Solidarity Assistance Program

Anchorage Chapter Application

Please return to: SAPGrant@afscmelocal52.org

The purposes of the Solidarity Assistance Program Grant is to provide emergency assistance to ASEA Anchorage Chapter Members. Every attempt is made to assist our members by providing grant assistance and/or referrals to other resources and programs that may be beneficial to each situation.

Your Contact Information:

Applicant Full Name:		SOA PCN or Employee ID #:	
Primary Contact #:	☐ Home ☐ Cell	Contact Preference: (email, text, phone)	
Alternate Contact #:	☐ Home ☐ Cell	May we Contact you via SMS text?	
Personal Email Address (Do not use state email)		Are you an ASEA Anchorage Chapter member in good standing?	
Full Mailing Address:			

Your privacy is important to us.
All personally identifiable information is removed before being submitted to the Grant Assistance Review Board.

Financial Resources and Household: (*Please provide the following for each member of your household. Use additional page if needed.*)

Name	Age	Fulltime Student (Y/N)	Employed (Y/N)	Date Unemployed (If Applicable)	Are you receiving unemployment benefits? (Y/N)	List if ASEA or member of another Union
1. Member:						
2. Spouse/Other:						
3. Child/Dep:						
4.						
5.						

Anticipated income for next 30 days (after mandatory deduction): $_______________

Anticipated expenses for next 30 days: $_________________

Have you applied or received any assistance in the last 60 days (if yes, please explain)?__________________________

Type of Assistance Requested: (*Check ALL that apply*)

☐Groceries ☐Prescription/Medical ☐Vehicle Gas ☐Utilities (electric, gas, propane only)
☐Dependent Care ☐Other ______________________

Grant Assistance Requested: (*please use an additional page if needed.*)

Please include a detailed explanation supporting your request for financial assistance. Please **do not** include names or other personal identifying information in your explanation. Please include a copy of documentation that supports your reason for the grant request your application (no originals will be returned). For audit purposes, you **must** include a copy of a bill or statement supporting assistance requested for utilities, dependent care, prescriptions/medical, and other assistance.

By signing this application, I understand that the information provided is for this assistance application only. I understand that my application for assistance is reviewed by a committee and based on need as well as funds available. I understand that my application may be approved in full, in part, or denied. By signing I am allowing SAP to contact me regarding this application.

(For recordkeeping purposes only / SAP use only)

____
Signature / Date

Date Received: ______________
Application Number: ____________
Applicant Number: ____________