRESS _____

MONTHLY TAKE HOME PAY _____

SUPERVISOR'S NAME: _____

PHONE: _____

DATES OF EMPLOYMENT FROM _____ TO _____ JOB TITLE _____

SPOUSE'S CURRENT EMPLOYER

EMPLOYER / COMPANY NAME AND ADDRESS _____

MONTHLY TAKE HOME PAY _____

SUPERVISOR'S NAME: _____

PHONE: _____

DATES OF EMPLOYMENT FROM _____ TO _____ JOB TITLE _____

Name of Applicant _____ Date _____

10. APPLICATION FOR ASSISTANCE:

DESCRIPTION OF REQUEST:

(use more space if necessary)

Amount requested: _____

Please include a copy of the most recent statement with the exact amount of the payment you are requesting.

1. Payee _____ Amount \$ _____
(name of company - account number)
_____ phone _____
(complete address and phone number)

(description of debt)

2. Payee _____ Amount \$ _____
(name of company - account number)
_____ phone _____
(complete address and phone number)

(description of debt)

3. Payee _____ Amount \$ _____
(name of company - account number)
_____ phone _____
(complete address and phone number)

(description of debt)

(use more space if necess

Name of Applicant _____ Date _____

11. FINANCIAL

List all income you and your spouse are currently receiving, including all pensions, social security payments, disability, worker's compensation, unemployment compensation, etc. and the amount you receive per month from each source.

Please provide the following documents with your application, or an explanation as to why they are not available. Please indicate that you have attached the requested documents by marking the box by each item identified below:

_____ Signed federal tax returns for applicant and spouse for the past 2 years

_____ Net worth statement - list of assets including property value, investment accounts and liabilities/debts (attached)

_____ Copies of current statements for all financial accounts for past 3 months

_____ Signed Authorization for Consent to Release Information and Records Form (attached)

_____ Signed Authorization for Use and Disclosure of General Protected Health Information (attached)

_____ Copies of any other documents you believe would be helpful in evaluating your application (i.e. verification of income, past due bills, medical evaluation from your doctor, legal notices, etc.)

(DO NOT SEND ORIGINAL DOCUMENTS – copies of the originals will be accepted)

List any/ALL other charitable gifts, grants, or financial assistance from any organization that you have received in the past three years, with the donor, date and amount received.

Name of Applicant _____ Date _____

12. CERTIFICATION, WAIVER AND RELEASE

By voluntarily executing and submitting this Application for Assistance to the CFLAA SUPPORT FUND COMMITTEE OR CFLAA BOARD OF DIRECTORS, I agree for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, not to sue or otherwise assert any claim for damages of any kind against the CFLAA SUPPORT FUND OR THE CFLAA BOARD OF DIRECTORS, its directors, officers, employees or agents (each a "Covered Party") in connection with any services or assistance provided or not provided by a Covered Party, including referrals to other service providers I hereby certify that the information provided in this Application for Assistance is true and correct.

Name _____ Date _____

Signature _____

FAILURE TO PROVIDE NECESSARY INFORMATION WILL RESULT IN DEL

Name of Applicant _____ Date _____



**CFL ALUMNI SUPPORT FUND AUTHORIZATION AND CONSENT TO RELEASE
INFORMATION AND RECORDS**

THIS FORM **MUST** BE RETURNED WITH YOUR APPLICATION

Name: _____

Home Address: _____ UNIT / APT #: _____

Phone Number: (_____) _____ Cell Phone: _____

Social Insurance Number: _____ Date of Birth: _____

Spouse/Partner Name: _____

I hereby authorize the CFL ALUMNI SUPPORT FUND (CFLASF), its agents and representatives to investigate my background in connection with my Application for Assistance.

As part of the investigation, I authorize the CFLASF to obtain and review any private and confidential information concerning me, including, but not limited to, consumer credit reports; bank and financial institution records; employment, military, civil, regulatory, and educational information and data; and reports from any individuals, corporations, partnerships, associations, institutions, schools, governmental agencies and departments, courts, law enforcement, and licensing agencies, consumer reporting agencies, and other entities, including my present and previous employers.

I hereby agree to release, hold harmless, and discharge the CFLASF its Board members, officers, agents, and all individuals, corporations, partnerships, associations, institutions, schools, agencies, employer, and all of their agents and employees, from any and all liability arising out of, or related to, any request for, receipt of, or use of any information or record pursuant to this authorization, or arising out of, or related to, any compliance, or attempted compliance, with such requests.

I understand that any information or record provided to the CFLASF pursuant to this authorization shall be used by the CFLASF solely for the purpose of evaluating my Application for Assistance. I further understand that I may request a copy of the materials obtained by the CFLASF pursuant to this authorization by submitting a request in writing to the CFLASF.

I have read this authorization carefully, understand it, and voluntarily sign it and agree to all of its terms and conditions. The above is my true and complete legal name, and all of the above information is true and correct. Should there be any question as to the validity of this release, I may be contacted as indicated below.

Signature: _____

Signature of Spouse/Partner _____

Name of Applicant _____ Date _____

PERSONAL STATEMENT OF ASSETS AND LIABILITIES

Assets	Amount / Worth
CASH	
Cash on hand	\$
Cash in checking accounts	\$
Cash in savings deposits	\$
Others (<i>retirement funds, emergency funds, etc.</i>)	\$
PROPERTIES (current or market value)	
Real estate	\$
Vehicles	\$
Appliances	\$
Others (<i>jewelry, collections, etc.</i>)	\$
INVESTMENTS	
Certificates of deposit (<i>time deposits, etc.</i>)	\$
Securities (<i>stocks, bonds, mutual funds, etc.</i>)	\$
Line of Credit (Total Amount)	\$
Line of Credit (Total Amount)	\$
Other assets (<i>specify – Life Insurance, etc.</i>)	\$
Total Assets	\$

Liabilities	Amount / Worth
LOANS AND PAYABLES	
Credit Card Debts	\$
Housing Loan	\$
Auto Loan	\$
Other investment debts (Line of Credit)	\$
Child or spousal support payments	\$
Other liabilities (<i>specify</i>)	\$
Total Liabilities	\$
NET WORTH (ASSETS-LIABILITIES)	
	\$

Name of Applicant _____ Date _____



Provide any additional information on this page below, or if you wish to provide further explanation to your circumstance: