



WISCONSIN STATE COUNCIL KNIGHTS OF COLUMBUS CHARITY REQUEST FORM

CONFIDENTIAL

This form is to be used for the presentation of a request for a charitable donation. It is understood that for various reasons it will not be necessary, and in some situations it may not be possible, to provide data for all areas shown below. Please fill in as much as possible. More comprehensive information presented below will expedite the processing and evaluation of this request. Some questions are difficult to ask but show the true financial need. The Form must be filled out by a Knight of Columbus but the beneficiary need not be a Knight of Columbus or a Catholic to be considered for a charitable donation from the Wisconsin State Council Charity Fund. The current Grand Knight must sign the Charity Request Form. Please re-review the form prior to submission. Print legibly. Attach additional pages as necessary.

Nature of illness, injury, disaster, catastrophic event, other	Size of Uninsured Debt Incurred	Amount Requested	Date of Request
Name of Beneficiary	If beneficiary is a minor, Name of Parent / Guardian / Power of attorney		
Address	City, State, Zip, County		Telephone
Current Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Widower	Beneficiary Age	If beneficiary is a minor, is Parent/Spouse/Guardian Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Dependents at Home Only and Ages of Dependents at Home		If beneficiary is a minor Reside with parent(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer of Beneficiary (or of parent/guardian if parent/guardian indicated above)		Beneficiary's Occupation	
Is beneficiary covered by any of the following? <input type="checkbox"/> Health Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> WI Disability Insurance <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Other Wage Continuation Plan <input type="checkbox"/> Social Security Disability Pension <input type="checkbox"/> Home Owners Insurance <input type="checkbox"/> Other			
If answer to any of above section is checked, please indicate payment provisions, exclusions or denied payment, application filed and/or pending, etc.			
Was illness or injury due in any way to: <input type="checkbox"/> Patient's occupation <input type="checkbox"/> Automobile Accident <input type="checkbox"/> Industrial Accident <input type="checkbox"/> Other type of Accident			
If accident is involved, please provide details.			
If result of auto accident, did individual have adequate auto liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Will individual's medical costs be paid by auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of incapacitation	Date able to return to work	Will they able to earn a wage to get out of debt? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Financial Assistance From Extended Family? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is it likely that the beneficiary can absorb the debt through reallocation of assets or sale of other holdings (retirement savings, home equity, etc?)		

Please provide brief narrative relative to beneficiary's accident/illness. Continue in Comments area below if needed.

If beneficiary is a Knight of Columbus; list Council name, number and location and years of membership.

Please indicate participation by local Knights of Columbus in efforts to assist beneficiary. If pending, indicate date of decision or planned benefit.

Cash Contributed?	Benefit Held or Planned?	Details of activities, hours worked, etc.

Comments/Miscellaneous Data (Expand on previous information, provide names of medical facilities or other factors pertinent to this request. For accidents, discuss if attorney was involved or was considered.)

Knight of Columbus Requester Who Interviewed Beneficiary	Telephone # of K of C Requester	District #
Email Address of K of C Requester	Council #	Diocese: Green Bay La Crosse Madison Milwaukee Superior
Email Address of Grand Knight	Printed Name of Grand Knight	Signature of Grand Knight

Send completed form to:
**WISCONSIN STATE COUNCIL
KNIGHTS OF COLUMBUS
4297 WEST BELTLINE HWY.
MADISON, WI 53711**

*Please do not send form to Charity Director, or Diocesan Coordinators. Expect 6 to 10 weeks for processing this request.
If you have any questions concerning this form please call the State Office at (608) 274-5750*