CALIFORNIA JAZZ FOUNDATION

A NONPROFIT CORPORATION

www.californiajazzfoundation.org

ONGOING FINANCIAL ASSISTANCE APPLICATION

- **Emergency Financial Assistance – For Basic Needs**
- **Medical Referral**

After review of an application by the Review Committee, the California Jazz Foundation (CJF), a nonprofit charitable organization, may in its sole and absolute discretion grant financial assistance for needs which have arisen due to unforeseen circumstances. Those needs may include rent, car payments, utilities, prescriptions, medical/dental expenses, psychotherapy and other expenses related to these categories. Financial assistance is not available for credit card debts, loans, or music projects. CJF also has a medical referral network whose members have agreed to offer services at a reduced rate to those jazz artists in need. Each application will be assessed based upon the exigencies of each case. Each application will be reviewed by the Review Committee and the CJF staff social worker on behalf of the CJF. The application also may be reviewed by other participants in the Entertainment Assistance Cooperative ("EAC").

ELIGIBILITY REQUIREMENTS AND PROCEDURES

Applicant must be able to show at least 5 years of primary employment as a jazz artist and California residency. Acceptance of a grant application does not assure issuance of a grant. Among the factors that historically have been employed by the CJF in assessing grant applications are (i) whether the individual applicant is eligible to apply for a grant as a California resident who is a Jazz musician who has worked as such for a minimum of five years; (ii) the reasons stated by the applicant in the grant application for requesting the grant; (iii) whether the applicant previously applied for a grant and the time between applications; (iv) whether the applicant has acted on any recommendations of the CJF respecting changes that could address the reasons for seeking the grant; (v) the earning potential of the applicant in light of the circumstances leading to the submission of the grant application; (vi) whether other sources of assistance are available to the applicant; and (vii) such other factors as the CJF in its sole discretion deem relevant to the particular applicant and application.

Applicants who are granted ongoing, monthly assistance through CJF are subject to quarterly reviews performed by a social worker. These reviews are a necessary part of the grant process and failure to meet for a quarterly review may result in termination of assistance. The purpose of these quarterly reviews is to assess for changes in the grantee's circumstances and may lead to an increase or decrease in the amount of assistance provided by the grant as well as possible termination after evaluation by the Review Committee. Grantee's will be informed prior to the review if the social worker will require any supporting documents.

CJF grants for ongoing assistance are intended to address chronic life changes that impact an applicant's ability to work and to care for basic needs. These life changes may be connected to physical illness, mental illness, or the normal effects of aging. If not initially approved for grant assistance or if reapplying after termination of assistance, applicants may be subject to greater scrutiny and denial. Denial of an application, even for first time applicants, is not a determination of the value of your needs. It is based upon a limitation of the scope of needs that CJF can address and the inability of CJF to approve all grant requests.

Please include the following required items with the completed application:
(We can assist with the completion of the application and the attachments.)

- Copies of bills for which assistance is being requested
- A resume or discography
- Complete copies of your three most recent bank statement(s) and investment accounts
- Current income verification of all household members, from all sources

If you have any questions about the application or supporting documents required, please call (818) 400-3263. Once the application is received by CJF, we will contact applicant to review the application and gather additional information if necessary. A summary of the situation will be compiled and forwarded to the Review Committee for consideration. Applicant will be notified of the Committee's decision as soon as possible. Decisions on applications are final and non-reviewable. Except in an emergency or crisis, please allow at least one to two weeks for processing.

ASSISTANCE LIMITATIONS

CJF has limited resources and cannot approve applications submitted by all eligible applicants. When financial assistance is provided by CJF, it is charitable in nature and, therefore, before seeking such assistance, applicant is required to investigate all other possible sources of aid. All approved assistance is paid directly to a creditor/third party. At its sole discretion, CJF reserves the right to deny or approve financial assistance.

MAIL OR EMAIL THE APPLICATION TO:

California Jazz Foundation
c/o Mara Roshal, MSW
5903 Noble Ave.
Van Nuys, CA 91411
help@californiajazzfoundation.org

The information contained in this application is strictly confidential, accessible only to the California Jazz Foundation Board of Directors and CJF's counterparts in the industry, emergency relief organizations and unions, in order to provide applicant with maximum opportunities for aid, while ensuring discretion. Our social worker is available, if necessary, to help you complete the Application. If you have any questions, please call (818) 400-3263

PLEASE PRINT CLEARLY IN INK

Name: _____
(As it appears on your Social Security Card)

Professional Name: _____
(If different)

Spouse/Partner Name: _____
(If applicable)

Home Address: _____

City/State: _____Zip:_____

Mailing Address: _____

City/State:_____Zip:_____
(If Different)

Daytime Phone Number: _____

Evening Phone Number:_____

Cell Phone Number: _____

Email Address:_____

Web Page Address:_____

Social Security Number: _____

Date of Birth: _____

Marital Status: _____Number of Dependents: _____

Age(s) of Dependent(s):_____

Is your spouse/partner employed? ○ Yes ○ No If yes, employer information:

_____

_____

PROFESSIONAL CAREER HISTORY:

Please state how many years you have been employed as a jazz musician: _____

Are you currently employed outside of the music industry? ○ Yes ○ No

If so, where?

_____

How long? _____

You may be eligible for additional assistance from other relief organizations. Are you or your spouse a member of any entertainment unions? ○ Yes ○ No

If yes, please list:

_____

Have you been and/or are you currently receiving any additional assistance from another organization(s)?

○ Yes ○ No If so, who?

_____

When? _____

How Much? _____

I authorize California Jazz Foundation to communicate with the additional parties below to discuss my current situation if needed. (If requesting rental assistance please include your landlord.)

*PLEASE DO NOT LIST PHYSICIANS.

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone:_____

MEDICAL INFORMATION, if Application is for medically-related need:

Are you currently receiving treatment for any medical issue? ○ Yes ○ No

If yes, what are you being treated for?

_____

Are you taking any medication? ○ Yes ○ No

If so, please list name(s), dosage(s), and amount(s) taken:

_____

_____

_____

Have you ever been treated for a psychiatric and/or addiction issue? ○ Yes ○ No

If so, when? _____

Where? _____

Physician's Name: _____

Address/ Phone: _____

_____

Do you have health insurance? ○ Yes ○ No Medicare? ○ Yes ○ No Medicaid? ○ Yes ○ No

Insurance Company:

_____

HOUSING:

(If applying for housing assistance, a copy of current lease or mortgage coupon is required.)

Number of people in your household? _____Monthly Rent/Mortgage: $_____

Your share: $_____

How long in residence? _____

LEASE/LENDER INFORMATION: (circle one)

Name: _____

Address: _____

Phone: _____

TRANSPORTATION:

Vehicle Information: Year/Make: _____

Model: _____

Registration Current? ○ Yes ○ No Insurance Current? ○ Yes ○ No

Payment Current? ○ Yes ○ No

Loan Balance: $_____

Legal Registered Owner: _____

I hereby certify that I have answered the foregoing questions to the best of my ability. The facts herein stated are true, to the best of my knowledge, and I understand that any misrepresentation of this information may disqualify me for any assistance from California Jazz Foundation.

Signature of Applicant: _____Date: _____

Signature of Applicant: _____Date: _____

DATE COMPLETED: _____

BANK / ASSETS

Checking (Name / Account #)_____Balance $ _____

Savings (Name / Account #)_____Balance $ _____

Other (Name / Account #)_____Balance $ _____

Other Assets: _____

_____

REASON FOR APPLYING FOR ASSISTANCE:

_____

_____

_____

_____

_____

BILLS FOR WHICH PAYMENT IS REQUESTED:

_____

_____

_____

TOTAL AMOUNT REQUESTED: $_____

I hereby certify that I have answered the foregoing questions to the best of my ability. The facts herein stated are true, to the best of my knowledge, and I understand that any misrepresentation of this information may disqualify me for any assistance from the California Jazz Foundation.

Signature of Applicant: _____ Date: _____

ACKNOWLEDGMENT AND WAIVER OF LIABILITY

I understand that the California Jazz Foundation is a nonprofit organization seeking to assist jazz musicians in need. The deliberations of each application by the Review Committee are confidential and may not be disclosed. I understand further that decisions respecting the grant or denial of my application are in CJF's discretion and are final and non-reviewable. In consideration thereof, I hereby release and hold harmless the Foundation, its Directors and Officers, its volunteers, and other emergency relief organizations and unions in the EAC who review this application from any liability or claims of injury to my body or property or of my right to privacy in applying for assistance.

Signature of Applicant: _____ Dated: _____

HelpLine: (818) 400-3263

MONTHLY BUDGET

INCOME:

Income from Work $_____

Residuals and Royalties $_____

Unemployment Insurance $_____

Social Security Income $_____

Social Security Disability $_____

SSI General Relief $_____

Food Stamps $_____

Veteran Benefit $_____

Spouse/Partner Income $_____

Alimony $_____

Child Support $_____

Union Pension $_____

OTHER INCOME:

$_____

$_____

$_____

Relief Grants: (specify)

$_____

$_____

$_____

TOTAL INCOME:

ASSETS

Checking Account $_____

Savings Account $_____

Other Account(s) $_____

Real Estate:

Date Purchased $_____

Purchase Price $_____

Present Value $_____

Payment $_____

In whose name is the property recorded?

_____

TOTAL ASSETS

$_____

EXPENSES:

Rent/Mortgage $_____

Second Mortgage $_____

Home Insurance $_____

Maintenance $_____

HomeOwner's Association Fee $_____

Food $_____

UTILITIES:

Gas $_____

Electric $_____

Water/Sewer/Garbage $_____

Telephone/Fax $_____

Cell Phone/Pager $_____

Cable $_____

TRANSPORTATION:

Car Payment $_____

Car Insurance $_____

Gasoline $_____

Public Transit $_____

MEDICAL/DENTAL:

Health Insurance $_____

Medical Bills $_____

Prescriptions $_____

Dental Bills $_____

MISCELLANEOUS EXPENSES

Life Insurance	$_____	$_____	
Union Dues	$_____	$_____	
Loan(s)	$_____	**TOTAL EXPENSES**	$_____
Credit Cards	$_____		
Child Support / Alimony	$ _____		
Laundry/Cleaning	$_____		

OTHER:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____hereby authorize the disclosure and release of any of my individually identifiable health information and any other medical records to my agent, the California Jazz Foundation, located at 5903 Noble Avenue, Van Nuys, CA 91411, (818) 400-3263. This Authorization is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (42 U.S.C. Section 1320d) (HIPAA) and the California Confidentiality of Medical Information Act (Civil Code Section 56 et seq.) (CMIA) for the disclosure of information to my agent.

The entities who are authorized to disclose and release my individually identifiable health information and any other medical records to my agent are any entity or entities that are subject to the privacy requirements of HIPAA and CMIA.

I intend that my agent be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. My agent who receives any such information and records pursuant to this authorization may make whatever use of such information as is necessary for purposes of carrying out that agent's duties toward me, as determined by my agent.

This Authorization is effective immediately.

Date: _____ _____

Signature