



Society of St. Vincent de Paul

Conference Client Packet & Assistance Request Form

Conference Information

Date Submitted to District President _____

Delivery Method E-mail USPS Fax Other _____

Conference _____

Home Visit Team

Name: _____ Tel: _____ Email: _____

Name: _____ Tel: _____ Email: _____

Client General Information

Client Name _____ Spouse / Other _____

Client DOB _____ Spouse / Other DOB _____

Client Profession _____ Spouse / Other Profession _____

Complete ONLY one of the following

Current Address _____

New Address (if moving) _____

City _____ State _____ Zip _____

Telephone _____ Email Address _____

Family / People Living at the Residence

Name _____ Age ____ Sex ____ Relationship _____

School or Employer _____

Name _____ Age ____ Sex ____ Relationship _____

School or Employer _____

Name _____ Age ____ Sex ____ Relationship _____

School or Employer _____

Name _____ Age ____ Sex ____ Relationship _____

School or Employer _____

Name _____ Age ____ Sex ____ Relationship _____

School or Employer _____



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What are the immediate needs of the person / family?

How did the person / family find out about the Society of St. Vincent de Paul Conference?

Has the person / family in need requested assistance from another organization and, if so, which ones and what were the results?

Ask the person / family in need to describe the relationship they have with their extended family. Are they able to assist in any way (spiritual, emotional, financial, other physical assistance)? If so, briefly describe which family member provides assistance and what type of assistance they provided.

Do you or anyone in your family have disabilities or special needs which require special accommodations? Yes No If yes, explain below:

Please explain how long the person / family in need has been at the current housing unit. Have they had previous difficulties making their monthly payments in time?

Prior Address: _____ City: _____ Zip: _____

Length of stay: Years ____ Months _____

Reason for moving: _____



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Monthly Income and Expense Review

Actual Monthly Income	
Client Salary	
Spouse/Significant Other Salary	
Dependent(s) Salary	
Child Support	
CalWorks Benefits	
Supplemental Security Income (SSI)	
Additional Income (please define)	
A. Other	
B. Other	
C. Other	
Savings/Checking Account Balance	
Total Monthly Income	

CalFresh Benefits	
DO NOT ADD TO TOTAL INCOME ABOVE	

Other Assistance / Benefit Programs	
Mark "Y" for YES and "N" for NO	
Childcare Assistance	
Housing Assistance (Section 8, HUDD, EAPE, etc.)	
Meal Programs (school lunch, Meals-On-Wheels, etc.)	
Transportation Assistance	
Utility Discount Programs (HEAP, CARE, etc.)	
Other (food banks, other non-profits, etc.)	

Average Monthly Expenses	
Rent / Mortgage	
Food (do not include CalFresh benefits)	
Telephone	
Cable/Internet Service	
Electricity	
Gas	
Water	
Transportation	
Automobile	
Automobile Insurance	
Gasoline	
Childcare	
Special Needs	
Child Support Payments	
Credit Card Debt	
Other	
Total Average Monthly Expense	

Monthly Cashflow Review / Debt-to-Income Ratio	
Total Monthly Income	
Total Monthly Expenses	
Difference (+/-)	
Debt-to-Income Ratio (expense/gross income = %)	

All income must be supported with documentation (copies of payroll checks, unemployment benefits, workers compensation benefits, SSI, federal & state benefits recap letters, court ordered payments/settlements (i.e. - spousal and/or child support), retirement distributions, etc.)



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Based upon the initial intake information provided by the family and / or review of their financial statement, should the family be referred to other resources that may assist them maintain a more stable home? If so, explain the resources needed.

Have you and the family / individual set any goals to help them move towards self-sufficiency? (attending classes, counseling, special training, legal aid, etc.) **Yes** **No**
Please explain.

Cooperation Agreement

I agree to cooperate with who will conduct follow up visits at least one month, three months and six months from the date services / funds are provided.

I also agree to seek financial advice if at any time during the next six months my financial situation does not remain stable.

I agree that all above information is truthful and I give permission to the members of the Society of St. Vincent de Paul to research all information provided for accuracy.

I also authorize the Society to contact my landlord to verify information. Please acknowledge approval with initials: _____

Head of Household Signature: _____ Date: _____

Spouse / Other Signature: _____ Date: _____



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Conference Action Items:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Tear on dotted line. Bottom portion of sheet to be given to our Friend In Need

Friend / Family In Need Action Items:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____



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Fund Request Details

Amount Requested: \$500 or Less **or** \$501 or More

Current Conference bank account balance: \$_____

Will the Conference or has the Conference provided financial support to this individual/family?
 Yes No If yes, how much? \$_____

The reason Conference is unable to provide complete financial support regarding this request is:

Has the Conference applied for Cardinal McIntyre funds? Yes No

Approved Denied Other

Explain: _____

REASON FOR REQUEST OF FUNDS: (Must meet criteria)

X	Event	Date of Event
	Termination of employment	
	Reduction in work hours	
	Work related injury	
	Family Illness	
	Death in the family	
	Rental deposit / moving expenses	
	Relocation / Transfer to another residence	
	Utilities disconnected	
	Other	

Include the necessary documents to justify request, including: (check list)

X	Document Description	X	Document Description
	Copy of official or school ID		Past rental payment receipts
	Most recent income / payroll statement (employer or social benefits - 2-3 payroll cycles)		Most recent utility bill(s)
	Eviction notice		Letter from Workers Compensation regarding disability benefit
	Past due rental statement (property management company)		Other
	Rental Agreement (terms & condition and signature page)		Other

If some important back up document is not available to verify situation, please explain why:



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Briefly explain friend's situation. How will the requested assistance help, and how will the friend/family improve their situation in the coming months (use additional sheets if necessary):

FUND REQUEST #1

Rental Security Deposit Utilities Other (specify): _____
Amount: _____ Date Required: _____

Make check payable to (please verify landlord mailing addresses via phone):

Name of Person or Company: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Tel: _____ Cell: _____ Email: _____

FUND REQUEST #2

Rental Security Deposit Utilities Other (specify): _____
Amount: _____ Date Required: _____

Make check payable to (please verify landlord mailing addresses via phone):

Name of Person or Company: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Tel: _____ Cell: _____ Email: _____

Total funds requested: \$ _____ (add additional sheet for issuance of addition checks)

Conference President Approval: _____ **Date:** _____
Signature



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HOUSING ASSISTANCE FOLLOW-UP VISIT

(Required for requests funded at \$501.00 or more)

One month **Three month** **Six month**

(Please mail in when due to Vincentian Services Department)

CONFERENCE / VINCENTIAN TEAM MAKING THE HOME VISIT

Conference _____ Date _____

1st Vincentian _____ Telephone _____

2nd Vincentian _____ Telephone _____

INFORMATION ON INDIVIDUAL / FAMILY SERVED

Name: _____
Last First Middle Initial

Spouse/Significant Other: _____
Last First Middle Initial

Current Address: _____

Follow-up Questions:

Has the family moved since assistance was provided? Yes No

If yes, explain the reason for the change (giving dates and details). _____

Has employment and/or employment income changed? Yes No

Please give a brief explanation of the of their current financial situation. _____

List any goals that were set when assistance was provided: _____

Is it necessary to refer the individual/family for:

Financial Counseling Legal Aid / Assistance Health / Medical Assistance

How have the funds helped the individual / family thus far? _____

Please mail, email or fax completed RA Follow-up form to your assigned coordinator at the Vincentian Services Department on

Office Use Only: Coordinator's Initials _____ Follow-up Needed _____



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the week after the follow-ups are due (first, third & six months, as stated at the top of this form).