

*What are your sources of **monthly** income? Check all that apply.* Monthly Amount

<input type="checkbox"/> Employment (salaries, tips, bonuses, etc.)	\$ _____
<input type="checkbox"/> Alimony/Child Support	\$ _____
<input type="checkbox"/> Social Security/Retirement/Disability.....	\$ _____
<input type="checkbox"/> Welfare/TANF/Food Assistance(SNAP).....	\$ _____
<input type="checkbox"/> Severance Pay.....	\$ _____
<input type="checkbox"/> Trust Funds/Annuities/Interest.....	\$ _____
<input type="checkbox"/> Lottery Winnings/Insurance Settlements, etc	\$ _____
<input type="checkbox"/> Family gifts.....	\$ _____
<input type="checkbox"/> Other:_____.....	\$ _____

What are your monthly expenses? Please provide documentation of these expenses when you submit your application.

<input type="checkbox"/> Rent	\$ _____
<input type="checkbox"/> Utilities.....	\$ _____
<input type="checkbox"/> Gas.....	\$ _____
<input type="checkbox"/> Water/Sewer.....	\$ _____
<input type="checkbox"/> Health Insurance	\$ _____
<input type="checkbox"/> Car Insurance	\$ _____
<input type="checkbox"/> Childcare.....	\$ _____
<input type="checkbox"/> Child Support/Alimony.....	\$ _____
<input type="checkbox"/> Other.....	\$ _____

*What other resources have you pursued? **You must provide an answer for each** (approved, terminated, denied etc.)*

APPLIED?

Housing Authority

Section 8 Rental Assistance/HUD/etc... Yes- Status:_____ No- Reason:_____

Social Security/Disability/etc..... Yes- Status:_____ No- Reason:_____

Social Services

TANF..... Yes- Status:_____ No- Reason:_____

Food Stamps/SNAP..... Yes- Status:_____ No- Reason:_____

Medicaid/CHP+

Emergency Funds..... Yes- Status:_____ No- Reason:_____

Misc COVID-19 Funds

Health Insurance..... Yes- Status:_____ No- Reason:_____

Private Charities..... Yes- Status:_____ No- Reason:_____

Family/Friends..... Yes- Status:_____ No- Reason:_____

Victim's Compensation..... Yes- Status:_____ No- Reason:_____

Other:_____ Yes- Status:_____ No- Reason:_____

Please explain how you have exhausted all your other resources: _____

Please provide us with any other information that you feel would help in determining your eligibility for the Good Neighbor Fund: _____

Attestation:

I certify that the information given on this application is accurate and complete to the best of my knowledge and belief. I also understand that false statements or information are grounds for denial of assistance and/or prosecution of fraud, as allowed by Colorado law.

Applicant Signature: _____

_____/_____/_____
Date

Coapplicant Signature: _____

_____/_____/_____
Date

Please submit this application, along with proof of the following,

- ✓ Proof of employment (e.g. paystubs, offer letter, etc.)
- ✓ Copies of all financial bills (car, electricity, insurance etc.)
- ✓ Copy of lease agreement or mortgage statement

Submit To:

Tri-County Health Network
Mail: PO Box 4178 Telluride, CO 81435
By fax: 888-595-3242 By email: GNF@tchnetwork.org
Any questions, call TCHNetwork : 970-708-7096