THE FUND FOR THE DIACONATE
OF THE EPISCOPAL CHURCH

Request for Financial Assistance

For 20____

Return to:
The Fund for the Diaconate
The Rev. Theresa Lewallen
P.O. Box 12621
Charlotte, NC 28220

To assist the Fund in processing your Request for Financial Assistance, we need some basic information about you and your diaconal ministry:

1. Name_____ 2. Address_____

3. Phone_____ _____

4. Date of Birth_____ Email address_____

5. Date of Ordination_____ 6. Diocese ordained in_____

7. Diocese in which you have Canonical Residence_____

8. Parish where you most recently served_____Diocese_____

Address_____

Name of Rector_____

When did you serve there? From_____ To_____

Brief description of your ministry_____

9. Previous parishes where you served and dates served_____

_____

10. What are you requesting from the Fund? ____Monthly assistance ____One-time grant Amount_____

11. Please give us the name of a relative or person who knows you well, wit whom we can be in touch in the event you have difficulty communicating with us. **If** your diocese has an archdeacon, please include the person's name and contact information on the back of this page.

Name_____ Address_____

Phone_____ _____

Relationship_____ _____

My signature below gives the Fund or their authorized person permission to contact my Diocese to obtain additional information. This authorization includes my Bishop or Archdeacon or a person appointed by them.

Date_____ Signature_____

*If a qualified representative, state your relationship*_____

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For 20___

Name _____

Address_____

In order to provide financial assistance, The Fund needs to know your financial situation for a full year. Please complete this form using your annual information. It may help to list your figures in the monthly column. If you do not state your income in the annual column, we will multiply the monthly numbers by 12. If your monthly income varies, be sure to state your income for a typical month and your annual total.

INCOME INFORMATION

The easiest place to get your income information is from your IRS Tax Return, Form 1040 or 1040s. It will assist us if you attach a copy of your tax return.
Please tell us if you did not file a return. **_____ I did not file a Federal Tax Return for the last year.**

Tell us where you live:
____Own your own home. Do you have a mortgage? _____Yes _____No
Do you have an equity line of credit? _____Yes _____No
____ Rent ____Live with family member ____Live in Health Care Facility ____ Other (specify)_____

Please list income for yourself and for your spouse. Most applicants will need only one or a few spaces. Please fill in only those that apply to your situation.

Household Income (self and spouse) *Parentheses refer to lines on IRS Form 1040.*	**Self**	**Spouse**	**Monthly**	**Annual Total**
Wages, salaries, etc. (W-2, line 7)				
Pension or Disability Income (line 16a)				
Social Security (line 20a)				
IRA Distributions (line 15a)				
Interest Income (lines 8a and b)				
Dividend Income (line 9)				
Capital Gains/Loss (line 13)				
Rental Income (line 17)				
Business Income (line 12)				
Other Income (please specify)				
Grant from Fund for the Diaconate				
Total Income Please add all lines.				

Please provide a list of other Financial Assets, such as Savings or Investment Accounts on a separate page

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*****Please complete the Expense Information on the next page.*****

EXPENSES INFORMATION

Please list your expenses in the following four groups: **Name:**_____

My usual expenses are:	**MONTHLY**	**FOR THE YEAR 20____**
A. BASIC LIVING EXPENSES		
Home, i.e., mortgage, rent nursing home cost, etc.		
Utilities		
Electricity		
Gas		
Heat		
Telephone		
Homeowners/Renters insurance		
Home real estate taxes		
Other Living Expenses		
Food		
Clothing		
Laundry		
Cleaning		
Other, please specify		
TOTAL BASIC LIVING EXPENSES		
B. AUTOMOBILE AND TRANSPORTATION		
Gas and Maintenance		
Car Insurance		
Taxes on Car		
Other Auto, please specify		
Other Transportation (non-auto), specify		
TOTAL AUTO AND TRANSPORTATION EXPENSES		
C. HEALTH RELATED EXPENSES		
Basic Health Insurance		
Supplemental Health Insurance		
Dental Care		
Doctors (not covered by insurance)		
Hospital (Not covered by insurance)		
Prescription Medicines (not covered by insurance)		
Other Health Supplies		
TOTAL HEALTH RELATED EXPENSES		
D. OTHER EXPENSES		
Life Insurance		
Income Tax-Federal		
Income Tax-States		
Business Expenses		
Other, please specify		
TOTAL OTHER EXPENSES		
TOTAL EXPENSES (ADD EACH COLUMN)		
TOTAL INCOME (FROM INCOME PAGE)		
NET NEED (SUBTRACT INCOME FROM EXPENSES)*		

*This is your request for the Fund's assistance. Please add a letter to note any special circumstances.

Signature_____ Date_____

If someone else signs for you, please indicate relationship.

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Approved by Board 4/6/2021