DROPPING DIMES FOUNDATION

APPLICATION FOR ASSISTANCE

This application will be used by Dropping Dimes Foundation to assess if you are eligible to receive a grant of financial assistance from Dropping Dimes Foundation.

Dropping Dimes Foundation aims to provide financial assistance to former American Basketball Association players, employees and family members who have suffered significant financial hardship due to sickness, accident, or other unexpected life circumstances.

By completing and submitting Dropping Dimes Foundation's Application for Assistance (with requested documentation), you are requesting the Foundation to provide you with financial assistance to address day-to-day needs including health care, shelter and similar items. If you receive such financial assistance from the Foundation, such financial assistance must be used only for these purposes.

If you would like the Foundation to consider providing you with a grant of financial assistance, the IRS requires that the Foundation collect some information from you in order to confirm that: (1) you have legitimate financial need; and (2) a grant would directly further the Foundation's charitable mission by addressing your particular life circumstances.

Please submit completed grant Application for Assistance and requested documentation to:

Dropping Dimes Foundation
111 Monument Circle, Suite 2700
Indianapolis, Indiana 46204

Please rest assured that the details of this application will be kept confidential unless the Foundation is required to demonstrate the legitimacy of its grant.

Name of Applicant: _____

_____

Additional Applicant Information

Contact Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Alternative Phone Number: _____

Email Address: _____

Background of Need for Assistance

Please describe the your situation and particular need for financial assistance, including how the financial assistance would be used to address your circumstances (continue on additional pages if needed)

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Individual/Family Financial Information

Please list the following information about all household members:

Name	Age	Total of Annual Income/Compensation

Total Number Household Members: _____

What are the average monthly expenses of your household? $_____

Total Annual Household Compensation/Income: $_____

Is the applicant currently employed: Yes _____ No _____

Employer: _____ Employer Telephone: _____

Employer Address: _____

Position: _____ How long have you been in this position? _____

Please indicate your expected level of income for the next year: _____

Spouse's last or current employer: _____

Last date of employment:_____

Insurance Information

Medicare: Yes _____ No _____

Date of eligibility: _____

Medicaid: Yes _____ No _____

Amount of Spenddown Provision (if applicable): _____

_____

Private Insurance: Yes _____ No _____

Insurance Company _____ Premium _____

After review of this Application, the Foundation may ask you for a copy of your most recent federal and state income tax return to supplement this Application.

I attest that the information contained within this Application for Assistance is accurate and true.

Applicant Signature: _____ Date: _____