FAR-WEST
FOLK ALLIANCE REGION – WEST
FOLK MUSICIANS RELIEF FUND

Application for Assistance
PLEASE PRINT ALL INFORMATION

_____ _____
Name Date of Application Age

_____ _____
Home Address Home/evening phone

_____ _____
Home Address Continued Cell phone/fax/other

_____ _____
E-Mail address Marital Status

I prefer to be contacted by (check one) Phone_____ E-mail_____ Ground mail_____

_____ _____ _____
Partner/Spouse name Age Employer

Please list the names, relationship to you, and ages of your dependents, if any: _____

_____

How many people live in your household? What is the total and your share of the monthly rent/mortgage payment? # of people_____ Total pmt_____ Your share_____

Please describe why you need assistance (e.g. for outstanding medical or hospital bills, for future treatment, for living expenses if retired or unable to work, etc.) _____

_____

Total Amount Requested:_____ How did you learn of FMRF?_____

_____

Please indicate below the categories in which you have been involved, whether you have recorded in that area (or others recorded your material), the length of time you have been active in that area and the number public performances. (Public performances are those that are open to the general public and include, but are not limited to, performances in nightclubs, on sidewalks, in parks, public auditoriums, theaters, or halls, and college auditoriums, theaters, or halls.)

Category	**Recordings? (Y or N)**	**Length of Time Active**	**Number of Public Performances per year (approx.)**
Vocalist, Singer	_____	_____	_____
Songwriter, Arranger	_____	_____	_____
Musician, Instrumentalist	_____	_____	_____

Please attach copies of any items indicating musician status, i.e. a bio, discography, newspaper clippings, sheet music, records, contracts, guild/union membership card, dues notice, or verification from other members of the music industry.

Are you or have you ever been a member of a performing rights organization (ASCAP, BMI, AFM, SAG-AFTRA, etc)? If yes, please indicate the name(s), year(s) you joined, and whether you are still an active member:_____
_____

What was your adjusted gross income for each of the last two years? (Note: You might be asked to supply your tax returns) 201__: $_____ 201__: $_____

Please fill out the monthly budget form attached to the application as page 4.

Have you (or your spouse, if applicable) applied for assistance from any other charitable fund, agency (governmental or otherwise), union, or guild? If yes, please list organizations and amount(s) requested, received or pledged:
_____
_____
_____

FAR-West Musicians Relief Fund's policy is to make payments directly to doctors, hospitals, medical service providers, or other providers of necessities. Please indicate below any special circumstances that the Grant Committee should consider in deciding whether another payment method should be used in your case.
_____
_____
_____

Please fill out the following section only if you are applying for assistance with medical costs OR assistance with living expenses if your medical condition prevents you from working. Otherwise, please skip to the Certification and Authorization.

Please attach copies of outstanding bills for which you are requesting assistance. Please be sure that the vendor's name, address, and phone number, and your account number, is on the bill.

If the attached bills do not indicate the nature of your medical condition, or you are requesting funds for future treatment or living expenses, please attach either a statement from a Medical Doctor (MD) or other medical or hospital bills containing a diagnosis.

If you are requesting funds for living expenses, please describe what you need help with (i.e. number of mos. rent at what amount, number of mos. utilities, etc. _____
_____

If you or your spouse has medical insurance, please tell us the name of your insurance company and the policy number._____

If you (or your spouse, if applicable) have other medical coverage, please indicate below:

Medicare A ____ B ____
Medicaid _____
Medi-Cal _____
Other _____

Certification and Authorization

I hereby certify that I have answered the questions in this application to the best of my ability without any limitations whatsoever; the facts stated herein are true and I understand that any misrepresentation or false information will disqualify me for any assistance from the Fund. I further agree to notify FAR - West Folk Musicians Relief Fund of any change in my financial situation from the time of my application to the time a grant is made to me.
I understand that the Grant Committee can require me to provide a copy of my first tax return filed after receiving a grant from the Fund and/or a summary of my total medical expenditures. (Any request for a summary of medical expenditures will be made within one year of the grant.) My signature below constitutes acceptance of this requirement.

Disclaimer: In the process of reviewing applications and funding grants, FMRF does not assess treatments or take responsibility for the actions or care of any treatment program chosen by the applicant, except to the extent that funds granted are applied directly to the needs described in the application request. All FMRF applications will be treated as confidential and only shared with members of the FMRF committee. Since email is not secure, FMRF recommends that applications be mailed to the address above.

Signature of Applicant _____

Signature of Spouse/Partner _____

Monthly Budget Form

Note: Please make sure you divide annual, semi-annual, quarterly, or other types of payments into monthly sums.

INCOME	**MONTHLY**
Total Monthly Income: _____	
Indicate Sources:	
__ Work income	
__ Rent	
__ Spouse/partner Income	
__ Residuals/Royalties	
__ Social Security/Disability	
__ Supplemental Security Income	
__ Unemployment	
__ State Disability	
__ General Relief	
__ Food Stamps	
__ Veterans Benefit	
__ Alimony	
__ Union Pension (s) Gasoline	
__ Child Support	
__ Trust fund/interest	
__ Relief Fund Grants	
__ Other (List Source)	
_____	
_____	
_____	

EXPENSES	**MONTHLY**
Mortgage	_____
Home Insurance	_____
Maintenance/ Homeowner's fees	_____
Food	_____
ISP/Website fees	_____
Utilities	_____
Landline/cellphone	_____
Cable/television	_____
Childcare/tuition	_____
Car payment (s)	_____
	_____
Car insurance	_____
Bus PO Box rental	_____
Parking/Gas/Transit	_____
Health Insurance	_____
Medical/Mental Health*	_____
Dental bills	_____
Prescriptions	_____
Supplements	_____
Life Insurance	_____
Professional fees and costs	_____
(please describe)	_____
_____	
_____	
Credit card payment	_____
Other (describe)	_____
_____	
_____	

Questions? Email us at:
fwrelief@gmail.com

*Medical expenses include deductibles or costs not covered by insurance.

TOTAL INCOME _____

TOTAL EXPENSES _____