**CASE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **APPLICATION FOR MONTHLY ASSISTANCE FROM FRATERNAL FUND**
2. Grand Chapter of Pennsylvania, Order of the Eastern Star, Inc.
3. Date: Are you a widow/wife of a Master Mason? \_\_\_\_Yes \_\_\_\_ No
4. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_ Marital Status \_\_\_\_
5. Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Telephone Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Member of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chapter No. \_\_\_\_\_\_\_\_ Region \_\_\_\_
8. Length of membership Years If dual/plural member, list Chapter name and # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. **List ALL persons residing in household (including applicant):**
10. **Name/Relationship to Applicant**  Age **Occupation and monthly income OF ALL IN HOUSEHOLD**
11. **Applicant**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Resident #1**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. **Resident #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
13. **Resident #3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
15. Have you ever applied for any form of local, county or state aid: \_\_\_\_Yes \_\_\_\_No When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
16. Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
17. Are you receiving assistance from the Masons (*e.g., local Lodge or Masonic Outreach Program)*? \_\_\_\_Yes \_\_\_\_\_No
18. TO THE APPLICANT: Give a brief statement as to why you need monthly assistance. (Use a separate sheet, if necessary.)
19. 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 the 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.
20. Applicant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
22. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
23. **THIS SECTION TO BE COMPLETED BY GRAND CHAPTER FRATERNAL COMMITTEE**
24. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Decision:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Next Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
25. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3 year member
26. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2 year member
27. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chairman
29. Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Worthy Grand Matron**
30. *Form Last Modified: June 2025*
31. PLEASE NOTE----ALL FIGURES LISTED SHOULD BE AMOUNT PER MONTH. IF QUARTERLY, DIVIDE BY 4. IF YEARLY DIVIDE BY 12.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **MONTHLY INCOME** | 1. **APPLICANT** | 1. **SPOUSE/RESIDENT** | 1. **RESIDENT** |
| 1. Wages |  |  |  |
| 1. Social Security |  |  |  |
| 1. Disability |  |  |  |
| 1. Workman’s Comp/Unemployment |  |  |  |
| 1. Public Assistance *(Cash Amount)* |  |  |  |
| 1. Alimony |  |  |  |
| 1. Child Support |  |  |  |
| 1. Pension/Retirement |  |  |  |
| 1. SNAP/Public Assistance |  |  |  |
| 1. LIHEAP |  |  |  |
| 1. ACCESS |  |  |  |
| 1. Property Tax or Rent 2. Rebate *(Divide by 12)* |  |  |  |
| 1. MEDICAID (Yes or No) |  |  |  |
| 1. OTHER Monthly Income |  |  |  |
| 1. **TOTAL INCOME** |  |  |  |
| 1. **ASSETS** |  |  |  |
| 1. Home Value |  |  |  |
| 1. Mortgage Balance |  |  |  |
| 1. Checking Account Balance |  |  |  |
| 1. Additional Checking Account Balance (if more than two, list additional) |  |  |  |
| 1. Savings, Xmas/Vacation Account Balances |  |  |  |
| 1. Bonds/Stocks/Mutual Funds Value |  |  |  |
| 1. Certificates of Deposit/Money Market Value |  |  |  |
| 1. IRA or Other Retirement Fund |  |  |  |
| 1. **TOTAL ASSETS** |  |  |  |

1. PLEASE NOTE----ALL FIGURES LISTED SHOULD BE AMOUNT PER MONTH. IF QUARTERLY, DIVIDE BY 4. IF YEARLY DIVIDE BY 12.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **MONTHLY EXPENSES** | 1. **APPLICANT** | 1. **SPOUSE/RESIDENT** | 1. **RESIDENT** |
| 1. Mortgage |  |  |  |
| 1. Rent |  |  |  |
| 1. Homeowner’s Insurance |  |  |  |
| 1. Renter’s Insurance |  |  |  |
| 1. Taxes *(real estate, city, county, school)* |  |  |  |
| 1. **UTILITIES** |  |  |  |
| 1. Heat –if use pellets/propane/fuel oil (supply yearly bills - break down monthly) |  |  |  |
| 1. Electric |  |  |  |
| 1. Phone/Internet/Cable |  |  |  |
| 1. Water/Sewer |  |  |  |
| 1. Trash Removal |  |  |  |
| 1. Misc Charges |  |  |  |
| 1. Groceries/Household Supplies |  |  |  |
| 1. Misc Supplies |  |  |  |
| 1. **AUTOMOBILE** |  |  |  |
| 1. Car Payment |  |  |  |
| 1. Gas/ Uber/Share Rides |  |  |  |
| 1. Car Insurance |  |  |  |
| 1. **MEDICAL** |  |  |  |
| 1. Doctor Visits (not covered by insurance) |  |  |  |
| 1. Prescriptions (not covered by insurance) |  |  |  |
| 1. Health Insurance |  |  |  |
| 1. Life Insurance |  |  |  |
| 1. Other Medical Expenses |  |  |  |
| 1. **CREDIT CARDS** |  |  |  |
| 1. Company Name Balance Due. | 1. Monthly Payment | 1. Monthly Payment | 1. Monthly Payment |
| 1. 1. |  |  |  |
| 1. 2. |  |  |  |
| 1. 3. |  |  |  |
| 1. 4. |  |  |  |
| 1. **Other Loan Payments** |  |  |  |
| 1. Lender Name Balance Due | 1. Monthly Payment | 1. Monthly Payment | 1. Monthly Payment |
| 1. 1. |  |  |  |
| 1. 2. |  |  |  |
| 1. **TOTAL EXPENSES** |  |  |  |