



***The Weber Foundation of Helping Hands, Inc.***  
*P.O. Box 760863, Melrose, MA 02176*

**REQUEST FOR INFORMATION**

Date of your Request: \_\_\_\_\_

Grant Recipients Legal Name: \_\_\_\_\_ SS No.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Spouse's or Parent's Legal Name: \_\_\_\_\_ SS No.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Second Parent's Legal Name: \_\_\_\_\_ SS No.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Home Address: \_\_\_\_\_  
 \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

<u>For Foundation Use Only</u>	
Received:	_____
1 <sup>st</sup> RFI:	_____
2 <sup>nd</sup> RFI:	_____
Date Approved:	_____
Amount:	_____
Date Sent:	_____
Grant No.:	_____
Approval/Denial Code:	_____

**Employment Information**

The following information must include the recipient and spouse's information. If the recipient is a minor, the parents/guardians must complete with their information

Current Employer: \_\_\_\_\_

Current Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Tel No.: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

**Medical Insurance Coverage**

**Do you have Medical Insurance Coverage? ( If you have coverage through a governmental agency then check yes and complete below):** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please complete the following:

Name of Medical Insurance Provider: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Insured: \_\_\_\_\_

**Does your insurance coverage include prescription medicines?** Yes \_\_\_\_\_ No \_\_\_\_\_

What are your co-payments: Doctor Visits: \_\_\_\_\_ Prescriptions: \_\_\_\_\_

**Please provide us with a copy of your medical insurance card**

**Disability Insurance Coverage**

**Do you have any type of disability insurance short or long term?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list:

Name of Disability Insurance Provider: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Insured: \_\_\_\_\_

Amount of Disability Payment: \$ \_\_\_\_\_

**Please provide us with a copy of your disability coverage policy.**

**Do you receive Supplement Security Income (SSI)?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, enter amount: \$ \_\_\_\_\_ and **attach your most recent statement** from the Social Security Administration detailing your payment and qualification.

**Do you receive Supplement Security Disability Income (SSDI)?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, enter amount: \$ \_\_\_\_\_ and **attach your most recent statement** from the Social Security Administration detailing your payment and qualification.

**Public Assistance Payments**

Does the Recipient or his/her parents/guardians receive assistance from federal or state public need-based aid programs such as welfare, food stamps or section 8 housing assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe the nature and amount of assistance explaining any future expected changes in benefits or amount of assistance? **You must provide a letter or other documentation from the assistance program detailing the assistance received and the expected duration of such benefits.** The grant recipient is responsible for determining whether the receipt of a grant from the Foundation will result in his or her ineligibility for public assistance benefits.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**All Requests for Medical Assistance must include the following information:**

Name of Treating Physician: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Address: \_\_\_\_\_

**Does medical insurance cover the Treating Physician's fees?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Complete the following Medical information release by inserting your name and the date, and signing below.**

I, \_\_\_\_\_ (Your Name), authorize the Treating Physician listed above to release any and any and all medical and other information requested by The Weber Foundation of Helping Hands, Inc., and its agents, necessary for them to assess and evaluation my medical condition for which I am requested a grant, including any and all confidential medical information that I would be entitled to receive and any and all information or records of any health or disability insurer. I hereby authorize The Weber Foundation of Helping Hands, Inc., to have immediate access to all information relating to my medical condition and all persons and entities shall not incur any liability to me or my estate as a result of permitting the Foundation access to any information. I hereby agree to indemnify and hold harmless any such third party by reason of such third party having relied on the provisions of this instrument.

This authorization and release shall be effective immediately, and unless revoked in writing by me, with actual delivery of said revocation to the Treating Physician named above and to the Foundation, shall continue indefinitely to be in force and effect and shall only expire two years from the date that of my signature below.

This authorization and release shall not be affected my subsequent disability or incapacity.

WITNESS my hand and seal this \_\_\_\_ day of \_\_\_\_\_, 200 \_\_ .

\_\_\_\_\_  
*Your Signature*

**Provide us with a brief description of your Grant Request:** *Do not attach additional pages for this response.*

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**Amount Request:** \$ \_\_\_\_\_

YOU MUST PROVIDE A SPECIFIC AMOUNT REQUESTED AND THE AMOUNT MUST BE SUPPORTED BY AN ITEMIZED LIST OF GOODS OR SERVICES FOR WHICH YOU ARE REQUESTING A GRANT. DO NOT LEAVE THIS LINE BLANK AND DO NOT ASK US TO RECOMMEND AN AMOUNT. IF YOU FAIL TO STATE AN AMOUNT OR FAIL TO SUPPORT THE AMOUNT WITH WRITTEN ESTIMATES OR BILLS, YOUR GRANT APPLICATION WILL BE AUTOMATICALLY DENIED AND YOU WILL NOT BE ELIGIBLE FOR RECONSIDERATION.

Please itemize your **Amount Requested**, above, by detailing your unmet medical needs, medically related expenses (such as travel expenses, lodging, prescriptions, unpaid medical bills, etc) and other expenses for which you are requesting assistance. Please attach all available supporting information including construction estimates, invoices, or other documentation. If you are requesting assistance with a specific assistive or medical device or medication, you must provide an estimate of the cost, documentation on where and how to purchase the item and a letter from the Treating Physician listed above recommending said medication or assistive or medical device. The items shown here must total to the Amount Request, above.

<b>Item</b>	<b>Amount</b>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

**Please give us a brief summary of how the money from the grant is to be utilized for the Grant Recipient:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Who referred you to us (Guardian Angel):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**How did you hear about the Foundation?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**YOU MUST SUBMIT THE FOLLOWING INFORMATION WITH THIS FORM:**

1. A **Personal Statement** detailing your circumstances and why the Board should award you the specific funds sought.
2. A Medical History Form completed by the Grant Recipient's primary treating physician.
3. A copy of your last two year's of Tax Returns (If the Grant Recipient is a minor, you must submit any return filed on his or her behalf and any returns for both of the recipient's parents). Applications are not considered complete until such information is received. If you did not submit tax returns for the last two years, you must attach a separate statement detailing why you were not required to file and a statement from a reliable third party (such as a social worker) confirming that you were not required to file such returns during the prior two years and that you should be exempt from providing such information.
4. A copy of your Homeowner's Insurance Policy (If applicable).
5. Completed Financial Disclosure Form

**In order for the Board to review your request, it must be completed with all necessary documentation. For questions regarding the necessary information, please refer to the Grant Submission Guidelines posted on our home page [www.theweberfoundation.com](http://www.theweberfoundation.com).**

*The Weber Foundation of Helping Hands, Inc. is a non-profit public charity, established under the laws of the Commonwealth of Massachusetts and is an exempt organization under Internal Revenue Code Section 501(c)(3).*





**The Weber Foundation of Helping Hands, Inc.**  
 P.O. Box 760863, Melrose, MA 02176

**FINANCIAL DISCLOSURE STATEMENT**

**I. General Information**

Grant Recipient's Legal Name: \_\_\_\_\_ SS No.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Spouse's or Parent's Legal Name: \_\_\_\_\_ SS No.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Second Parent's Legal Name: \_\_\_\_\_ SS No.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

<b>For Foundation Use Only</b> Received: _____ Reviewed: _____ Approval/Denial Code: ____
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***I attest that the following disclosure is a complete and accurate description of my financial holdings and that all information contained in this disclosure, my grant request and the Request for Information are true and accurate to the best of my knowledge and belief.***

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**II. Financial Information**

*Please provide us with information regarding your assets and investments. The more we know about your assets, the more we will be able to assist you. You must also provide a copy of the relevant bank, brokerage, or retirement plan statement with this questionnaire for a three month period beginning on the date of your request for assistance.*

<b>Investment Assets(Not including Retirement Plans, IRAs, Deferred Compensation)</b>	
Cash & Cash Equivalents	
Bonds & Other Fixed Income	<i>(See Worksheet A-1)</i>
Bond Mutual Funds	<i>(See Worksheet A-1)</i>
Individual Stock Portfolio	<i>(See Worksheet A-2)</i>
Equity Mutual Funds	<i>(See Worksheet A-2)</i>
Hard Assets (Real Estate/Gold/Energy Stocks)	

<b>Retirement Plans (401(k), IRAs, Keoghs)</b>		
Cash & Cash Equivalents	(See Worksheet B)	
Fixed Income (Bonds, GICs)	(See Worksheet B)	
Equities (Stocks)	(See Worksheet B)	
Hard Assets	(See Worksheet B)	

<b>Other Investments</b>		
Closely-Held Businesses	(See Worksheet C)	

<b>Personal Assets</b>		
Primary Residence		
Secondary Residence (vacation homes, investment property, etc)		
Other Real Property		
Other Personal Property (Cars, Jewelry)		

<b>Liabilities</b>		
Mortgages		
Home Equity Loans		
Investment Loans		
Personal Debt/Credit Cards		
Other (Family Loans, etc.)		

### III. Life Insurance

INSURANCE COMPANY	FACE VALUE	CASH VALUE	ANNUAL PREMIUM	INSURED PARTY*	POLICY TYPE*	POLICY OWNER*	BENEFICIARY*
	\$	\$	\$				
	\$	\$	\$				
	\$	\$	\$				
	\$	\$	\$				
	\$	\$	\$				
	\$	\$	\$				
	\$	\$	\$				

<b>* Key for above Chart</b>							
Insured Party		Policy Type		Policy Owner		Beneficiary	
Client	1	Whole Life	1	Client	1	Client	1
Spouse	2	Universal or Variable	2	Spouse	2	Spouse	2
Children	3	Decreasing Term	3	Trust	3	Trust	3
Second to Die	4	Level Term	4	Employer	4	Children	4
Other	5	Group Term	5	Other	5	Estate	5
		Single Premium Whole Life	6			Other	6
		Other	7				



**Worksheet A-2: Stocks & Stock Mutual Funds**

Individual Stocks Held Outright <i>(Please provide name of company and number of shares held)</i>	
Investment	Amount
<b>Total</b>	
Stock Mutual Funds <i>(Please provide full name of fund and number of shares held)</i>	
<b>Total</b>	

**NOTES:** \_\_\_\_\_

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\_\_\_\_\_

**Worksheet B: Retirement Plans**

*(Please list specific investment and identify the retirement vehicle, e.g., IRA, 401(k) plan, etc.)*

Plan	Beneficiary	Amount
Total		

**Worksheet C: Business Interests**

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**Miscellaneous**

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Name of Insurance Agent: \_\_\_\_\_ Tel: \_\_\_\_\_

Name of Accountant: \_\_\_\_\_ Tel: \_\_\_\_\_

Name of Financial Advisor: \_\_\_\_\_ Tel: \_\_\_\_\_

Location of Safety Deposit Box: \_\_\_\_\_