

**APPLICATION TO THE AKRON BAR FOUNDATION
WILLIAM C. BECKER LAWYERS' FUND**

Dated: _____

PLEASE NOTE: *The information supplied on this application will be used solely by the Governors and Staff of the Akron Bar Association/Foundation and the members of their respective committees in considering your application for a loan/grant and will be kept in strict confidence.*

I. PERSONAL DATA

Applicant Name: _____

Business Address: _____

Business Phone #: _____ **Cell Phone #:** _____

Email Address: _____

Home Address: _____

Own? **Rent?**

Home Phone #: _____ **Date of Birth:** _____

Marital Status: _____

Names and Ages of Dependents:

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Names of Those With Whom You Reside:

Have you received assistance from the William C. Becker Lawyers' Fund in the past?

Yes **No**

Please explain your need(s) for assistance and/or ways in which the William C. Becker Lawyers' Fund might help.

II. PROFESSIONAL INFORMATION

A. Year of Admission to Practice: _____ OH Bar Number: _____
Akron Bar Association Member? Yes No

B. EMPLOYMENT DATA (current and/or recent)

Annual Income for the Last 12 Months: \$ _____

C. ADDITIONAL EMPLOYMENT INFORMATION

If you are *not* presently employed, specify employment-related issues or concerns and list any relevant employment experience and job skills.

D. EMPLOYMENT OF SPOUSE AND ANY INDIVIDUAL WITH WHOM YOU RESIDE

Employer: _____ Title: _____
(if self-employed, so state)

Address: _____

Length of Employment: _____

Annual Income for the Last 12 Months: \$ _____

E. Do you have Lawyers Professional Liability (LPL) Insurance? Yes No

Name of Carrier: _____

Limits of Liability: _____

Policy Period: _____

Have you ever been denied LPL Insurance? Yes No

If yes, please provide details:

III. PUBLIC BENEFITS INFORMATION

Have you applied for social service assistance? If so, please list current payments (i.e. Food Stamps, Medicaid, Home Relief, SSI,SSD, etc.)

IV. DISCIPLINARY INFORMATION

Are you now, or have you been, a subject to any disciplinary proceedings before the Ohio Board Of Commissioners on Grievances & Discipline, or other similar Board, Committee or Commission in Ohio or any other state? If yes, briefly give details of all disciplinary matters, including any claim involving *misuse or co-mingling* of client funds.

If represented by an attorney in connection with Disciplinary complaint(s), give name of counsel:

Name: _____

V. SUMMARY STATEMENT OF FINANCES

<u>ASSETS</u>	PERSONAL	BUSINESS
Real Estate (Market Value)	\$	\$
Cash on Hand	\$	\$
Bank Account & Loans	\$	\$
Retirement Accounts	\$	\$
Stocks & Bonds	\$	\$
Cash Value Life Insurance	\$	\$
(Net of Loans)	\$	\$
Autos, Boats & Other Vehicles	\$	\$
Business Accounts	\$	\$
Accounts Receivable	\$	\$
Employer or Other Pension Benefits	\$	\$
Disability Benefits	\$	\$
Other Assets (Itemize):	\$	\$
	\$	\$
	\$	\$
	\$	\$
TOTAL ASSETS:	\$	\$
<u>LIABILITIES:</u>		
Real Estate Mortgages	\$	\$
Notes Payable (Secured)	\$	\$
Notes Payable (Unsecured)	\$	\$
Accounts and Bills Due	\$	\$
Unpaid Income Taxes	\$	\$
Unpaid Real Estate Taxes	\$	\$
Unpaid Employee Taxes	\$	\$
Debts (Itemize):	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
TOTAL LIABILITIES:	\$	\$
NET WORTH:	\$	\$
(Total Assets Minus Total Liabilities)		

VI. STATEMENT OF INCOME AND EXPENSES ON A MONTHLY BASIS (Average for the last three months)

A. <u>Current Monthly Income</u>	APPLICANT	SPOUSE
Gross Salary or Receipts	\$ _____	\$ _____
Dividends or Interest	\$ _____	\$ _____
Real Estate Income	\$ _____	\$ _____
Other:		
	\$ _____	\$ _____
	\$ _____	\$ _____
TOTAL MONTHLY INCOME:	\$ _____	\$ _____
B. <u>Current Monthly Expenses</u>	PERSONAL	BUSINESS
Rent	\$ _____	\$ _____
Mortgage	\$ _____	\$ _____
Total Taxes (Realty, Income, Payroll)	\$ _____	\$ _____
Insurance		
Life	\$ _____	\$ _____
Medical	\$ _____	\$ _____
Property	\$ _____	\$ _____
Auto	\$ _____	\$ _____
Professional Liability	\$ _____	\$ _____
Disability	\$ _____	\$ _____
Food	\$ _____	\$ _____
Utilities (including telephone)	\$ _____	\$ _____
Clothing	\$ _____	\$ _____
Transportation (oil, gas, tolls)	\$ _____	\$ _____
Medical & Dental (uninsured)	\$ _____	\$ _____
Repairs & Maintenance	\$ _____	\$ _____
Installment Obligations		
Auto Payment	\$ _____	\$ _____
Credit Card(s)	\$ _____	\$ _____
Other	\$ _____	\$ _____
Miscellaneous (itemize)		
Tuition	\$ _____	
Maintenance/Child Support	\$ _____	
Secretarial		\$ _____
Other Supplies & Equipment/Postage		\$ _____
Professional Dues & Fees		\$ _____
Other Office Expenses		\$ _____
TOTAL MONTHLY EXPENSES:	\$ _____	\$ _____
NET MONTHLY INCOME:	\$ _____	

VII. INFORMATION REGARDING APPLICANT HEALTH

Complete this information and sign the attached Consent for Release of Confidential Information in accordance with HIPAA requirements if the reason for the assistance is related to the applicant's health condition.

A. Are you presently under the care of a physician, therapist or rehabilitation program?

Yes No

If yes, name of therapist or program: _____

Please detail your health situation.

B. What prescribed medications are you currently taking? For what conditions? Name of pharmacy?

C. If hospitalized within the last two years, indicate name of hospital(s), date(s) of admission and reasons for admissions.

D. Limitations on your ability to earn income:

E. Do you have medical insurance? Yes No

Name of Carrier: _____

Type of Plan (individual, family, major medical, etc.): _____

Amount of quarterly premium: _____

Premium paid for by applicant/employer/spouse: _____

F. Do you have Disability Insurance? Yes No

Name of Carrier: _____

Waiting Period and amount of coverage: _____

Amount of quarterly premium: _____

Premium paid for by applicant/employer/spouse: _____

VIII. CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION IN ACCORDANCE WITH HIPAA REQUIREMENTS

I, _____, authorize _____
(Name) (Name of designation of medical/program/person disclosing)
at _____ to disclose
(address of medical/program/person disclosing)
to _____
(name of person or organization to which disclosure is made)

mental health/medical/addiction information including diagnosis, prognosis, treatment plan, medication and/or other non-medical information pertaining to applicant.

(Nature and amount of information is to be as limited as possible.)

The purpose of the disclosure authorized is to provide information to the Akron Bar Foundation William C. Becker Lawyers' Fund in conjunction with an application for assistance.

I understand that my records are protected under the Federal regulations governing Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164; Confidentiality and Drug Abuse Patient Record, 42 C.F.R. Pt. 2, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year or when applicant no longer requires assistance. If applicant is requesting assistance for more than one year and the consent for information has expired, the applicant is required to reapply for assistance.

Dated: _____

Signature of Applicant

or Signature of Authorized Representative

State of Ohio)
County of Summit) SS:

On this _____ day of _____, 20_____, before me, the undersigned, a notary public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acts, executed the instrument.

Notary Public

IX. STATEMENT OF FOUNDATION POLICY

Applicant understands that, by virtue of this Application to the William C. Becker Lawyers’ Fund of the Akron Bar Foundation there is no guarantee of financial assistance. Applicant agrees to a personal interview with the Executive Director of the Foundation and a member of the William C. Becker Lawyers’ Fund committee. Applicant understands that *no* funds of the Bar Foundation will be used to pay for any income or business taxes. *No* Foundation funds will be used to reimburse applicant or others for misappropriation of client funds.

X. CONSENT FOR USE OF INFORMATION

I hereby authorize the Lawyers’ Fund of the Akron Bar Foundation, its Governors and authorized employees to verify and to utilize the information provided in this application solely in connection with my request for assistance, and I hereby consent to such actions and agree to comply therewith and to execute any authorization that may be required. I understand that this information will not be disseminated to third parties unrelated to my request for assistance from the William C. Becker Lawyers’ Fund.

CERTIFICATION

I hereby certify that the information contained herein is true and accurate.

Signature

Print Name

Date