RECORDING ACADEMY
MUSICARES

EMERGENCY FINANCIAL ASSISTANCE APPLICATION

MusiCares may grant financial assistance for needs that have arisen due to unforeseen circumstances such as: rent, car payments, utilities, prescriptions, medical/dental expenses, psychotherapy, and other expenses related to these categories. Financial assistance may also be granted for needs related to substance or addiction problems, which may include, but are not limited to, substance abuse treatment, psychotherapy, aftercare expenses, sober living, prescription costs, psychiatric care, and other expenses related to these categories.

ELIGIBILITY REQUIREMENTS AND PROCEDURES

Applicants must be able to document participation in one of the following areas:

- At least 5 years of employment in the music industry
- At least 6 commercially released recordings (singles)
- At least 6 commercially or promotionally released music videos

Please include the following required items with the completed application:

- Copies of bills for which assistance is being requested
- Detailed music industry background documentation (articles, liner notes, letters from employers, etc.)
- A résumé or discography
- A copy of your most recent bank statement(s)
- A copy of your most recent tax return

Once the application is received by MusiCares, our Health and Human Services staff will contact the applicant to review the application and gather additional information if necessary. A summary of the situation will be compiled and forwarded to the MusiCares Grant Review Committee for approval. The applicant will be notified of the committee's decision as soon as possible. Except in an emergency or crisis, please allow at least one week for processing.

ASSISTANCE LIMITATIONS

When financial assistance is provided by MusiCares, it is charitable in nature and therefore, before seeking such assistance, applicants are required to investigate all other possible sources of aid. All approved assistance is paid directly to a creditor/third party. At its sole discretion, MusiCares reserves the right to deny or approve financial assistance.

MusiCares for Music People South

Toll-Free Number: 1.877.626.2748

1904 Wedgewood Ave., Nashville, TN 37212
Phone: 615.327.0050 | Fax: 615.327.0876
musicares.org

EMERGENCY FINANCIAL ASSISTANCE APPLICATION

Name: _____
(As it appears on your Social Security Card)

Recording Academy Member? ◯ Yes ◯ No Member Number: _____
(Applicants do not have to be a Recording Academy member to receive assistance—for statistical purposes only)

Professional Name: _____
(If different)

Spouse/Partner Name: _____
(If applicable)

Home Address: _____ City/State: _____ Zip: _____

Daytime/Evening Phone Number: _____ / _____

Email Address: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Education: ◯ Some High School ◯ H.S. Diploma/GED ◯ Some College ◯ College Degree ◯ Advanced Degree

Ethnicity: ◯ African-American ◯ Asian-Pacific Islander ◯ Biracial ◯ Caucasian ◯ Latino ◯ Native American ◯ Other
(For statistical purposes only—optional)

Marital Status: _____ Number of Dependents: _____ Ages of Dependents: _____

Is your spouse/partner employed? ◯ Yes ◯ No If yes, employer information: _____

PROFESSIONAL CAREER HISTORY

Please state how many years you have been employed in the music industry: _____

In what capacity? _____ Primary Genre: _____

Do you have any commercially released recordings and/or videos? ◯ Yes ◯ No

If yes, please list: _____

Do you play an instrument(s)? ◯ Yes ◯ No

If yes, please list: _____
(It is required that you attach your work history documentation such as a resume or discography to this application.)

Are you currently employed outside of the music industry? ◯ Yes ◯ No

If yes, where? _____

You may be eligible for additional assistance from other relief organizations. Are you or your spouse a member of any entertainment unions? ◯ Yes ◯ No

If yes, please list: _____

MEDICAL INFORMATION

Are you currently receiving treatment for any medical issue? ◯ Yes ◯ No

If yes, what? _____

Are you able to work?: ◯ Yes ◯ Limited ◯ No Are you taking any medication? ◯ Yes ◯ No

If yes, please list *(name, dosage and amount taken)*: _____

Have you ever been hospitalized and/or treated for a psychiatric and/or addiction issue? ◯ Yes ◯ No

If yes, when? _____ Where? _____

Do you have health insurance? ◯ Yes ◯ No Medicare? ◯ Yes ◯ No Medicaid? ◯ Yes ◯ No

Insurance Company: _____

Do you have dental insurance? ◯ Yes ◯ No Company Name: _____

HOUSING

(If applying for housing assistance, a copy of current lease or mortgage coupon is required.)

Number of people in your household: _____ Monthly Rent/Mortgage: $ _____ Your share: $ _____

Current amount in arrears: $ _____ Lease/Lender Information: *(circle one)* Name: _____

Address: _____ Phone: _____

Have you been and/or are you currently receiving any other financial assistance from another organization(s)?

◯ Yes ◯ No If yes, from whom?_____

When? _____ How much? _____

MONTHLY BUDGET FORM

Income:

Income from Work	$_____
Residuals and Royalties	$_____
Unemployment Insurance	$_____
Social Security Income	$_____
Social Security Disability	$_____
SSI *(Supplemental Sec.)* General Relief	$_____
Food Stamps	$_____
Veterans Benefits	$_____
Spouse/Partner's Income	$_____
Alimony	$_____
Child Support	$_____
Union Pension*(s)*	$_____
	$_____
Fund/Interest	$_____

Other Income *(Financial assistance from family and friends)*:

$_____

$_____

$_____

Relief Grant*(s)*(*Specify)*

$_____

$_____

$_____

Total Income: $_____

Assets:

Checking Account	$_____
Savings Account	$_____
Other Accounts	$_____
$_____	
$_____	
Real Estate *(if applicable)*	
Date Purchased	_____
Purchase Price	$_____
Present Value	$_____
Payment	$_____
Are payments delinquent? ◯ Yes ◯ No	
If yes, how much?	$_____
In whose name is the property recorded?	
_____	

Total Assets: $_____

Expenses:

Rent/Mortgage	$_____
Second Mortgage	$_____
Home Insurance	$_____
Maintenance	$_____
Homeowner's Association Fee	$_____
Food	$_____

Utilities:

Gas	$_____
Electric	$_____
Water/Sewer/Garbage	$_____
Telephone	$_____
Cell Phone	$_____
Cable/Internet	$_____

Transportation:

Car Payment	$_____
Car Insurance	$_____
Gasoline	$_____

Medical/Dental:

Health Insurance	$_____
Medical Bills	$_____
Prescriptions	$_____
Dental Bills	$_____

Miscellaneous Expenses:

Life Insurance	$_____
Union Dues	$_____
Loan(s)	$_____
Credit Card(s)	$_____
$_____	
$_____	
$_____	
$_____	
Child Support Payments	$_____
Alimony Payments	$_____
Laundry/Cleaning	$_____

Other *(list)*:

$_____

$_____

Total Expenses: $_____

The applicant's reason for applying for assistance: _____

_____

_____

_____

_____

_____

_____

Amount requested: $_____

If applying for financial assistance for medical or dental bills please review and sign the following.

As MusiCares (including its employees and other representatives) deems necessary to review and/or determine my eligibility to receive financial or medical assistance or other services from MusiCares, I hereby authorize MusiCares to obtain, and any health care provider (individual or entity, including any type of health care facility or ancillary provider) to release to MusiCares, any and all information about my health status and any medical condition. I understand and acknowledge that: a).such information may include, but is not limited to paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, and b). such information may include information deemed confidential under State and/or Federal laws which regulate disclosure of same by a health care provider.

I also agree to reasonably cooperate with MusiCares in its efforts to obtain, and to update as necessary, such information, and such cooperation shall include executing any additional written consent(s). This authorization for medical information is valid for one year from the date of my signature below.

Signature of Applicant: _____ Date: _____
or Guardian/Proxy

I authorize MusiCares to communicate with the additional parties below to discuss my current situation if needed.
(If requesting rental assistance, please include your landlord.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I hereby certify that I have answered the foregoing questions to the best of my ability. The facts herein stated are true and I understand that any misrepresentation of this information may disqualify me for any assistance from MusiCares.

I, the undersigned, also acknowledge and fully understand that MusiCares is a voluntary charitable organization that provides financial assistance to music industry participants in its sole discretion. MusiCares will not be liable to applicant/participant for any reason, including if it does not provide financial assistance. MusiCares does not provide medical, social or psychiatric services of any kind. MusiCares is not responsible for services that it funds with its financial assistance.

Applicant/participant agrees not to sue and releases MusiCares from any claims whatsoever related to this application, the determination to provide financial assistance to the applicant or any service provided through such assistance.

Signature of Applicant: _____ Date: _____
or Guardian/Proxy

To the best of my knowledge, I certify that the above information is true.

FOR MORE INFORMATION ON ELIGIBILITY, PLEASE GO TO MUSICARES.ORG.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1. I, the undersigned, authorize MusiCares® and its employees and representatives to use and/or disclose my Health Information for any purpose related to the [Emergency Financial Assistance Application/MAP Fund Application] ("**Application**"). This shall include, but not be limited to, that Health Providers may disclose my Health Information to MusiCares, its employees, and representatives for any purpose related to the Application.

In this Authorization, "**Health Providers**" means physicians, hospitals, laboratories, clinics, and any other medical or health professionals or organizations.

In this Authorization, "**Health Information**" is defined as all medical and/or health information about me, including but not limited to, all of my past, present or future physical or mental health or condition or medical record, including, but not limited to, all information relating to any injury, sickness, disease, condition, medical history, laboratory report, X-ray or other imaging test result, screening, medical or clinical status, diagnosis, treatment or prognosis.

I understand that Health Information may include sensitive information about me, such as mental health records (except psychotherapy notes), alcohol or drug abuse records, and HIV/AIDS records.

2. I understand that my Health Information that is disclosed pursuant to this Authorization may be re-disclosed by the recipient of that information and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) or other applicable privacy or health privacy laws. Except as expressly stated in this Authorization, nothing in these acknowledgements or this Authorization shall be considered as a waiver of any rights to privacy or nondisclosure of information that I may otherwise have under any applicable law.

3. I understand that my medical treatment will not be conditioned upon whether or not this Authorization is signed, except that health assessments, tests and health care that are specifically for the purpose of creating Health Information for disclosure to MusiCares, may, to the extent permitted by applicable law, be withheld if I do not sign this Authorization.

4. Unless previously revoked, this Authorization expires five years from the date it is signed.

5. I understand that I have the right to revoke this Authorization at any time, but that the revocation will not be effective to the extent that any information has already been released in reliance on this Authorization. Any revocation must be in writing and sent to MusiCares, [_____] Attention: [_____], with the revocation effective upon actual receipt. I further understand that the right to revoke this Authorization shall not serve to excuse any failure by me to comply with all Application-related requirements.

By signing below, I acknowledge that I have read and accept all of the above, and that I will be provided with a copy of this executed Authorization upon request.

Date _____ **Signature** _____

Print Name _____

Print Address _____