C O N F I D E N T I A L R E F E R R A L

YOU REQUESTED ASSISTANCE FROM

B.P.O. ELKS LODGE No. 309
GEORGE W. TRIMBLE CHARITY FUND

P.O. Box 7165
Colorado Springs, CO 80933-7165

Phone: (719) 634-7360

APPLICANT INFORMATION
PLEASE PRINT

PHONE NUMBER _____

****** PHOTO ID REQUIRED ******

NAME: _____ DOB: _____ AGE _____

STREET ADDRESS: _____ APT or LOT# _____

CITY & STATE: _____ ZIP: _____

EL PASO COUNTY RESIDENT FOR _____ YEARS. US CITIZEN? YES ___ NO ___

FILL OUT THIS REQUEST FORM COMPLETELY

TYPE OF AID REQUESTED _____

DO YOU OR WILL YOU RECEIVE OTHER FINANCIAL AID FOR THIS REQUEST? YES ___ NO ___

AGENCY: _____

LIST ANY ADDITIONAL PEOPLE WHO LIVE WITH THE APPLICANT AS OF THE DATE OF THIS REQUEST.

ATTACH ANOTHER PAGE NECESSARY. DO NOT LIST THE APPLICANT AGAIN.

NAME	RELATIONSHIP	AGE	MONTHLY INCOME? (Yes or No)	EMPLOYED (Yes OR No)

TOTAL NUMBER IN HOME _____

WORK STATUS: **EMPLOYED** **UNEMPLOYED** **RETIRED** **DISABLED**

IN THE SPACES TO THE RIGHT, PLEASE TELL US ABOUT THE MONTHLY INCOME AND EXPENSES FOR YOUSELF, YOUR SPOUSE, AND OTHER MEMBERS IN THE HOME. INFORMATION MUST BE COMPLETE OR IT MAY VOID THIS APPLICATION WITHOUT CONSIDERATION.

ATTACH COPIES OF VERIFICATION OF INCOME

DO YOU OWN, RENT OR ARE BUYING YOUR HOME?

RENT _____

BUYING _____

OWN _____

HOUSEHOLD MONTHLY INCOME:	APPLICANT	SPOUSE & OTHERS
WAGES AFTER TAXES		
SOCIAL SECURITY		
SSI		
SSDI		
DIB / DWB		
AND / AFDC / TANF		
FOOD STAMPS		
CHILD SUPPORT		
UNEMPLOYMENT		
WORKMEN'S COMP		
PENSIONS		
INTEREST / DIVIDENDS		
TOTAL INDIVIDUAL INCOME		
TOTAL COMBINED INCOME		

HOUSEHOLD MONTHLY EXPENSES:	MONTHLY PAYMENT
RENT / HOUSE PAYMENT	
FOOD	
MEDICINE & DOCTORS	
UTILITIES & TRASH	
CLOTHING	
PHONE & INTERNET & TV	
CAR LOAN PAYMENTS	
AUTO GAS, OIL, ETC.	
CREDIT CARD PAYMENTS	
INSURANCE (HOUSE, CAR, MEDICAL, DENTAL)	
CHILD CARE	
OTHER	
TOTAL MONTHLY EXPENSE	

DO NOT WRITE BELOW THIS LINE **FOR TRIMBLE OFFICE USE ONLY** **Revised August 2025**

DATE APPROVED: _____ **PURCHASE ORDER No.** _____

DOLLAR AMOUNT: _____ **SERVICE PROVIDER** _____

PLEASE DO NOT MODIFY OR ALTER THIS APPLICATION. USE ADDITIONAL PAGES IF NECESSARY. THANK YOU.

A. PLEASE INCLUDE AN EXPLANATION OF YOUR ECONOMIC SITUATION AND THE REASON FOR THIS REQUEST.

B. IF THIS REQUEST IS FOR DENTAL, PLEASE EXPLAIN YOUR CURRENT DENTAL NEEDS. PLEASE BE SPECIFIC SO THAT WE MAY EVALUATE YOUR REQUEST PROPERLY.

A. _____

B. _____

IF YOU ARE USING A REFERRAL AGENCY, PLEASE PRINT NAME OF AGENCY AND HAVE THE AGENT SIGN. THANK YOU.

NAME OF AGENCY _____ PHONE _____

AGENCY ADDRESS _____ ZIP _____

AUTHORIZED AGENT _____

PRINTED NAME SIGNATURE

THE APPLICANT MUST READ THE STATEMENT TO THE RIGHT AND SIGN BELOW IT. A PARENT OR GUARDIAN MUST SIGN IF THE APPLICANT IS UNDER 18 YEARS OF AGE.

I certify that the information provided is complete to the best of my knowledge. I authorize verification and I give the Trimble Charity Fund permission to obtain information on my case from federal, state, county, and local agencies in order to process my request for assistance. I understand that failure to answer all questions completely or failure to sign this application will result in the delay of processing this application.

APPLICANT SIGNATURE _____ **DATE** _____

ITEMS TO SEND WITH APPLICATION

_____ Photo ID

_____ Verification of Income

_____ Copy of dental treatment plan (if you have been to a dentist), or other pertinent information regardingyour request.