



**The Inter-Club Fund of San Francisco, Inc.**

**P. O. Box 14112**

**San Francisco, CA 94114-0112**

A domestic nonprofit corporation (Federal ID 23-7185340; California ID C0751875)  
San Francisco's oldest continuous gay charity, formed January 8, 1972

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# GRANT APPLICATION

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**Please Note: This is a grant, not a loan**

1. One purpose of the Inter-Club Fund is to provide relief and assistance to
  - Members associated with the organizations comprising the Fund
  - Persons who have actively participated with and supported the organizations comprising the Fund
 who, because of accident or severe illness, are in serious financial distress.
2. Only life-line expenses will be considered for a grant:
  - Rent
  - Electricity, Gas
  - Basic Telephone
  - Food (normal basic maintenance)
  - Medical, Insurance (if none other is available).
3. Statement of expenses must be supported by documents.
4. We encourage the grant applicant to be present at all readings of the grant application. It is not required by the Board to have you there to process the application. Should you choose to let your Sponsoring Director represent you at the reading, you should be advised of the following: that the processing of the application could be held up from seven to 30 days. This would be due to questions and clarifications on the application that your Sponsoring Director could not address. An explanation as to why the applicant chooses not to attend will be supplied by the Sponsoring Director. Any application presented to the Board for review that is not complete and cannot be completed and clarified at the time of review will not be voted on by the Board.
5. Payments will be made directly to creditors whenever possible.
6. This application as well as the reviewing process are confidential; creditors are requested to maintain such confidentiality.
7. This application must be reviewed by a sponsoring ICF Director and two other Directors: a second reviewing Director and the Treasurer before presentation to the Board of Directors for approval.
8. Seven days are required for review prior to consideration at a Board meeting.

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**Review**

I have reviewed this application and am satisfied that the information provided is valid and that the request falls within the requirements of the Inter-Club Fund.

Sponsoring Director: \_\_\_\_\_ Date: \_\_\_\_\_

We have reviewed this application and recommend it for consideration by the Board of Directors of the Inter-Club Fund.

Reviewing Director: \_\_\_\_\_ Date: \_\_\_\_\_

Treasurer: \_\_\_\_\_ Date: \_\_\_\_\_

**Applicant**

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

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

City: \_\_\_\_\_, CA Zip Code: \_\_\_\_\_

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

Social Security # \_\_\_\_\_ California ID # \_\_\_\_\_

Residence in Bay Area: \_\_\_\_\_ Years \_\_\_\_\_ Months

Total amount requested: \$ \_\_\_\_\_ (Total from next page)

Is this your first grant application? \_\_\_\_\_ If not, please give dates and amounts:

\_\_\_\_\_

In completing this application I certify that all of the statements and information are true and complete. I have completely read and understand this grant application process.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Basis for Application**

Circumstances of accident/illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospitalized: \_\_\_\_\_ Where: \_\_\_\_\_ How long: \_\_\_\_\_

Date you returned (or expect to return) to work: \_\_\_\_\_

Please furnish your doctor's report regarding the length of convalescence.

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Action**

This grant request was presented to the Board of Directors on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_. It was APPROVED NOT APPROVED by a vote of:

Yes \_\_\_\_\_ No \_\_\_\_\_ Abstentions \_\_\_\_\_ for the amount of \$ \_\_\_\_\_

Recording Secretary: \_\_\_\_\_

**Payments Requested**

Show earliest due date for the payment requested as "For Period Beginning". For each item include documentation in the form of bills or other supporting evidence of need. All bill stubs, coupons, and creditor's payment envelopes must be submitted at the time of review of application.

Amount Requested: \$ \_\_\_\_\_ For Period Beginning \_\_\_\_/\_\_\_\_/\_\_\_\_

Purpose: \_\_\_\_\_

Payee on Check: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Amount Requested: \$ \_\_\_\_\_ For Period Beginning \_\_\_\_/\_\_\_\_/\_\_\_\_

Purpose: \_\_\_\_\_

Payee on Check: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Amount Requested: \$ \_\_\_\_\_ For Period Beginning \_\_\_\_/\_\_\_\_/\_\_\_\_

Purpose: \_\_\_\_\_

Payee on Check: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Amount Requested: \$ \_\_\_\_\_ For Period Beginning \_\_\_\_/\_\_\_\_/\_\_\_\_

Purpose: \_\_\_\_\_

Payee on Check: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

*For ICF use*

Check No. \_\_\_\_\_

Amount Approved

\$ \_\_\_\_\_

Check No. \_\_\_\_\_

Amount Approved

\$ \_\_\_\_\_

Check No. \_\_\_\_\_

Amount Approved

\$ \_\_\_\_\_

Check No. \_\_\_\_\_

Amount Approved

\$ \_\_\_\_\_

**Financial Status**

Employed? \_\_\_\_\_ Basic Salary: \$ \_\_\_\_\_  Weekly  Monthly  Other \_\_\_\_\_

Full-time  Part-time If part-time, how many hours? \_\_\_\_\_

Employer's Name \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

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

Length of Employment: \_\_\_\_\_

If less than one year, list previous employers:

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

**Assets**

Home \_\_\_\_\_ Value: \$ \_\_\_\_\_ Owned? \_\_\_\_\_ Payment: \$ \_\_\_\_\_

Car \_\_\_\_\_ Value: \$ \_\_\_\_\_ Owned? \_\_\_\_\_ Payment: \$ \_\_\_\_\_

Motorcycle \_\_\_\_\_ Value: \$ \_\_\_\_\_ Owned? \_\_\_\_\_ Payment: \$ \_\_\_\_\_

Bank Accounts \_\_\_\_\_ Value: \$ \_\_\_\_\_ Owned? \_\_\_\_\_ Payment: \$ \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Expenses**

Rent: \$ \_\_\_\_\_ Do you share? \_\_\_\_\_ % of Rent: \_\_\_\_\_

Food: \$ \_\_\_\_\_ Telephone: \$ \_\_\_\_\_ P.G.&E.: \$ \_\_\_\_\_ Living: \$ \_\_\_\_\_

Medicine: \$ \_\_\_\_\_ Insurance Premium: \$ \_\_\_\_\_ Medical Bills: \$ \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Insurance**

Name: \_\_\_\_\_ Type: \_\_\_\_\_ Policy # \_\_\_\_\_

Name: \_\_\_\_\_ Type: \_\_\_\_\_ Policy # \_\_\_\_\_

Employer insurance coverage: \_\_\_\_\_ Type: \_\_\_\_\_

Are you covered by another person's insurance? \_\_\_\_\_ \$ \_\_\_\_\_

Insurance coverage: Hospitalization: \_\_\_\_\_ Physician: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Resources**

	Yes/No	Amount/Why Not
Unemployment Insurance	_____	_____
Social Security Disability - SSA	_____	_____
State Disability Insurance	_____	_____
Supplemental Security Income - SSI	_____	_____
General Assistance - GA	_____	_____
Veterans Administration - VA	_____	_____
Food Stamps	_____	_____
AIDS Emergency Fund - AEF	_____	_____
Positive Resource Center (was ABC)	_____	_____
Catholic Charities	_____	_____
CHIPS (S.F. AIDS Foundation)	_____	_____
Other: _____		

**Your Contributions to Our Community**

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Are you a club member? \_\_\_\_\_ Name of Club: \_\_\_\_\_

How Long? \_\_\_\_\_ Status: \_\_\_\_\_

Club functions you have supported within the past three years:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Other contributions to the community: \_\_\_\_\_

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Any other comments that you feel might affect this grant application: \_\_\_\_\_

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