The George Bailey Memorial Program

# APPLICATION FOR TEMPORARY DISABILITY FUNDS

*FUNDS PROVIDED BY THE GEORGE BAILEY MEMORIAL PROGRAM ARE A TEMPORARY LOAN TO THE INJURED PARTY AND WILL BE FULLY REPAID WITHIN 30 DAYS OF RECEIVING SOCIAL SECURITY DISABILITY FUNDS*

## CONTACT INFORMATION

Injured Party (applicant) Name:

Home Phone: Cell: E-mail:

Address:

City: State: ZIP Code:

Have two doctors provided a prognosis of less than 18 months to live for injured party? Yes__ No__
(if yes, please attach at least two medical opinions)

Incident description:

Was injured party engaged in a criminal activity at time of incident? Yes __ No__ (if yes, please explain)

Was the injured party the proximate cause of his/her injury? Yes__ No__ (if yes, please explain)

## EMPLOYER INFORMATION

Employer Name:
Address:

City: State: ZIP Code:

Telephone: Primary contact: E-mail:

## FINANCIAL INFORMATION

Projected Social Security Disability monthly award amount (attach copy of recent Social Security Statement or logon to https://www.ssa.gov/myaccount/ and provide a copy of estimate benefits): $

Life Insurance Company: Policy #:

Is victim eligible for Worker's Compensation? Yes __ No__ W/C Insurer:

List any other means to repay
fund loan:

## ARMED FORCES SERVICE

Was the injured party a member of the Armed Forces of the United State of America? Yes__ No__

If yes, was he/she a legal resident of Illinois for at least 12 months prior to enlisting? Yes__ No__
(if Yes, please provide documentation)

If yes, was the injured party planning on returning to Illinois? Yes__ No__

## AGREEMENT

1. All loans are to be repaid 30 days from the date Social Security Disability is received.
2. By submitting this application, you authorize 1BThe George Bailey Memorial Program to seek full reimbursement for any funds provided from the injured party's estate.

## SIGNATURE (INDICATE RELATIONSHIP TO INJURED PARTY IF SIGNING ON BEHALF OF INJURED PARTY AND INCLUDE A COPY OF APPLICABLE POWER OF ATTORNEY)

Relationship:
Date: