Spirit of Schuyler
PO Box 294
Watkins Glen, NY 14891

Page 1

EMERGENCY Assistance Form

607-228-7345

Name _____ Date of Birth ___/___/____

Address _____ Phone ( ) _____

City _____ State _____ Zip _____

Schuyler County Resident ☐ YES ☐ NO

Household Members

Name	M/F	Date of Birth	Relationship	Resident (Yes or No)

Household Income (monthly)

If household has multiple residents over 16, list income for each separately.

Employment $ _____ Pension $ _____ Food Stamps $ _____

Public Assistance $ _____ SSI $ _____ Other Income (list)

Social Security $ _____ Heap $ _____ $ _____

Unemployment $ _____ Child Support $ _____ $ _____

Expense Information (List Monthly Expenses)

Rent $ _____ Child Support $ _____ Other Expenses (list) $ _____

Annual Taxes $ _____ Car $ _____ $ _____

Utilities $ _____ Car Insurance $ _____ $ _____
(Elec, Gas, Fuel Oil)

This Emergency Assistance Request is for:
(List detailed information)

Amount Requested $ _____

More room on Page 3

All vendors are paid directly by SOS. Please provide Name, Address & Phone # (Landlord, Gas or Electric Company, Etc. where payment is to be made)

You MUST Complete Page 1 & 2 and *Sign Page 3*

INCOMPLETE APPLICATIONS WILL BE RETURNED

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What Agencies have you Contacted for Assistance? *Required

Agency: _____ Date: _____

Name of Contact: _____ Phone #: _____ Amount Requested: $ _____

Amount Received: $ _____

Agency: _____ Date: _____

Name of Contact: _____ Phone #: _____ Amount Requested: $ _____

Amount Received: $ _____

Agency: _____ Date: _____

Name of Contact: _____ Phone #: _____ Amount Requested: $ _____

Amount Received: $ _____

Agency: _____ Date: _____

Name of Contact: _____ Phone #: _____ Amount Requested: $ _____

Amount Received: $ _____

Additional Notes here:

★ You MUST Complete Page 1 & 2 and *Sign Page 3*

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NOTICE: Applicants who seek emergency assistance from S.O.S. agree and understand as follows:

1. S.O.S. does not guarantee emergency assistance to applicants. All applications are subject to review and approval by the officers of S.O.S and the granting of emergency assistance is solely within the discretion of S.O.S. and/or the S.O.S. advisory board. Applicant understands and agrees by signing this form that no promise of assistance is provided, and that no duty is created by S.O.S. to provide assistance of any kind.

2. S.O.S. agrees to review the application for assistance and in consideration thereof, applicant agrees to provide the information requested herein, and any additional supplemental information that S.O.S. determines is necessary to complete its review of the application for assistance. Applicant further agrees to release, remise and forever discharge any claim against S.O.S., its officers, directors, employees, members or agents for any claim arising out of the application for emergency assistance, for any alleged acts or omissions pertaining the provision or failure to provide emergency assistance; to any alleged administrative errors; to any claims for violation of New York State or federal laws pertaining to release of protected health care information or personal identity information; from any claims relating to slander or libel, or any other claims that are related in any manner to the request or provision of assistance.

3. That no relation between S.O.S. and the applicant or member of the applicants family or household is created by the application for emergency assistance.

4. Applicant understands that S.O.S. may seek information from third parties relative to its review of the applicant's request for assistance.

AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

I, _____ (DOB)_____ authorize Spirit of Schuyler to obtain information, including copies of records, concerning me or any person for whom I am the natural or appointed guardian, or for whom I have been given the power of attorney, from the following:

1. Any County Department of Social Services.
2. Schuyler Outreach
3. Any entity to whom we have requested emergency assistance or charitable assistance or which has provided us with emergency assistance in the past 12 months.
4. My employer,_____ , limited to records pertaining to wages.

I request that any party having possession of information or records to which this authorization applies cooperate with Spirit of Schuyler and provide such requested information to them

This authorization is not intended to authorize release of any private health care information or medical records.

A copy of this authorization may be used in lieu of the original.

This authorization will expire 1 year from the date of execution.

_____
(PRINT NAME)

Witnessed: _____ Date: _____