Financial Assistance Request

Thank you for reaching out to the AZZ Cares Foundation during this time of need. We are here to help and support you through this season. Please complete this form in its entirety.

Date: _____

APPLICANT INFORMATION

First Name: _____ Last Name:_____ Date of Birth:_____

Phone:_____ Cell: _____Email: _____

Name of Employee (if not Applicant) / Applicant's Relationship to Employee: _____

Employee Number (Or Social Security Number if not Employee) : _____

Applicant's Employer: _____

Work Address: _____City: _____ State: ____ Zip: _____

Applicant's Occupation/Title: _____

Are you paid hourly or salary? _____ What is your base pay? _____

Marital Status (please check one):☐Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Full Name: _____

Other people living in your household:

Name: _____Age: _____ Relationship to Applicant: _____

Name: _____Age: _____Relationship to Applicant: _____

Name: _____Age: _____Relationship to Applicant: _____

Name: _____Age: _____Relationship to Applicant: _____

Home Address: _____City: _____ State: ___ Zip: _____

WORK HISTORY

Which AZZ location are you employed? _____

Job title? _____

When was your start date at AZZ? _____

FINANCES

What type of financial assistance are you requesting?

☐ Rent/Mortgage - Amount: _____ ☐ Electric - Amount: _____ ☐ Gas - Amount:_____

☐ Water -Amount: _____ ☐ Other-Amount: _____

Please explain your current financial situation, *in detail*:

_____

_____

_____

_____

Is your financial situation related to an accident? _____ If so, was the accident work related?_____

Do you have short-term disability? _____ If so, please provide the monthly amount you are receiving: __

Are you receiving workman's compensation? _____ If yes, please provide the monthly amount you are receiving: _____

What other type of assistance do you receive? (e.g. child support, governmental assistance)

Annual Gross Household Income Prior to Event Requiring Assistance: _____

Annual Gross Household Income Following Event Requiring Assistance: _____

If any amounts requested are covered by insurance, indicate reason that additional relief is warranted:

_____

_____

_____

_____

What steps are you taking to improve your current financial hardship or the situation?

_____

_____

_____

_____

Have you ever met with a financial consultant or attended a financial course? ☐ Yes ☐ No

If yes, explain in detail: _____

_____

_____

Have you applied for, or received assistance from the AZZ Cares Foundation in the past? ☐ Yes ☐ No

If so, what was the amount given: _____Date Given: _____

Have you applied for or received assistance from any of the following sources in the last year?

Check all that apply:

☐ Family ☐ Friends ☐ Unemployment ☐ Social Security ☐ Disability ☐ Food Stamps ☐ Day Care

☐ Housing Assistance ☐ Food Pantry ☐ Clothing Assistance ☐ Other Churches

☐ Local AZZ Cares Team ☐ Other

MONTHLY BUDGET

MONTHLY INCOME

SOURCE	AMOUNT
Salary 1	$
Salary 2	$
Salary 3	$
Alimony	$
Child Support	$
Unemployment	$
Social Security	$
Pension	$
Disability	$
Food Stamps	$
Other Income	$
Other	$
TOTAL	$

Do you have a savings account?

☐ Yes ☐ No Balance:$

Do you have a retirement fund?

☐ Yes ☐ No Balance: $

MONTHLY EXPENSES

HOUSING	AMOUNT	BALANCE	
Mortgage #1	$	$	
Mortgage #2	$	$	
Rent	$		
Home Ins.	$		
UTILITIES	**AMOUNT**		
Electricity	$		
Gas	$		
Water/Sewer	$		
Phone	$		
Cable	$		
Trash	$		
VEHICLES	**AMOUNT**	**BALANCE**	
Car 1 Payment	$	$	
Car 2 Payment	$	$	
Gas	$		
Auto Insurance	$		
PERSONAL	**AMOUNT**		
Cell Phone	$		
Child Care	$		
Groceries	$		
Clothing	$		
Insurance	$		(e.g., Life, Health, Disability)
Tithe/Offering	$		
Donations	$		
Miscellaneous	$		(e.g., Memberships, recreation)
CREDIT CARDS	**AMOUNT**	**BALANCE**	
Card #1 Payment	$	$	
Card #2 Payment	$	$	
Card #3 Payment	$	$	
Card #4 Payment	$	$	
Card #5 Payment	$	$	
TOTAL	$	$	

By signing below, I am certifying that the information I have provided is true and accurate. AZZ Cares Foundation has my permission to verify any information I have reported on this form. I hereby certify the following (check all boxes that apply):

☐ I have attached supporting documentation to this Application, if available.

☐ I do not have access to [all] / [some] supporting documentation. The supporting documentation is not in my possession due to the damage sustained as a result of _____.
I agree to make my best reasonable efforts to obtain copies of such missing documentation from other sources and submit such copies to the AZZ Cares Foundation if and when obtained.

_____ Date: _____
Applicant's Signature

_____
Print Name

** AZZ Cares Foundation shall not require, request, or obtain any information that would constitute "protected health information," as such term is defined in 45 CFR 160.103, from AZZ Inc. and its subsidiaries (the "***Employers***") or any group health plan sponsored or maintained by an Employer.

For AZZ Cares Foundation Use Only

*Applicant Name:*_____

*Amount Approved:*_____

*Payable To:*_____

*Address:*_____

Account# _____

*Dates of previous financial assistance:*_____

*Date:*_____