Good Samaritan Fund Application

Self Sufficiency Assistance

Criteria for Funding:

- The applicant must reside within a 20-mile radius of St. Cloud, MN.
- The applicant has not received a grant from the Good Samaritan Fund within the last 24 months.
- The need has been created by an unforeseen event that has resulted in an emergency, or this request will assist the applicant in becoming self-sufficient. These include payments of automobile repairs, insurance and license tabs, purchase of uniforms, work shoes and tools, and temporary transportation or childcare costs.
- The grant will solve a problem which is not expected to reoccur in the near future.
- If the emergency has resulted from the applicant's deteriorated economic situation, the grant will be approved only if financial plans have been developed with the assistance of the referring organization, or if the referring organization can verify that other corrective action has been taken.

Ineligible Requests:

- The Good Samaritan fund does not fund attorney fees, travel costs, or expenses related to child custody issues.
- Requests are not approved for payment of bail, traffic tickets, fines, or other expenses related to illegal activities.
- **Self-referrals will not be accepted.**

How to contact the Good Samaritan Fund: If you have questions on your client's eligibility, please reach out at aburton@communitygiving.org

Funding Decisions: Decisions on grants are usually made within two weeks of the time the application is received. **If an application is not completed or does not have the required attachments this can cause delays in processing.**

Payment of Grants: If granted, a check will be made payable to the payee (landlord, utility company, etc.) and mailed to the address you provide. **Cash grants are not made to clients.**

For fastest processing, email this form and any supporting documents to:
Karyn.Parks@ccstcloud.org
Optionally, you may fax your application to 320.229.4562.

GOOD SAMARITAN FUND APPLICATION

MUST BE COMPLETED BY REFERRING AGENT

Please complete application electronically. Handwritten submissions will not be accepted

REFERRING AGENTS NAME:	**AGENCY:**	**REFERRING AGENT'S PHONE #:**
REFERRING AGENT EMAIL ADDRESS:		

CLIENT NAME:	AGE/DOB:	ETHNICITY:

ADDRESS:	APT:	CITY:	STATE:	ZIP:
IF MOVING, NEW ADDRESS:				

OTHERS IN THE HOUSEHOLD:		
NAME	**AGE**	**RELATIONSHIP TO CLIENT**
1		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Amount requested: $_____ Requested for: _____

What circumstances lead to the current crisis?

SOURCE OF HOUSEHOLD NET MONTHLY INCOME: (INDICATE AMOUNT FOR ALL THAT APPLY)			
$	EMPLOYMENT		
$	COUNTY BENEFITS (DWP, MFIP,GA, MSA, SNAP, etc.)		
$	RECEIVE CHILD/SPOUSAL SUPPORT		
$	SOCIAL SECURITY		
$	OTHER: (ex. Veteran Benefits, Retirement/Pension, etc.)		
$	OTHER:		
$	OTHER:	**$** 0	**TOTAL INCOME**

MONTHLY EXPENSES: (INDICATE AMOUNT FOR ALL THAT APPLY)			
$	RENT, MORTAGE, AND/OR LOT RENT	$	UTILITIES (ex. telephone, internet, electricity, heat, etc.)
$	FOOD/HOUSEHOLD NEEDS		
$	CAR PAYMENT	$	TRANSPORTATION EXPENSE (ex. Fuel)
$	INSURANCE (car, renters, house, etc)	$	OTHER DEBT
$	CHILDCARE	$	OTHER:
$		**$** 0	**TOTAL EXPENSES**

Has the client been assisted by County Emergency Assistance within the last 18 months? Yes___ No___

If yes, for what purpose? _____

What other community resources have been contacted for help?

***SUPPORTING DOCUMENTS ARE REQUIRED FOR THE SPECIFIC ASK ON THE APPLICATION AND MUST BE INCLUDED UPON SUBMISSION.**

If approved, check should be written to:

PAYEE NAME	
PAYEE ADDRESS	
PAYEE PHONE NUMBER	

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