**APPLICATION FOR ASSISTANCE**

**from**

**ASSOCIATION OF PROFESSIONAL BALL PLAYERS OF AMERICA**

**Please answer all questions and sign the completed form. Attach copies of documentation to support your income information. Acceptable documentation includes copies of most recent tax returns, Social Security Award letters and Disability documentation. If you do not file taxes please indicate at the end of this application.**

**If the statements in this application are found to be falsified in any way assistance will be terminated immediately.**

**Association of Professional Ball Players of America**

**Bobby Grich, President**

**23623 N Scottsdale Rd # 290 Scottsdale, AZ 85255**

**480-404-9339**

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| --- | --- | --- |
| Date: |  | |
| Name: | Date of Birth: | |
| Place of Birth | | Age: |
| Current Address: City, State, ZIP: | | |
| Home Phone: Mobile Phone: Email: | | |
| Mailing Address: City, State, ZIP: | | |
| Married? Yes No Wife’s Name: Age: | | |
| Number of Children now living with you: Ages: | | |
| If children are married and not living with you, please provide names and addresses: | | |
| Name: Address: City, State, ZIP: Phone: | | |
| Name: Address: City, State, ZIP: Phone: | | |
| Name: Address: City, State, ZIP: Phone: | | |

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| --- | --- | --- | --- |
| If you are single, please give the names and addresses of the 2 nearest living relatives: | | | |
| Name: Address: City, State, ZIP: Phone: | | | |
| Name: Address: City, State, ZIP: Phone: | | | |
|  | | | |
| Do you own your home? Yes No Estimated Value: Date of Last Estimate: | | | |
| Is your home paid for? Yes No Balance Due: | | | |
| Amount of Equity in home: Payment per Month: | | | |
| Do you rent? Yes No Rent per Month: | | | |
| Do you own any other property? Yes No Income from Property: | | | |
| Location and description of property: | | | |
| Do you own a vehicle? Yes No Year: Make/Model: | | | |
| Is vehicle paid for? Yes No Amount Owed: Monthly payment: | | | |
| Date of purchase: | | | |
| Do you have Medical insurance? Yes No Type of Insurance: | | | |
| Name of Insurance Company: | | | |
| Do you or have you ever used **TOBACCO**? Yes No How Long? Type: CHEW / DIP / CIGARETTES / OTHER | | | |
| Would you like help in fixing any tobacco, alcohol, or other addiction issues? Yes No | | | |
|  | | | |
| Bank: Branch Address: | | | |
| Checking Account No.: Current Balance: | | | |
| Savings Account No.: Current Balance: | | | |
| Certificates of Deposits: | | | |
| Money Market Accounts: | | | |
| What is your total income per month from all sources? (This also must include income which your wife receives.)  List sources and amount from each: | | | |
| Source: | | Amount: | |
| Source: | | Amount: | |
| Source: | | Amount: | |
| Source: | | Amount: | |
| Source: | | Amount: | |
| Source: | | Amount: | |
|  | |  | |
|  | | TOTAL | |
|  | |  | |
| **If you are not collecting Social Security at this time, when will you become eligible? List your wife’s anticipated eligibility and allotment:** | | | |
| Date: Anticipated Amount: | | | |
| Date: Anticipated Amount: | | | |
| Are you eligible for assistance from any other state of federal agency? Yes No | | | |
| Name of agency Amount: | | | |
| **If and when you receive additional income other than reported above, this office must be notified immediately. If not reported our assistance will be discontinued at once.** | | | |
| Are you a Veteran? Yes No Branch of Service: | | | |
| Years in Service: Are you entitled to Veteran’s Hospital? Yes No | | | |
| If not, give reason: | | | |
| Are you able to work? Yes No Date Last Employed: | | | |
| Reason for leaving last job: | | | |
| Last Employer: Address/City/State Phone: | | | |
| Condition of your health at this time: | | | |
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|  | | | |
| Doctor Name: Address/City/State Phone: | | | |
| Doctor’s report attached: Yes No Type of Doctor: Next Appointment: | | | |
| Doctor Name: Address/City/State Phone: | | | |
| Doctor’s report attached: Yes No Type of Doctor: Next Appointment: | | | |
| Doctor Name: Address/City/State Phone: | | | |
| Doctor’s report attached: Yes No Type of Doctor: Next Appointment: | | | |
| List your years in organized baseball: | | | |
| Name of Club | League | Year | Position |
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| Were you ever disbarred from baseball? Yes No | | | |
| If yes, reason | | | |
|  | | | |
| Have you ever been convicted of a felony? Yes No | | | |
| If yes, reason | | | |
|  | | | |
| List three personal references (not relatives): | | | |
| Name: Address: City, State, ZIP: Phone: | | | |
| Name: Address: City, State, ZIP: Phone: | | | |
| Name: Address: City, State, ZIP: Phone: | | | |
| **SOCIAL MEDIA** (Facebook, LinkedIn, Instagram, Snaphat, GoFundMe, Kickstarter, etc)  Please list ALL social media accounts including any CROWD FUNDING PAGES: | | | |
|  | | | |
|  | | | |
| **TAX STATEMENT**  No I do not file taxes  I have not filed taxes since (list date): | | | |

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

**All information submitted to this office is kept confidential.**

**This Association reserves the right to re-examine cases at any time.**

**FEB 2019**