BASIC INFORMATION

**Please note that this request must be submitted by a first level supervisor or an H/R Supervisor.*

Today's date: ____________ **Department / Agency**: ____________________________________

Name of Individual in need: ____

Title/Position of individual in need: ____

Email address: ________________________ **Date of birth:** __________ **Years of service:** _______

Home Phone: __________________ **Mobile:** ___________________ **Other:** __________________

Home Address: ____

City:_______________________________ **State:**________________ **Zip:** ______________________

Is individual a full-time paid employee? YES/NO

Is individual sworn or certified? YES/NO

Is individual struggling with the emotional impact of their public safety position? YES/NO

Is there an official diagnosis in place? YES/NO
**If diagnosis has been given, please provide on a separate page*

Describe circumstances that led up to this diagnosis as they pertain to individual's employment (*describe the incident- was it one incident or multiple incidents? Please continue on a separate page if necessary*).:

____
____
____
____
____
____

Is individual under treatment of a licensed mental health counselor or therapist? YES/NO

If the question above was answered with YES, may we contact the licensed therapist/counselor? YES/NO

Counselor/Therapist name:____

Counselor/Therapist contact number:____

Are we able to provide payment directly to licensed counselor/therapist? YES/NO

**If the above question was answered with 'YES' please provide the following information:*
Counselor/Therapist Office Address:____

City:_____________________________ **State:**_______________ **Zip:** ____________________

Counselor/Therapist Office Direct Account #:____

Are there any expenses incurred that are not being reimbursed by the department? YES/NO

If the above question was answered with 'YES', please provide amount incurred: __________
** documentation of these expenses may be requested*

BENEFICIARY INFORMATION (IF DIFFERENT THAN ABOVE)

Beneficiary Name: ____

Home Phone: ________________ **Mobile:** _________________ **Other:** ________________

Home Address: ____

City:_____________________________ **State:**_______________ **Zip:** ____________________

Email Address: _________________________________

Make Benefit Check To: ______________________ **Relationship to Injured:** ______________

Where Shall Payment Be Delivered? ____

How Many Dependents (Other Than Spouse): _______

Name, Sex, and Date of Birth of Dependents:

**This information is used internally to provide opportunities to dependents such as: summer camp, holiday gift giving, scholarship opportunities, etc.*

1. Name: ______________ **Sex:** ___ **DOB:** _________

2. Name: ______________ **Sex:** ___ **DOB:** _________

3. Name: ______________ **Sex:** ___ **DOB:** _________

4. Name: ______________ **Sex:** ___ **DOB:** _________

5. Name: ______________ **Sex:** ___ **DOB:** _________

**if needed please continue information on separate document*

INFORMATION PROVIDED BY

**Must be submitted by a first level supervisor or an H/R Supervisor.*

Your Name: ______________________________________ **Title:** ___________________________

Department/Agency: ____

Agency Address: ________________________________ **City/St/Zip:** _______________________

Office Phone: _________________ **Mobile:** _________________ **Other:** ____________________

Email: ________________________________

Your Signature: ____ **Date:** ___________

To submit form by email, send to benefits@100club.org | To submit by fax, use (602) 242-1715

....

TO BE COMPLETED BY AUTHORIZED 100 CLUB PERSONNEL

Verified/Approved: _______________________ Date: ______ Data ID: _______ Payment ID: ________

Posted: _________________________________ Date: ______ Check #: _______ Amount: __________

Denied: ________________________________ Date: ______