

# Joe Realino Fund - Application for Assistance

Applicant must answer all questions. Incomplete application will be returned for completion with no action taken. This will delay your request for at least one month, if a block is not applicable put in N/A.

Applicant's name \_\_\_\_\_ DOB \_\_\_\_\_

Mailing address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ How long at this address \_\_\_\_\_

Tel No \_\_\_\_\_ Email \_\_\_\_\_

Date last worked \_\_\_\_\_ Date expected to return \_\_\_\_\_

Employed by \_\_\_\_\_ How long \_\_\_\_\_

Address of employer \_\_\_\_\_

Occupation \_\_\_\_\_ Approx earnings per week \_\_\_\_\_

Immediate supervisor's name \_\_\_\_\_ Tel No \_\_\_\_\_

If less than one year with current employer, previous employers name \_\_\_\_\_

\_\_\_\_\_ Tel no \_\_\_\_\_

Have you been helped by this fund before? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Name of spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ How long \_\_\_\_\_

Approximate earnings per week \_\_\_\_\_

No. of Children \_\_\_\_\_ Ages \_\_\_\_\_ Children at home \_\_\_\_\_

Is anyone sharing household expenses with you? \_\_\_\_\_

Name \_\_\_\_\_ Employed by \_\_\_\_\_

Amount of income you are receiving from:

Child Support \_\_\_\_\_ Social Security Income (not SS#) \_\_\_\_\_

Workman's Comp \_\_\_\_\_ Other \_\_\_\_\_

Property you own: Home \_\_\_\_\_ Auto \_\_\_\_\_ Other \_\_\_\_\_

Landlord's name \_\_\_\_\_

Landlord's address \_\_\_\_\_

Description of Illness, Accident or Tragedy \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If receiving treatment, Where? \_\_\_\_\_ How Long \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone No \_\_\_\_\_

Your share of Rent or Mortgage \_\_\_\_\_ Date Due \_\_\_\_\_

FPL \_\_\_\_\_ Approx food per month \_\_\_\_\_

What are your immediate needs \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(We DO NOT pay for phone, cable or medical expenses)

**Qualifications for Expenses:**

1. Applicant must be a Brevard County Resident for at least one year prior to application.
2. Applicant must have worked in an establishment serving alcoholic beverages, in Brevard County for the last year prior to application.
3. Applicant must be out of work (at least) 30 days prior to illness or injury prior to application.

**Each case is investigated. False or incomplete information will result in no assistance.**

Applicant must submit the following documents with application:

- Copy of your last pay stub.
- Copy of FPL/city gas bill.
- Copy of rent/mortgage payment.
- Copy from your doctor's office concerning your case.

**I certify all information to be true, accurate and complete.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date Received \_\_\_\_\_ Investigated by \_\_\_\_\_

Action taken \_\_\_\_\_

**Return to:** Joe Realino Memorial Fund, P.O.Box 320364, Cocoa Beach, Florida 32932-0364