APPLICATION TO THE AKRON BAR FOUNDATION
WILLIAM C. BECKER LAWYERS' FUND

Dated: fdsajkl;fdsajkl;

PLEASE NOTE: ***The information supplied on this application will be used solely by the Governors and Staff of the Akron Bar Association/Foundation and the members of their respective committees in considering your application for a loan/grant and will be kept in strict confidence.***

I. PERSONAL DATA

Applicant Name: fdsahjklfdsahjklfdsakj

Business Address: fdsahjklfdsahkjfdsa

fdsahkfdsajhklfsda

Business Phone #: fdsahklfdsahkjl **Cell Phone #:** fdsahkjfdsahk

Email Address: fdsajklf;dsajkl;

Home Address: fdsajil;fdsajkl;

fdsjkl;fdsajkl;fds

☒ **Own?** ☒ **Rent?**

Home Phone #: jkfld;sajklf;dsa **Date of Birth:** fdsajkl;fdsajkl;

Marital Status: fdsjakl;fdsajkl;

Names and Ages of Dependents:

Name: fdsajkl;fdsajkl; **Age:** fdsajkl;

Name: fdsajkl; **Age:** fdsajkl;

Name: fdsajkl;f **Age:** fdsajkl;

Name: fdsajkl; **Age:** fdsajkl;

Name: fdsajkl; **Age:** fdsajkl;

Name: fdsajkl; **Age:** jkl;fdsa

Names of Those With Whom You Reside:

fdsajkl;

jfklad

jklf;dsajkl;fas

Have you received assistance from the William C. Becker Lawyers' Fund in the past?

☐ **Yes** ☒ **No**

Please explain your need(s) for assistance and/or ways in which the William C. Becker Lawyers' Fund might help.

jkfladjkflldjfkad;jkfld;ajklf;djsak;fjkld;ajkl;fdsjaklfjda;jfkladjkfl;dsajkl;fjdsakjfklda; fjdsak;fdjsakl;f jdka; fjdak;fjdkla;fj dkjsal;jfdkla; fjdak;lkdfj

II. PROFESSIONAL INFORMATION

A. Year of Admission to Practice: fdsajklf;dsa **OH Bar Number:** fdsjakl;fdsa

Akron Bar Association Member? ☐ **Yes** ■ **No**

B. EMPLOYMENT DATA (current and/or recent)

jklfd;sajkl;fdsajkl;

Annual Income for the Last 12 Months: **$** fdsajkl;fdsaj

C. ADDITIONAL EMPLOYMENT INFORMATION

If you are *not* presently employed, specify employment-related issues or concerns and list any relevant employment experience and job skills.

fdsajkl;fdsa

D. EMPLOYMENT OF SPOUSE AND ANY INDIVIDUAL WITH WHOM YOU RESIDE

Employer: fdsajkl;fds **Title:** fdsajkl;fsda

(if self-employed, so state)

Address: fdsajkl;fdsa

fdsjakl;fdsa

Length of Employment: fdsajkl;fdsa

Annual Income for the Last 12 Months: **$** fdsajkl;fdsa

E. Do you have Lawyers Professional Liability (LPL) Insurance? ☒ **Yes** ☐ **No**

Name of Carrier: fdsajkfld;sa

Limits of Liability: fdjskal;fdsa

Policy Period: fdsjakl;fdsa

Have you ever been denied LPL Insurance? ☐ **Yes** ☒ **No**

If yes, please provide details:

jklf;dsajkl;fds

III. PUBLIC BENEFITS INFORMATION

Have you applied for social service assistance? If so, please list current payments (i.e. Food Stamps, Medicaid, Home Relief, SSI,SSD, etc.)

fdsjakl;fdsajkl;

IV. DISCIPLINARY INFORMATION

Are you now, or have you been, a subject to any disciplinary proceedings before the Ohio Board Of Commissioners on Grievances & Discipline, or other similar Board, Committee or Commission in Ohio or any other state? If yes, briefly give details of all disciplinary matters, including any claim involving *misuse* or *co-mingling* of client funds.

fdsajkl;fdsak

If represented by an attorney in connection with Disciplinary complaint(s), give name of counsel:

Name: fdsajkl;fdsajkl;

V. SUMMARY STATEMENT OF FINANCES

ASSETS	**PERSONAL**	**BUSINESS**
Real Estate (Market Value)	$ 1.00	$ 1.00
Cash on Hand	$ 1.00	$ 1.00
Bank Account & Loans	$ 1.00	$ 1.00
Retirement Accounts	$ 1.00	$ 1.00
Stocks & Bonds	$ 1.00	$ 1.00
Cash Value Life Insurance	$ 1.00	$ 1.00
(Net of Loans)	$ 1.00	$ 1.00
Autos, Boats & Other Vehicles	$ 1.00	$ 1.00
Business Accounts	$ 1.00	$ 1.00
Accounts Receivable	$ 1.00	$ 1.00
Employer or Other Pension Benefits	$ 1.00	$ 1.00
Disability Benefits	$ 1.00	$ 1.00
Other Assets (Itemize):	$ 1.00	$ 1.00
	$ 1.00	$ 1.00
	$ 1.00	$ 1.00
	$ 1.00	$ 1.00
TOTAL ASSETS:	**$ 16.00**	**$ 16.00**
LIABILITIES:		
Real Estate Mortgages	$ 1.00	$ 1.00
Notes Payable (Secured)	$ 1.00	$ 1.00
Notes Payable (Unsecured)	$ 1.00	$ 1.00
Accounts and Bills Due	$ 1.00	$ 1.00
Unpaid Income Taxes	$ 1.00	$ 1.00
Unpaid Real Estate Taxes	$ 1.00	$ 1.00
Unpaid Employee Taxes	$ 1.00	$ 1.00
Debts (Itemize):	$ 1.00	$ 1.00
1	$ 1.00	$ 1.00
1	$ 1.00	$ 1.00
1	$ 1.00	$ 1.00
1	$ 1.00	$ 1.00
1	$ 1.00	$ 1.00
1	$ 1.00	$ 1.00
1	$ 1.00	$ 1.00
TOTAL LIABILITIES:	**$ 15.00**	**$ 15.00**
NET WORTH:	$	$
***(Total Assets Minus Total Liabilities*)**		

VI. STATEMENT OF INCOME AND EXPENSES ON A MONTHLY BASIS (Average for the last three months)

A. Current Monthly Income	APPLICANT	SPOUSE
Gross Salary or Receipts	$ 1.00	$ 1.00
Dividends or Interest	$ 1.00	$ 1.00
Real Estate Income	$ 1.00	$ 1.00
Other:		
	$ 1.00	$ 1.00
	$ 1.00	$ 1.00
TOTAL MONTHLY INCOME:	**$ 5.00**	**$ 5.00**

B. Current Monthly Expenses	PERSONAL	BUSINESS
Rent	$ 1.00	$ 1.00
Mortgage	$ 1.00	$ 1.00
Total Taxes (Realty, Income, Payroll)	$ 1.00	$ 1.00
Insurance		
Life	$ 1.00	$ 1.00
Medical	$ 1.00	$ 1.00
Property	$ 1.00	$ 1.00
Auto	$ 1.00	$ 1.00
Professional Liability	$ 1.00	$ 1.00
Disability	$ 1.00	$ 1.00
Food	$ 1.00	$ 1.00
Utilities (including telephone)	$ 1.00	$ 1.00
Clothing	$ 1.00	$ 1.00
Transportation (oil, gas, tolls)	$ 1.00	$ 1.00
Medical & Dental (uninsured)	$ 1.00	$ 1.00
Repairs & Maintenance	$ 1.00	$ 1.00
Installment Obligations		
Auto Payment	$ 1.00	$ 1.00
Credit Card(s)	$ 1.00	$ 1.00
Other	$ 1.00	$ 1.00
Miscellaneous (itemize)		
Tuition	$ 1.00	
Maintenance/Child Support	$ 1.00	
Secretarial		$ 1.00
Other Supplies & Equipment/Postage		$ 1.00
Professional Dues & Fees		$ 1.00
Other Office Expenses		$ 1.00
TOTAL MONTHLY EXPENSES:	**$ 20.00**	**$**
NET MONTHLY INCOME:	**$**	

VII. INFORMATION REGARDING APPLICANT HEALTH

Complete this information and sign the attached Consent for Release of Confidential Information in accordance with HIPAA requirements if the reason for the assistance is related to the applicant's health condition.

A. Are you presently under the care of a physician, therapist or rehabilitation program?

☑ **Yes** ☐ **No**

If yes, name of therapist or program: feasfdsa

Please detail your health situation.

fdsafdsafdsa

B. What prescribed medications are you currently taking? For what conditions? Name of pharmacy?

fdsafdsa

C. If hospitalized within the last two years, indicate name of hospital(s), date(s) of admission and reasons for admissions.

fdsafdsa

D. Limitations on your ability to earn income:

fdsafdsa

E. Do you have medical insurance? ☑ **Yes** ☐ **No**

Name of Carrier: fdsa

Type of Plan (individual, family, major medical, etc.): fsda

Amount of quarterly premium: fdsa

Premium paid for by applicant/employer/spouse: fdsa

F. Do you have Disability Insurance? ☑ **Yes** ☐ **No**

Name of Carrier: fdsafdsa

Waiting Period and amount of coverage: fdsafdsa

Amount of quarterly premium: fdsafds

Premium paid for by applicant/employer/spouse: fdsa

VIII. CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION IN ACCORDANCE WITH HIPAA REQUIREMENTS

I, fdsafdsa , authorize fdsafdsa
(Name) (Name of designation of medical/program/person disclosing)

at fdsafdsa to disclose
(address of medical/program/person disclosing)

to fsdafdsa
(name of person or organization to which disclosure is made)

mental health/medical/addiction information including diagnosis, prognosis, treatment plan, medication and/or other non-medical information pertaining to applicant.

(Nature and amount of information is to be as limited as possible.)

The purpose of the disclosure authorized is to provide information to the Akron Bar Foundation William C. Becker Lawyers' Fund in conjunction with an application for assistance.

I understand that my records are protected under the Federal regulations governing Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164; Confidentiality and Drug Abuse Patient Record, 42 C.F.R. Pt. 2, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year or when applicant no longer requires assistance. If applicant is requesting assistance for more than one year and the consent for information has expired, the applicant is required to reapply for assistance.

Dated: fdsafdsa

Signature of Applicant

or Signature of Authorized Representative

State of Ohio)
County of Summit) SS:

On this fdsafdsa day of fdsafdsa ,20 fdsa , before me, the undersigned, a notary public in and for said state, personally appeared fdsafdsa , personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acts, executed the instrument.

fdsafdsa
Notary Public

IX. STATEMENT OF FOUNDATION POLICY

Applicant understands that, by virtue of this Application to the William C. Becker Lawyers' Fund of the Akron Bar Foundation there is no guarantee of financial assistance. Applicant agrees to a personal interview with the Executive Director of the Foundation and a member of the William C. Becker Lawyers' Fund committee. Applicant understands that *no* funds of the Bar Foundation will be used to pay for any income or business taxes. *No* Foundation funds will be used to reimburse applicant or others for misappropriation of client funds.

X. CONSENT FOR USE OF INFORMATION

I hereby authorize the Lawyers' Fund of the Akron Bar Foundation, its Governors and authorized employees to verify and to utilize the information provided in this application solely in connection with my request for assistance, and I hereby consent to such actions and agree to comply therewith and to execute any authorization that may be required. I understand that this information will not be disseminated to third parties unrelated to my request for assistance from the William C. Becker Lawyers' Fund.

CERTIFICATION

I hereby certify that the information contained herein is true and accurate.

Signature

fdsafdsa

Print Name

fdsafdsa

Date