



# **CALIFORNIA JAZZ FOUNDATION**

**A NON-PROFIT CORPORATION**

[www.californiajazzfoundation.org](http://www.californiajazzfoundation.org)

## **EMERGENCY FINANCIAL ASSISTANCE/MEDICAL REFERRAL APPLICATION**

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

After review of applications by a Review Committee, the California Jazz Foundation (CJF), a non-profit, 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”).

## **ELIIBILITY 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.

CJF grants are intended to address unforeseen emergencies and should not be viewed by applicants as an alternative source of revenue. A grant applicant who applies for second and third (or more) grants may be subject to greater scrutiny and denial as inconsistent with CJF’s mission to provide financial assistance for needs which have arisen due to unforeseen circumstances. 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 APPLICATION PACKET TO:**

Amanda Steele, LCSW  
c/o California Jazz Foundation  
PO Box 352010  
Los Angeles, CA 90035

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:

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

Yes  No If so, who?

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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?

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Are you taking any medication?  Yes  No

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

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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 non-profit 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: \_\_\_\_\_

**Help Line: (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)	\$ _____	<b>TOTAL EXPENSES</b>	\$ _____
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 13205 Cheltenham Drive, Sherman Oaks, CA 91423 (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