



Request for Financial Assistance

For 20_____

Return to:
The Rev. Theresa Lewallen
5904 Mt. Eagle Dr., #1612
Alexandria, VA 22303

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, with 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 _____

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.

Send to: Deacon Theresa Lewallen
5904 Mt. Eagle Dr. #1612
Alexandria, VA 22303