

Please print the application, fill out legibly, and mail to address at bottom.

**PORTLAND ADVERTISING INDUSTRY EMERGENCY FUND, INC.**

**Application for Financial Aid Page 1**

Please complete all sections of this form as detailed information will help speed up a response. Please print legibly. Special attention should be given to section "Purpose of Funds." Financial assistance cannot be provided where the reason for assistance is not explained or where the reason given is "personal", or words to that effect.

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS # \_\_\_\_\_ # of Dependents \_\_\_\_\_ Married \_\_\_ Divorced \_\_\_ Single \_\_\_ Widow \_\_\_ Age \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Are you presently employed? Yes \_\_\_ No \_\_\_ If yes, please answer the following questions:

Name of Company \_\_\_\_\_ How long? \_\_\_\_\_ Position \_\_\_\_\_

Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Place of Employment \_\_\_\_\_

Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Annual Income \$ \_\_\_\_\_ Assets \$ \_\_\_\_\_

**EMPLOYMENT HISTORY**

Co. Name _____	Address _____	From _____	To _____
Co. Name _____	Address _____	From _____	To _____
Co. Name _____	Address _____	From _____	To _____

Do you currently have health insurance? Yes \_\_\_ No \_\_\_ If yes please answer the following:

Company Name \_\_\_\_\_ Address \_\_\_\_\_ Policy # \_\_\_\_\_

**PURPOSE FOR FUNDS (Give ALL information for requesting aid)**

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**PORTLAND ADVERTISING INDUSTRY EMERGENCY FUND, INC.**

**Application for Financial Aid Page 2**

AIEF will not give cash directly to any individual. Please list items (examples: medical, prescriptions, nursing care, housing, utilities, child care) that you need aid to take care of. If medical bills are listed, please name doctors:

Item or doctor _____	Address _____	Phone _____	Amount \$ _____
Item or doctor _____	Address _____	Phone _____	Amount \$ _____
Item or doctor _____	Address _____	Phone _____	Amount \$ _____
Item or doctor _____	Address _____	Phone _____	Amount \$ _____
Item or doctor _____	Address _____	Phone _____	Amount \$ _____
Item or doctor _____	Address _____	Phone _____	Amount \$ _____
Item or doctor _____	Address _____	Phone _____	Amount \$ _____
Item or doctor _____	Address _____	Phone _____	Amount \$ _____

If you are applying for aid for future medical treatment/care, please fill out the following:

Item or doctor _____	Address _____	Phone _____
Item or doctor _____	Address _____	Phone _____
Item or doctor _____	Address _____	Phone _____
Item or doctor _____	Address _____	Phone _____
Item or doctor _____	Address _____	Phone _____

If your needs are other than those listed above, use the following space to describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you applied to other institutions for aid? Yes \_\_\_ No \_\_\_ If yes, please list below:

Institution _____	Address _____
Institution _____	Address _____
Institution _____	Address _____
Institution _____	Address _____

Have you received help from any of the above? Yes \_\_\_ No \_\_\_

Have you applied to AIEF for aid before? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_ Amount requested? \_\_\_\_\_

For what purpose? \_\_\_\_\_

Referred to AIEF by: \_\_\_\_\_

Signature of applicant \_\_\_\_\_

If applicant is unable to sign or fill out form and second party is involved, please sign below:

2nd Party Signature \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Please send this form with any attachments or additional comments to:  
AIEF Eligibility Committee, P.O. Box 40586, Portland, OR 97240