CASE # _____

APPLICATION FOR MONTHLY ASSISTANCE FROM FRATERNAL FUND

Grand Chapter of Pennsylvania, Order of the Eastern Star, Inc.

Date: _____ Are you a widow of a Master Mason? ____Yes ____ No
Name_____Age_____ Marital Status _____
Address_____
Telephone_____ Email Address: _____
Member of _____ Chapter No. _____ Region _____
Length of membership_____Years If dual/plural member, list Chapter name and # _____

List ALL persons residing in household (including applicant):

Name/Relationship to Applicant Age **Occupation and monthly income OF ALL IN HOUSEHOLD**

Applicant _____
Resident #1 _____
Resident #2 _____
Resident #3 _____

Have you ever applied for any form of local, county or state aid: ____Yes ____No When _____
Result _____

Are you receiving assistance from the Masons (*e.g., local Lodge or Masonic Outreach Program)*? ____Yes _____No

TO THE APPLICANT: Give a brief statement as to why you need monthly assistance. Use a separate sheet, if necessary.

I hereby apply for monthly assistance from the Grand Chapter of Pennsylvania, Order of the Easter Star, Incorporated, Fraternal Fund and affirm that I have given all true facts concerning my income and income of those residing in this household, assets, and expenses in stating my need for aid. I fully understand that any false statements contained herein, when discovered, will be reason for immediate termination of such aid. I also fully understand that monthly assistance is not meant to be long term assistance, and that I will do all in my power to help myself recover from financial burden and will immediately notify the Grand Chapter Fraternal Committee of any changes in household income, assets or expenses.

Applicant Signature _____

THIS SECTION TO BE COMPLETED BY GRAND CHAPTER FRATERNAL COMMITTEE

Date:_____Decision:_____Next Review: _____

_____ 3 year member
_____ 2 year member
_____ Chairman

Approved: _____ **Worthy Grand Matron**

Form Last Modified: 1 July 2022

MONTHLY INCOME	APPLICANT	SPOUSE/RESIDENT	RESIDENT
Wages			
Social Security			
Disability			
Workman's Comp/Unemployment			
Public Assistance *(Cash Amount)*			
Alimony			
Child Support			
Pension/Retirement			
SNAP/Public Assistance			
LIHEAP			
ACCESS			
Property Tax or Rent Rebate *(Divide by 12)*			
MEDICAID (Yes or No)			
OTHER Monthly Income			
TOTAL INCOME			
ASSETS			
Home Value			
Mortgage Balance			
Checking Account Balance			
Savings, Xmas/Vacation Account Balances			
Bonds/Stocks/Mutual Funds Value			
Certificates of Deposit/Money Market Value			
IRA or Other Retirement Fund			
TOTAL ASSETS			

PLEASE NOTE----ALL FIGURES LISTED SHOULD BE AMOUNT PER MONTH. IF QUARTERLY, DIVIDE BY 4. IF YEARLY DIVIDE BY 12.
IF NEEDED, PLEASE COPY PAGE FOR ADDITIONAL RESIDENTS.

Form Last Modified: 1 July 2022

MONTHLY EXPENSES	APPLICANT	SPOUSE/RESIDENT	RESIDENT
Mortgage			
Rent			
Homeowner's Insurance			
Renter's Insurance			
Taxes *(real estate, city, county, school)*			
UTILITIES			
Heat			
Electric			
Phone			
Internet			
Cable			
Cell Phone			
Water/Sewer			
Trash Removal			
Groceries			
AUTOMOBILE			
Car Payment			
Gas			
Car Insurance			
MEDICAL			
Doctor Visits (not covered by insurance)			
Prescriptions (not covered by insurance)			
Health Insurance			
Life Insurance			
Other Medical Expenses			
CREDIT CARDS			
Company Name Balance Due.	Monthly Payment	Monthly Payment	Monthly Payment
1.			
2.			
3.			
4.			
Other Loan Payments			
Lender Name Balance Due	Monthly Payment	Monthly Payment	Monthly Payment
1.			
2.			
TOTAL EXPENSES			

PLEASE NOTE----ALL FIGURES LISTED SHOULD BE AMOUNT PER MONTH. IF QUARTERLY, DIVIDE BY 4. IF YEARLY DIVIDE BY 12.
IF NEEDED, PLEASE COPY PAGE FOR ADDITIONAL RESIDENTS.

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