

**MICHIGAN COUNCIL 25 AFSCME MEMBERSHIP ASSISTANCE FUND
ELIGIBILITY CRITERIA**

- 1) A member **MUST** be:
 - a. Laid Off (30 days or more) without income
 - b. Medical Leave (30 days or more) without income
 - c. Discharged/Suspended (30 days or more) awaiting arbitration without income.
2. Maximum income of five hundred dollars (\$500) per month, per household.
3. A member can only qualify **ONCE** every twelve (12) months for a grant (either cash for food **OR** direct payment, except in case of a major disaster within the household (example: *Fire, Flood or Tornado*). In this case, eligibility requirements are waived.
4. A member may receive **EITHER** cash for food **OR** a direct payment grant - **NEVER BOTH**

Cash for Food

\$200 maximum, per twelve months

OR

Direct Payment Grants

\$300 maximum per twelve months

Direct Payment requests **must be accompanied by supporting documentation, i.e. utility bill, statement from landlord indicating amount of rent, telephone bill, medical bill, etc.*

If approved, the direct payment check will be made payable and sent directly to whichever bill you requested to be paid.

COMPLETING THE MEMBERSHIP ASSISTANCE FUND APPLICATION FORM

1. Local's telephone number and address where indicated.
2. Member's full address and telephone number, where indicated.
3. Reason for application (*discharge, suspension, layoff, medical, major disaster*)
4. List type of income and amount receiving - be sure to include spouse's if applicable.
5. Local Presidents, Vice-Presidents, Chairpersons, Chief Stewards and Regional Community Service Representatives are the **only** recognized signers.

*****Please be sure all information is completed on the application so there will be no delays - insert N/A where not applicable. Application will not be processed if incomplete and will be sent back to the representative for completion.***

RETURN COMPLETED FORM TO:

Michigan AFSCME Council 25
Community Services Committee
600 W. Lafayette Blvd.
Detroit, MI 48226
(313) 964-1711

MICHIGAN COUNCIL 25 AFSCME MEMBERSHIP ASSISTANCE FUND
APPLICATION FORM
(please print)

Name of Member: _____ Date: _____

Local Number: _____ Daytime Phone Number: () _____

Address: _____ City: _____ Zip: _____

Spouses Name (if applicable): _____

Number of dependents under 18 or between 18 and 21, in school and living at home. _____

Reason for Application
(Please check all that apply)

Illness Suspension Discharge Fire Medical Emergency Injury Natural Disaster

Other: _____

Last Date of Employment: _____

If on medical leave, what is your expected return to work date? _____

If suspended, what is your expected return to work date? _____

If a grievance has been filed on your behalf, what Step of the procedure is it pending? _____

Is your case pending arbitration? yes no

If yes, what is your arbitration date: _____

What is your arbitration case #? _____

(Please Check One)

Request: Cash for Food

OR

Direct Payment

If requesting direct payment, please fill out completely
(MUST HAVE BILL FOR CREDITOR OR LANDLORD STATEMENT ATTACHED)

Creditor or Landlord Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: () _____ Account Number: _____

LAST DATE OF INCOME: _____

SPECIFY SOURCE OF INCOME AT THE TIME OF APPLICATION
(Please Check All that Apply)

- Child Support Alimony Social Security Benefits Worker's Comp.
- Short-Term Disability Long Term Disability Unemployment Benefits
- Other _____

Gross Income: \$ _____ Net Income: \$ _____

Weekly: \$ _____ Bi-Weekly: \$ _____ Monthly: \$ _____

Spouse's Income: Gross Income: \$ _____ Weekly: \$ _____ Monthly: \$ _____

Last Assistance received from the Membership Assistance Fund/Date: _____ Amount: \$ _____

THE FOLLOWING IS TO BE COMPLETED BY THE APPLICANT'S LOCAL UNION REPRESENTATIVES

Local #: _____ Local Name: _____ Phone: () _____

Local Address: _____ City: _____ Zip: _____

Referred by: _____ Title: _____ Date: _____
(Signature of Local Officer)

THE FOLLOWING IS TO BE COMPLETED BY THE MEMBERSHIP ASSISTANCE FUND ADMINISTRATIVE COMMITTEE

If Approved, does the member want: Cash: \$ _____ OR Direct Payment: \$ _____

If Denied, state reason(s): _____

Date Applicant Contacted: _____ Authorized by: _____