

# **CASE**

**Committee to Aide State Employees**

**PO Box 341**

**Jefferson City, MO 65102-0341**

**Telephone:**

**Toll-Free**

**(888)753-CASE (2273)**

CASE, Inc. Application  
PO Box 341  
Jefferson City, MO 65102-0341  
Toll Free (888)753-CASE (2273)

CASE may contact your employer, utility companies and financial institutions for verification of information.

**PERSONAL  
INFORMATION**

Please print all information:

Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Other/Cell Phone (\_\_\_\_) \_\_\_\_\_ Best time to call: \_\_\_\_\_

**EMPLOYER  
INFORMATION**

Agency Name and Division: \_\_\_\_\_

Agency Address: \_\_\_\_\_

Date of Employment: \_\_\_\_\_ Working Title: \_\_\_\_\_

Supervisors Name and Telephone Number: \_\_\_\_\_

Have you worked at least 1,000 hours for the State of Missouri within the last year? If yes, how many hours have you worked? \_\_\_\_\_

# FINANCIAL INFORMATION

The items that will be considered for financial assistance are: rent or mortgage payments, medical insurance, medical bills, utilities, vehicle payments or insurance.

Instructions: It is important that all financial information be completed. Please provide current copies of your most recent statements/documentation to support your request for financial assistance. Include additional pages as necessary.

Reason for grant request and total amount being requested from CASE: \_\_\_\_\_

Please include all income sources and amounts for your household. If income sources are from another person in the household, please include the relationship to you.

Assets: (List Amounts)

Checking Account: \_\_\_\_\_

Savings Account: \_\_\_\_\_

Social Security/Disability: \_\_\_\_\_

Long-term Disability: \_\_\_\_\_

Retirement Income: \_\_\_\_\_

Deferred Comp: \_\_\_\_\_

Vehicles/Transportation: \_\_\_\_\_

Have you requested any monies from your deferred compensation account? If so, have you received your request (date and amount)? \_\_\_\_\_

Have you applied for Social Security or Social Security Disability? \_\_\_\_\_

Have you applied for Long-Term disability and/or Shared Leave through your employer? If so, have you been approved or denied? If you were approved, what is the date of approval? \_\_\_\_\_

Expenditures from Income:

Rent/Mortgage Payment: \_\_\_\_\_ Vehicle Payment(s): \_\_\_\_\_

Utilities: Water: \_\_\_\_\_ Electric: \_\_\_\_\_ Heat: \_\_\_\_\_

Gas (home heating/cooking): \_\_\_\_\_ Trash: \_\_\_\_\_ Auto Gas: \_\_\_\_\_

Health/Medical Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_ Food: \_\_\_\_\_

Auto Insurance: \_\_\_\_\_ Home/Renter Insurance: \_\_\_\_\_

Medication: \_\_\_\_\_ Other: \_\_\_\_\_

Household Information:

List number of household members and ages: \_\_\_\_\_

# CATASTROPHIC/MEDICAL OCCURRENCE INFORMATION

Please provide a copy of your most recent physician's diagnosis/prognosis for this event.

Type of catastrophic/medical occurrence (i.e. illness, injury, flood, fire, etc.) \_\_\_\_\_

\_\_\_\_\_

Were you a state employee at the time of the occurrence? \_\_\_\_\_

When was your last day at work and the date of your most recent paycheck? \_\_\_\_\_  
(Provide a copy of your most recent pay stub.)

If illness or injury, what was the date of the onset of illness or injury? \_\_\_\_\_

Do you have pending lawsuit or litigation due to catastrophic event? \_\_\_\_\_

Did your catastrophic event require hospitalization? \_\_\_\_\_

Are you currently under doctor's care for the catastrophic event? \_\_\_\_\_  
Physician's Name, Address and Phone Number:

\_\_\_\_\_

Please provide dates and full description of the catastrophic/medical event. If needed, additional paper may be used. This information is confidential and used only in the review of your request for funds from CASE.

\_\_\_\_\_

I hereby certify all information made on or in connection with this application is accurate and complete to the best of my knowledge and I have not knowingly withheld any fact or circumstance. I understand if any of the statements made by me on this application are false, it will be sufficient grounds for denial of my application for funds from CASE.

I hereby authorize any employer, banking institution, utility company/supplier, doctor, hospital, mortgage lender/landlord to release information to the members of CASE committee reviewing my application for assistance. I understand this information will be kept confidential to the extent necessary and will only be used in the application review process.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

The Committee to Aid State Employees (CASE) is an Equal Opportunity Provider.