# **Dwight Brill Fund**

# **P.O. Box 2404**

**Breckenridge, Colorado 80424**

**The Dwight Brill Fund provides assistance to Breckenridge Ski Resort employees who are experiencing a financial hardship due to a medical crisis.
\*** The Dwight Brill Fund is not affiliated with Breckenridge Ski Resort or Vail Resorts.

**The criteria for funding are as follows:**

* You must be a full time/part time Breckenridge Ski Resort employee.
* You have been employed for a period of at least six months, excluding break in service for seasonal employees, and are in good standing with Breckenridge Ski Resort.
* You have a medical crisis that involves you or your immediate family, resulting in financial hardship.
* You have exhausted all other appropriate means of financial assistance.
* Priority is given to those with catastrophic health care conditions.
* Because Dwight Brill raises funds for support and funds are not guaranteed from year to year, we may fund all, part or none of your request. .
* Income documentation and any relevant bills (medical, utility, health insurance, rent), should be included with the application for consideration of payment.
* Payments can only be made directly to medical providers, businesses, landlords, etc.
* No payments will be made directly to the applicant.

### Applicant Information:

#### Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (what method of contact do you prefer?)

Marital Status: \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_Widowed

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| Household Information: (Please list all family members living in your home including yourself) |  |
| Name |  | Age |  | Relationship |  | Occupation/School |
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| **Family Members at Other Addresses:**(List children/immediate family members living outside your home, for whom you are financially responsible) |
| Name |  | Age |  | Relationship  |  | Occupation/School |
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### Employment Information:

#### Years/months of Service with Breckenridge Ski Resort: \_\_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_\_\_\_\_\_\_

Status: \_\_\_\_Year Round \_\_\_\_Seasonal

 \_\_\_\_ Full time \_\_\_\_ Part time \_\_\_\_ Holiday Help

#### Current Hourly Rate: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average Hours a Week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work any other Jobs? \_\_\_\_Yes \_\_\_\_No

#### Current Hourly Rate: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average Hours a Week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your crisis caused a reduction in work hours? Please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Is your spouse/significant other employed: \_\_\_\_ Full time \_\_\_\_ Part time \_\_\_\_ Holiday Help

#### \_\_\_\_ Homemaker \_\_\_\_ Unemployed

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Current Hourly Rate: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average Hours a Week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your crisis caused a reduction in their work hours? Please describe.

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**HEALTH InsurANce Information:**

Do you have health insurance: \_\_\_\_Yes \_\_\_\_ No

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Out of Pocket Maximum: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Financial Information:**ASSETS |  |  DEBTS/OBLIGATIONS |  | MO. PYMT |
| Cash in Bank |  | $ |  | Credit Card Balances |  | $ |  | $ |
| Real Estate  |  |  |  |  |  |  |  |  |
|   | Primary Residence |  | $ |  | Mortgage Balance |  | $ |  | $ |
|  | Other Properties |  | $ |  | Mortgage Balance |  | $ |  | $ |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Automobiles(Year and Make) |  | $ |  | Auto Loan/Lease |  | $ |  | $ |
|  |  | $ |  | Auto Loan/Lease |  | $ |  | $ |
|  |  | $ |  | Auto Loan/Lease |  | $ |  | $ |
|  |  |  |  |  |  |  |  |  |
| Other Assets (Describe) |  |  |  | Other Debts (Describe) |  |  |  |  |
|  |  | $ |  |  |  | $ |  | $ |
|  |  | $ |  |  |  | $ |  | $ |
|  |  |  |  |  |  |  |  |  |
| GROSS MONTHLY INCOME (pre-tax) |  | MONTHLY EXPENSES |
| Monthly Salary of Applicant |  | $ |  | Rent |  | $ |
| Salary of Spouse |  | $ |  | Homeowner’s Dues |  | $ |
| Salary of Family Members in Home |  | $ |  | Utilities |  | $ |
| Income from Tips/Bonuses |  | $ |  | Health Insurance |  | $ |
| Rental Income |  | $ |  | Auto Insurance |  | $ |
| Alimony/Child Support Received |  | $ |  | Other Insurance (Describe) |  | $ |
| Other Household Income (Describe) |  |  |  | Food |  | $ |
|  |  | $ |  | Outstanding Medical Bills |  | $ |
|  |  | $ |  | Prescriptions |  | $ |
|  |  | $ |  | Childcare |  | $ |
|  |  |  |  | Alimony/Child Support Paid |  | $ |
|  |  |  |  | Other Expenses (Describe) |  | $ |
|  |  | $ |
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### Specific Assistance REQUESTED:

What is your crisis? Please use the space below to describe the circumstances that have lead to your current situation. Please include diagnoses, treatments, prognosis, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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#### What assistance do you need? What bills do you need help paying? Please list in order of priority and include these bills with your application.

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| **OTHER EXpenses:** |
| If you are requesting help with routine living expenses such as rent, mortgage, utilities, COBRA payment, etc., please list below and include copies of the bills with your application.  |
| Item |  | Pay To |  | Reference or Account # |  | Mailing Address |
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#### **What steps have you taken to seek assistance other than the Dwight Brill Fund?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Additional Information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The information I have included in this application is true and accurate. I have provided all necessary billing and insurance information to substantiate the financial assistance request. I understand that p**ayments can only be made directly to medical providers, businesses, landlords, etc**. **This application is a request for financial assistance and does not guarantee the approval of such funds.** I give the Dwight Brill Fund permission to contact medical providers and persons with whom I may have accounts, if needed. I further understand that the Dwight Brill Fund is not providing legal, tax, or accounting advice or services for me and will assume no legal responsibility or obligation for any of my affairs, liabilities, or accounts.

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_