Les Clefs d'Or Foundation
Of the Americas

GRANT APPLICATION

Eligibility Requirements

Active concierges are defined as:

Staff having held full concierge status covering at least one year in tenure.

Staff working a minimum of 32 hours a week within an American, Canadian, Mexican, or Brazilian hotel as a concierge.

Staff have to have been actively employed within the last six months.

Any professional or social affiliated member of Les Clefs d'Or, in good standing, as well as immediate family members and significant others of one of the above concierges are also eligible.

Application Date: _____

Concierge's Name:

(Last) _____, (First) _____

(Middle) _____

Social Security or Federal Identification Number:
_____

Home Address: _____

_____

_____

Phone Numbers: Home: _____

Work: _____

In case of emergency, whom may we contact?

_____

Phone Numbers: _____, _____

How long have you been employed as a concierge?

Years / Months _____ / _____

Name of hotel which concierge is or has been employed:

_____

Is the concierge still working at his or her hotel? Yes _____ No _____

If no, how many months has it been since he or she has worked on a full time basis: _____

If the above criteria cannot be completely fulfilled by the applicant, please explain:

Is this application for you or for your spouse, significant other, dependent child or parent?

Name: _____Relationship: _____

Reason for request (in applicant's words):

I attest that the above information is complete, correct and true.

_____ _____

Signature Date

Note: The completed Financial Information Application and a Statement of Diagnosis from the attending physician with name, address and signature of physician, must be enclosed with the completed application.

Signature above authorizes Les Clefs d'Or Foundation of the Americas to participate in needed information exchange with the designated parties above with the intent of assisting the Foundation in making eligibility determinations.
These benefits are available to all qualified applicants regardless of race, creed, religion, national origin or sexual orientation.

Les Clefs d'Or Foundation of the Americas
22 Prairie Landing Court
North Potomac, Md 20878 USA
Telephone: 301-309-2077 Fax: 301-309-8255

Les Clefs d'Or Foundation of the Americas
FINANCIAL INFORMATION APPLICATION

NAME: _____

SOCIAL SECURITY / FEDERAL IDENTIFICATION (USA), _____

SOCIAL INSURANCE (CANADA) _____

SEGURO SOCIAL (MEXICO) _____

(BRAZIL) _____

HEALTH INSURANCE

Yes _____ No _____

If yes:
Private: ____ Monthly Premium: $ _____ Medicare (USA only) ____

Part A ____Part B _____

Other (specify):
_____

ASSISTANCE

Are you currently receiving assistance from any public or private agency?
Yes _____ No _____

If yes:	Applicant
Spouse/Partner	
SSI (USA only)	
$_____	$ _____
Social Security Benefits (USA only)	
$_____	$_____
AFDC / General Assistance	
$ _____	$_____
Veteran's Benefit	
$_____	$_____
Pension	
$_____	$_____
Child / Spousal Support	
$_____	$_____
Unemployment, Private Disability	
$_____	$_____

State / Provincial Disability, Other (specify):

_____

WAGES (if any)

Monthly Gross	
$_____	$_____
Monthly Net	
$_____	$_____
Last Year's Adjusted Gross Income	
$_____	$_____

HOME OWNERSHIP

Current Market Value $ _____

1st Mortgage $ _____ 2nd $ _____

Joint Ownership: Yes _____ No _____

Other Property Owned:

_____

ASSETS

Checking Account:
$ _____ $ _____

Savings Account:
$_____ $_____

Investments:
$_____ $_____

Stocks / Bonds:
$_____ $_____

Business Assets:
$_____ $_____

Life Insurance:
Amount: $_____ Cash Value: $_____

$_____ $_____

TOTAL: $_____

MAJOR MONTHLY EXPENSES

Rent / Mortgage: $_____

Transportation (gasoline, tolls, fares): $_____

Car Payments: $_____

Day Care (children, seniors, disabled): $_____

Child / Spousal Support (owed): $_____

MEDICAL DEBTS

Medical Bills in Collection:

To Whom	Initial Total	Balance Due	Monthly Payments
1) _____	$_____	$_____	$ _____

Outstanding Medical Bills:

To Whom	Initial Total	Balance Due	Monthly Payments
1) _____	$_____	$_____	$ _____

Projected Medical Expenses:

To Whom	Initial Total	Balance Due	Monthly Payments
1) _____	$_____	$_____	$ _____

Additional Monthly Expenses

To Whom	Initial Total	Balance Due	Monthly Payments
1) _____	$_____	$_____	$ _____

Unexpected Expenses:

To Whom	Initial Total	Balance Due	Monthly Payments
1)_____	$_____	$_____	$ _____

OTHER (please feel free to use the back of this form if necessary)

I attest that the above information is complete, correct and true.

_____ _____

Signature Date