Jewish Family Service of Greater New Orleans (JFS)
Financial Resource Center
COVID-19 EMERGENCY FINANCIAL ASSISTANCE

Mission Statement: To provide grants for Jewish residents of the Greater New Orleans community. Emergency financial assistance is for those in crisis and need help to meet basic living expenses such as food, housing, medical and other essential expenses due to COVID-19. Jewish Family Service Financial Resource Center is funded by members of the Jewish community and allocates money only to members of the Jewish community. You must be Jewish to obtain assistance.

1. Emergency Financial Assistance is need based.

2. Emergency Financial Assistance Eligibility

- ❖ Jewish
- ❖ Permanent residency in Greater New Orleans for a minimum of 1 year prior to application
- ❖ 25 years of age or older
- ❖ Explored other sources of assistance

3. Emergency Financial Assistance Available For:

- ❖ Housing
- ❖ Utilities
- ❖ Food
- ❖ Medical Emergencies *
- ❖ Other Emergencies

4. Emergency Financial Assistance Application Documentation

- ❖ Completed Application
- ❖ Documentation of current residence (select one):
  - ☐ Rent/Mortgage Receipt
  - ☐ Current Gas/Electric Bill
- ❖ Documentation that each child listed on the intake form resides with you. Check one:
  - ☐ School Principal's Note
  - ☐ Immunization Chart
  - ☐ Doctor's Bill
  - ☐ Report Card
  - ☐ Other
- ❖ Proof of employment/income
- ❖ Copy of Louisiana Driver's License
- ❖ Most recent tax return
- ❖ Supporting Documentation of Emergency

*As a general rule, most medical emergencies are beyond the capacity of JFS. However, assistance may be given for necessities that might not be completely paid for by health insurance such as medications and medical equipment.

Are you Jewish Yes ☐ No ☐ Synagogue Affiliation _____
Have you or anyone in your household ever applied for assistance from JFS? Yes ☐ No ☐ When? ____
Have you or anyone in your household ever received assistance from JFS? Yes ☐ No ☐ When? ____
How did you hear about JFS? _____

PLEASE PRINT

Amount requested $_____ Purpose of assistance _____

Name _____ Maiden name or AKA _____

Street address _____ City _____

State _____ Zip _____ Home telephone (____)_____ Cell phone (____)_____

E-mail _____ Driver's license no. _____

Date of birth _____ /_____ / _____ U.S. citizen: Yes ☐ No ☐ In Louisiana since: _____

City/State of birth _____ If foreign born, emigrated from: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widower ☐

Rent ☐ Own ☐ Rent/Mortgage $_____/month How long at this address: _____

Applicant's occupation _____ Name of employer _____

Salary (gross) $_____ Employed since _____ Employer Phone (____)_____

Business address_____ City _____ Zip _____

Name of nearest relative/friend _____ Relationship _____

Relative/Friend's address_____ City _____ Zip _____

Relative/Friend's Phone (____) _____

Number of dependents _____ Names/Ages _____
_____
_____

Please explain why you need financial assistance: _____
_____
_____
_____

What will the assistance pay for? _____
_____
_____

I have read the Eligibility, and I believe that I am eligible for financial assistance. I agree to abide by the terms of agreement.

_____ _____
Applicant Signature Date

Spouse or Domestic Partner Information

Co-Applicant's name_____ Maiden name _____

Cell phone (____)_____ E-mail _____

Driver's license no. _____ Date of birth ___ /___ / ____ U.S. citizen: Yes☐ No☐

City of birth_____ State _____

Occupation_____ Name of employer _____

Salary (gross) $_____ Employed since _____ Employer Phone (____)_____

Business address_____ City _____ Zip _____

Please Provide 3 Personal References:

1. Name:_____ Relationship:_____

Address: _____ City, State, Zip: _____

Phone: (____)_____ Email: _____

2. Name:_____ Relationship:_____

Address: _____ City, State, Zip: _____

Phone: (____)_____ Email: _____

3. Name:_____ Relationship:_____

Address: _____ City, State, Zip: _____

Phone: (____)_____ Email: _____

Bank Information

Name of bank _____ State ____ Type of account _____

Name of bank _____ State ____ Type of account _____

Name of bank _____ State ____ Type of account _____

CERTIFICATION OF COMPLETENESS AND ACCURACY

I certify that the information contained in this application is complete and accurate.

Applicant's signature _____

Date _____

DISBURSEMENT INFORMATION (for office use only)

Case Worker: _____

Case #: _____ Distribution Date: _____

Amount: $_____ Check #: _____

Expense Category: _____

Personal Financial Statement

Monthly Income		***Monthly Expenses***	
Gross Wages	$	Rent	$
Wages after Taxes	$	Mortgage	$
Dividends and Interest	$	Utilities	$
Pension	$	Telephone	$
Alimony	$	Insurance	$
Child Support	$	Car Payment	$
Social Security	$	Car Maintenance	$
Public Assistance	$	Childcare/Dependent Care	$
Food Stamps	$	Student Loan	$
Family Support	$	Other Loan	$
Other	$	Food	$
Other	$	Medical Bills/Prescriptions	$
Other	$	Other	$
Other	$	Other	$
Other	$	Other	$
Other	$	Other	$
TOTAL GROSS INCOME	**$**	**TOTAL EXPENSES**	$
TOTAL After Taxes	**$**		
ASSETS		**LIABILITIES**	
Checking	$	Credit Card Debt	$
Savings	$	Loans	$
Real Estate	$	Unpaid Bills (Specify)	$
Stocks and Bonds	$	Mortgage	$
Retirement Funds	$	Other	$
Automobile	$	Other	$
Personal Property	$	Other	$
Other	$	Other	$
TOTAL ASSETS	**$**	**TOTAL LIABILITIES**	**$**
Gross Monthly Income	**$**		
Minus Monthly Expenses	**$**		
Income Less Expenditures	**$**		

_____ _____ _____ _____

Applicant Signature Date Caseworker Signature Date

NEW CLIENT INFORMATION

Date: _____

Have you been to Jewish Family Service before? _____ Yes☐ No☐ If Yes, which program _____

Legal Name: _____

Preferred Name: _____ Preferred Pronoun:_____

Religion:_____ Sex:_____ Gender Identity: _____ Sexual Orientation: _____

Race/Ethnicity: _____ Email Address: _____

Relationship Status:_____ Birthdate:_____

Address: _____

City:_____State:_____Zip: _____

Phone(H):_____Phone(C): _____

Please check one: Employed☐ Unemployed☐ Retired☐ Disabled☐ Other:_____Occupation/School: _____

Name of Employer: _____

Referred By:_____

In case of emergency, who should be notified?

Name:_____Relationship: _____

Address:_____

Phone(H):_____Phone(W):_____Cell Phone: _____

I authorize _____to contact the individual named above in the event of an emergency.
Therapist/case manager

_____ _____

Client signature Date

Jewish Family Service of Greater New Orleans

Upon entering counseling, people often have many questions. Please read through the following policies. Your counselor or case manager is available to discuss any questions or concerns you may have about our procedures.

Staff and Credentials

Rachel Lazarus Eriksen, LCSW-BACS, Director of Clinical Services
Michelle Beard, LCSW, MBA Intern Program Supervisor
Desislava Altazova, LPC
Fran Dinehart, LCSW
Ruth Goldberg, LCSW-BACS
Stephanie Crowder, LPC, LMFT
Sean Comiskey, LSU Social Work Intern
Colin Foret, UNO Counseling Intern
Claire Kohne, Loyola Counseling Intern
Virginia Williams, Tulane Social Work Intern
Erin Wright, Tulane Social Work Intern
Langley Laporte, UNO Counseling Intern

Contact

Our phones are answered Monday - Thursday, 9 to 5, and Friday 9 to 4 in our office. You may leave a confidential message on your therapist/case manager's voice mail at any time. If you would like to leave a message after office hours, call the main office number and the menu will guide you to your therapist's voicemail. If you do not hear back from your therapist the next day, please call again—it is possible for a message to get lost in voice mail. Messages are usually not retrieved on nights, holidays or weekends, so please discuss emergency procedures with your therapist. Each member of the JFS staff also has a direct email address. All messages are returned as promptly as possible. For after-hours emergencies please call 211, 911 or go to your local emergency room.

Office Hours and Appointments

Our office is open for normal business hours Monday through Friday. All therapy and case management sessions are by appointment only.

Your appointment is time set aside just for you. If you are late, your appointment will still finish at the set time. However, if your therapist is late, you will receive your full time or we will arrange to make it up at another time. Individual, couple and family sessions are all 50 minutes unless otherwise arranged in advance.

Minors

We ask that parents/guardians remain in the waiting room for the entire time your child is in session. No child under the age of 18 is to be left unaccompanied in the JFS waiting room at any time. For minor clients, both parents/guardians must consent to therapy unless a divorce decree stating consent from the non- custodial parent is presented.

Cancelation and Rescheduling

Your session time is reserved for you. If for some reason you must cancel an appointment, as much advance notice as possible is appreciated. You will be charged for any appointment cancelled less than 24

hours in advance. If the appointment can be re-scheduled, there will still be a charge for the missed appointment if 24hour notice was not given. Insurance will not pay for missed appointments; therefore it will be your responsibility to pay the full fee.

Payment

In order to maximize your therapy time, please have your checks made out prior to your session. Checks should be made out to Jewish Family Service. All checks returned as NSF will be assigned an additional $1 0 fee. We also accept cash payments. We accept Visa and MasterCard.

Confidentiality

No information about the content of your sessions will be communicated to anyone without your written authorization (insurance forms require your signature and release of information, which is a possible waiver of your confidentiality). The only exceptions to this are cases of child abuse, elder abuse, suicidal, homicidal, or life-threatening emergencies and when otherwise required by law. Remember that once insurance or third party payments are involved (HMO's, PPO's, Managed Health Care, Insurance) your signature waives your rights to confidentiality, although your therapist still attempts to honor your confidences by sharing the fewest details possible and only when required. There is a legal exception to your rights of confidentiality in certain cases when you file a lawsuit. Please speak further with your therapist about this clarification.

Consultation

While anonymity is always maintained, all therapists may process cases with their licensed supervisors, the Director of Clinical Services, and agency staff. Please know that this consultation and discussion happens in an attempt to offer the best possible treatment. Your name will never be disclosed in these consultations. Should you have any questions about this process, please consult your therapist.

Termination

Experience shows that people often terminate counseling in a manner similar to how they terminate other relationships. We believe it is essential that if you make a decision to stop counseling, you do this directly with your therapist rather than by phone or letter. In order for clients to feel positive about themselves as well as their treatment, this agreement is vital.

If you have any questions, concerns or complaints that you cannot resolve with your therapist, please call the Executive Director, Roselle Ungar. We want your experience with our agency to be helpful and rewarding.

I have read the policies and agree to abide by them.

Client Name: _____ Client's Signature: _____

Therapist/Case Manager's Signature:_____ Date: _____

For Minors:

Client Name _____

(1)Parent/Guardian Name _____ Parent/Guardian Signature _____

(2)Parent/Guardian Name _____ Parent/Guardian Signature _____