

**HONOR EMERGENCY FUND**  
OF THE  
**FIRE DEPARTMENT OF THE CITY OF NEW YORK**  
EMS Application

**EMS EMPLOYEE**

Name: \_\_\_\_\_ Rank: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Reference/Employee Number: \_\_\_\_\_ Station Number: \_\_\_\_\_

Current Work Location:(if different) \_\_\_\_\_ D.O.B: \_\_\_\_\_

Veteran: Yes  No  Active Duty: Yes  No  Start Date: \_\_\_\_\_

**FAMILY STATUS:**

Married  Single  Divorced  Domestic Partner

Name of Dependents: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

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**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone/Landline: \_\_\_\_\_ Email: \_\_\_\_\_

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**Reason you are seeking assistance:**

- Financial
- Medical
- Prescription
- Respite
- Home Care | Respite Care | Emergency Child Care
- Additional therapy (*Speech, Occupational Therapy, Physical Therapy, Psychotherapy*)
- Emergency (*Please list*) \_\_\_\_\_
- Other (*Please list*) \_\_\_\_\_

**HEALTHCARE COVERAGE:**

- Primary Healthcare Coverage (*list plan*) \_\_\_\_\_
- Secondary Healthcare Coverage (*list plan*) \_\_\_\_\_
- Medicare | Medicaid Number (*if applicable*) \_\_\_\_\_

Is Civil Action Planned or Pending?      Yes       No

Worker's Compensation Pending?      Yes       No       Amount Received: \_\_\_\_\_

Is Social Security Disability or Retirement Planned or Pending?      Yes       No

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**FAMILY MONTHLY INCOME:**

- Average Monthly FDNY Income:           Gross Amount: \_\_\_\_\_ Net Amount: \_\_\_\_\_
- Other Monthly Employment Source:   Gross Amount: \_\_\_\_\_ Net Amount: \_\_\_\_\_
- Spouse/Partner Monthly Income:       Gross Amount: \_\_\_\_\_ Net Amount: \_\_\_\_\_
- Social Security Received (for self): \_\_\_\_\_ Social Security for Partner Received: \_\_\_\_\_
- Veteran Compensation: \_\_\_\_\_ Veteran Compensation for Partner: \_\_\_\_\_
- Child Support Received (for self): \_\_\_\_\_ Child Support Received for Partner: \_\_\_\_\_
- Pension(s) Amount: \_\_\_\_\_
- Government Assistance Amount: \_\_\_\_\_

**SAVINGS AND ASSETS:**

Name of Bank: \_\_\_\_\_

Type of Account: Checking  Savings  Amount: \_\_\_\_\_

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Type of Account: Checking  Savings  Amount: \_\_\_\_\_

457 Deferred Compensation Plan:   Yes            No            Ending Balance: \_\_\_\_\_

401K Plan:                               Yes            No            Ending Balance: \_\_\_\_\_

IRA:                                       Yes            No            Ending Balance: \_\_\_\_\_

CDs            Brokerage Accounts  Money Market    Bonds           Total Value: \_\_\_\_\_

Stocks        Mutual Funds    Retirement Accounts   Total Value: \_\_\_\_\_

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Other Assets: \_\_\_\_\_ Total Value: \_\_\_\_\_

**RESIDENCE:**

Do you own a home? Yes  No

Type of home: Single  2-Family  Multi-Family  Townhouse  Condo  Co-op

Year of Purchase: \_\_\_\_\_ Purchase Price: \_\_\_\_\_

Held By: \_\_\_\_\_ Monthly Mortgage: \_\_\_\_\_ Mortgage Balance: \_\_\_\_\_

Second Mortgage or Home Equity Loan: Yes  No

Loan Held By: \_\_\_\_\_ Amount of Loan: \_\_\_\_\_ Current Loan Balance: \_\_\_\_\_

Do you pay rent? Yes  No  Monthly Rent: \_\_\_\_\_

**OUTSTANDING DEBT:**

Credit Card Total Amount Owed: \_\_\_\_\_ Monthly Payment: \_\_\_\_\_

Medical Total Amount Owed: \_\_\_\_\_ Monthly Payment: \_\_\_\_\_

Dental Total Amount Owed: \_\_\_\_\_ Monthly Payment: \_\_\_\_\_

Personal Loan Total Amount Owed: \_\_\_\_\_ Monthly Payment: \_\_\_\_\_

Car Loan or Lease Total Amount Owed: \_\_\_\_\_ Monthly Payment: \_\_\_\_\_

Student Loan Total Amount Owed: \_\_\_\_\_ Monthly Payment: \_\_\_\_\_

Vehicle Make: \_\_\_\_\_ Year: \_\_\_\_\_ Model: \_\_\_\_\_ Mileage: \_\_\_\_\_

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Vehicle Make: \_\_\_\_\_ Year: \_\_\_\_\_ Model: \_\_\_\_\_ Mileage: \_\_\_\_\_

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Please list all other financial obligations:

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Have you previously received assistance from the **Honor Emergency Fund**? Yes  No

I hereby certify that each of the statements made by me are true to the best of my knowledge and hereby authorize your office to obtain any additional information you may deem pertinent to this application.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_