



CONFIDENTIAL

DISASTER RELIEF FORM

Family Name: _____

Conference _____

No. People in Household _____

Today's Date _____

Date of Disaster _____

CLIENT INFORMATION

Client's Name: _____

Phone: _____

Clients Address: _____

ID DL #: _____

(City) (State) (Zip Code)

[Get a copy of Photo ID if possible.]

MEMBERS OF THE HOUSEHOLD

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

FINANCIAL RESOURCES

Homeowner's/Renter's Insurance: _____ (yes/no)

FEMA, Applied: _____ (yes/no)

FEMA, Award: \$_____ (yes/no)

Other Assistance Received:

If yes from what agency?

If yes, how much did you receive \$_____

Employed: _____ (yes/no)

Other: _____

Financial Resources Section is very important during a disaster. IF you the survivor receives financial assistance from FEMA, there are specific guidelines for the funds you will receive. FEMA can recoup disbursements awarded if financial help was given to the survivors from other agencies. Go to the FEMA website for more details. <https://www.fema.gov/>

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All information collected by the Society of St. Vincent de Paul (SVDP) staff, volunteers, and/or interns regarding clients or potential clients is confidential. SVDP is committed to protecting the privacy of all clients as completely as possible. However, in some cases, it is necessary or desirable for us to either receive and/or share information with others. The purpose of obtaining and/or sharing this information is to ensure clients receive the assistance needed.

_____, hereby authorizes The Society of St. Vincent de Paul to access and release any information or records that are relevant for the purpose of providing assistance for my needs for twelve months.

Social Security # (for utility assistance only): _____

Client signature _____

Date _____

Witness signature _____

Date _____



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DISASTER RELIEF FORM

Family Name:

Goods	Items Needed	Name of Other Agencies Helping	Estimated \$ Value
A. Food			
B. Beds <small>Twin and Full Size only. Upgrades are paid for by client or conferences.</small>			
C. Furniture			
D. Clothing			
E. Other			
F. Gift Card (If given)	Last 4 Digits of Gift Card: _____		
Services	Description	Name of Other Agencies Helping	\$ Value
G. Utility Assistance			
H. Rent/mortgage			
I. Car Purchase			
J. Car Repair			
K. Medical			
L. Dental			
M. Other			
Total Goods and Services			

SUBMIT THE FOLLOWING DOCUMENTS WITH THIS FORM TO

Varrietta Anthony varriettaa@sudpstl.org or Fax to: 314-881-6089.

- Red Cross Referral [If Pre-MARC instruct the client to contact the Red Cross to get certified at 314-516-2800.]
- Signed and Witness Confidentiality Release (on this form)
- Copy of Photo ID
- Verification of Income: Annual Gross Amount _____
- Receipts
- Voucher # _____
- W9 is required by IRS for us to write the vendor a check. Such vendors include, but not limited to, Landlords, Hotels, Car Repair if not on Council List.
- Client Story/Reason for Request

