



**Application for Assistance**  
**Mail to Bloom Again: the Molly Bloom Foundation**  
**C/o Bernadine Bloom**  
**1550 S. Cherry St.**  
**Denver, CO 80222**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Parents Names (if applicable): \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Are you an athlete? \_\_\_\_\_ What sport(s) did you participate in? \_\_\_\_\_

\_\_\_\_\_

Dates you participated: From: \_\_\_\_\_ to: \_\_\_\_\_

Level of competition (e.g. school, competitive, pro. Etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ATTACH SEPERATE SHEET IF NEEDED

**Brief Description of Circumstances**

1. Describe your injury or illness (include dates, circumstances, and how this has impacted or will impact your life style.)

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**Description of Assistance Needed**

2. Please describe what you need help with to get you back into sports participation. (e.g. physical therapy, gym equipment, training, transportation, assistance with medical expenses, etc.)

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**Please provide a copy of your most recent Federal income tax return.**

**Employment History:**

	Client	Father(if applicable)	Mother (if applicable)
<b>Currently employed:</b>			
<b>Name of current or Previous employer:</b>			
<b>Address of current or previous employer:</b>			
<b>Type of Business:</b>			
<b>Gross monthly wages:</b>			
<b>Net monthly wages:</b>			

**Income/Financial Resources (\$\$):**

Household gross monthly wages:\$	*SSDI: \$	How long?
Household net monthly wages:\$	*SSI: &	How long?
Social Security: \$	<b>*attach copy of award letter for SSDI &amp; SSI</b>	
Pension/retirement:\$	OAP: \$	How Long?
Other income:\$	AFCD/TANF:\$	How long?
Checking accounts balances:\$	AND:\$	How long?
Savings accounts balances:\$	Food stamps:\$	How long?
Real Property owned: Value:\$		
Other investment values:\$		

**Have you received an insurance settlement?** \_\_\_\_\_

**Do you have a Life Care Plan?** \_\_\_\_\_

**If yes, please attach a copy.**

**Monthly Expenses (\$\$):**

Mortgage or rent:	Auto Payment	Health Insurance
Electric/gas	Gasoline/oil	Pharmacy
Telephone	Auto Insurance	Medical Exp.
Water/sewer	Public Trans.	Dental
Food	Child Care	Life Insurance

Please list any other expenses: \_\_\_\_\_

\_\_\_\_\_

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Are other agencies providing assistance (i.e. Medicaid, etc)? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, who and what is their involvement?\_\_\_\_\_

\_\_\_\_\_

Please list any organizations that have denied other assistance:

Organization Name:\_\_\_\_\_

Contact:\_\_\_\_\_ Phone:\_\_\_\_\_

**Personal references:**

<b>Name</b>	<b>Address</b>	<b>Phone #</b>	<b>Relationship</b>

May we visit your home?\_\_\_\_\_

If not, why?\_\_\_\_\_

Applicant's signature\_\_\_\_\_ Date\_\_\_\_\_

Guardian's signature (if applicable)\_\_\_\_\_ Date\_\_\_\_\_

**Please be advised that the foundation will conduct a background check and credit report check.**