| Double-Click project Loan Application | | | | | | | | | | | |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please **Print** and fill out the application as completely as possilble, writing “na” to questions that do not apply to your situation. Complete the Co-applicant section if there is a co-applicant or if applicant is under the age of 18. Note: This form will be used to determine the amount of loan assistance to be provided by the Double click project loan. | | | | | | | | | | | | |
| **Applicant Information (please enter who the computer is for)** | | | | | | | | | | | | |
| NAME: | | | | | | | | | | | | |
| DATE OF BIRTH: | | | | | | PRIMARY PHONE: | | | | EMAIL: | | |
| TXDL, ID OR SSN: | | | | | | ALTERNATE PHONE: | | | |
| CURRENT ADDRESS: | | | | | | | | | | COUNTY: | | |
| CITY: | | | | | | STATE: | | | | ZIP CODE: | | |
| GENDER | MALE | FEMALE | | | | RACE: | | | |  | | |
| **Co-Applicant Information** | | | | | | | | | | | | |
| NAME: | | | | | | | | | | | | |
| DATE OF BIRTH: | | | | | | PRIMARY PHONE: | | | | EMAIL: | | |
| TXDL, ID OR SSN: | | | | | | ALTERNATE PHONE: | | | |
| CURRENT ADDRESS: | | | | | | | | | | COUNTY: | | |
| CITY: | | | | | | STATE: | | | | ZIPCODE: | | |
| GENDER | MALE | FEMALE | | | | RACE: | | | | RELATIONSHIP TO CLIENT: | | |
| **Request Statement** | | | | | | | | | | | | |
| Please explain the reason for your request for a loan from the ‘double-click’ project loan. include why you are facing a financial situation that led you to applying for a loan (examples include a hospitalization or illness, breaks in medicaid coverage or ssi income, natural disasters or loss of employment). | | | | | | | | | | | | |
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| HAVE YOU TRIED TO ACCESS ASSISTANCE FROM OTHER ORGANIZATIONS? IF ‘YES’ PLEASE EXPLAIN. | | | | | | | | YES | | | NO | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Income** | | | | | | | | | | | | |
| list all **gross** monthly income received by the applicant and co-applicant including but not limited to social security benefits, retirement, child support, alimony, va benefits, employment income, etc. | | | | | | | | | | | | |
| **APPLICANT: INCOME** | | | | | | | | **CO-APPLICANT: INCOME** | | | | |
| SOURCE | | | AMOUNT | | | | | SOURCE | | | AMOUNT | |
| EMPLOYMENT | | | $ | | | | | EMPLOYMENT | | | $ | |
| SOCIAL SECURITY | | | $ | | | | | SOCIAL SECURITY | | | $ | |
| SSI | | | $ | | | | | SSI | | | $ | |
| SSDI | | | $ | | | | | SSDI | | | $ | |
| RETIREMENT | | | $ | | | | | RETIREMENT | | | $ | |
| VA BENEFITS | | | $ | | | | | VA BENEFITS | | | $ | |
| OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | $ | | | | | OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | $ | |
| OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | $ | | | | | OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | $ | |
| **APPLICANT MONTHLY INCOME TOTAL** | | | $ | | | | | **CO-APPLICANT MONTHLY INCOME TOTAL** | | | $ | |
|  | | | | | | | | | | | | |
| **OTHER INCOME** | | | | | | | | | | | | |
| LIST ALL OTHER MONTHLY INCOME RECEIVED BY ALL OTHER FAMILY MEMBERS. | | | | | | | | | | | | |
| **RELATIONSHIP TO APPLICANT** | | | | | **SOURCE** | | | | | | | **AMOUNT** |
|  | | | | |  | | | | | | | $ |
|  | | | | |  | | | | | | | $ |
|  | | | | |  | | | | | | | $ |
|  | | | | | | | | **OTHER MONTHLY INCOME TOTAL** | | | | $ |
|  | | | | | | | | | | | | |
| **TOTAL INCOME FROM ALL SOURCES** | | | | | | | | | | | | |
| PLEASE ENTER THE TOTALS FROM ALL **INCOME** SOURCES IN THE SPACES PROVIDED | | | | | | | | | | | | |
| **SOURCE** | | | | | | | | | | | | **AMOUNT** |
| APPLICANT’S TOTAL MONTHLY INCOME | | | | | | | | | | | | $ |
| CO-APPLICANT’S TOTAL MONTHLY INCOME | | | | | | | | | | | | $ |
| OTHER FAMILY MEMBERS’ TOTAL MONTHLY INCOME | | | | | | | | | | | | $ |
|  | | | | | | | | **TOTAL MONTHLY INCOME** | | | | $ |
|  | | | | | | | | | | | | |
| **ALTERNATE CONTACTS** | | | | | | | | | | | | |
| PLEASE LIST, AT LEAST, TWO (**2**) CONTACTS, A FAMILY MEMEMBER OR TRUSTED FRIEND, THAT WE MAY CONTACT IN THE EVENT THAT WE ARE UNABLE TO GET IN CONTACT WITH YOU | | | | | | | | | | | | |
| **NAME** | | | | | **ADDRESS** | | | | **PHONE** | | | |
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| **eXPENSES** | | | | | | | | | | | | |
| PLEASE PROVIDE INFORMATION ABOUT YOUR TOTAL HOUSEHOLD MONTHLY EXPENSES BY ENTERING THE AMOUNT IN THE APPROPRIATE BOX. WRITE “NA” IN THE BOXES FOR EXPENSES YOU DO NOT HAVE. | | | | | | | | | | | | |
| **EXPENSE** | | | | **SOURCE** | | | | | | | **AMOUNT** | |
| RENT/MORTGAGE PAYMENT | | | |  | | | | | | | $ | |
| UTILITIES | | | | GAS, ELECTRIC, PHONE, ETC. | | | | | | | $ | |
| INSURANCE | | | | AUTO, HEALTH, LIFE | | | | | | | $ | |
| GROCERIES | | | | CASH SPENT ON FOOD (**NOT INCLUDING FOODSTAMPS**) | | | | | | | $ | |
| LIABILITIES | | | | CREDIT CARDS, AUTO LOANS, STUDENT LOANS, FINANCE COMPANIES, GAS CARDS, PAGERS, CELL PHONES, DEPT. STORE CREDIT CARDS | | | | | | | $ | |
| TRANSPORTATION | | | | BUS, TAXI, AUTO MAINTENANCE | | | | | | | $ | |
| CHILD CARE | | | |  | | | | | | | $ | |
| MEDICAL/PRESCRIPTIONS | | | |  | | | | | | | $ | |
| EDUCATION | | | | TUITION, BOOKS | | | | | | | $ | |
| ALIMONY/CHILD SUPPORT | | | |  | | | | | | | $ | |
| PERSONAL EXPENSES | | | | PERSONAL HYGIENE PRODUCTS, CLOTHING, DRY CLEANING, BEAUTY/BARBER SHOP | | | | | | | $ | |
| HOUSEHOLD EXPENSES | | | | MAINTENANCE, CLEANING SUPPLIES, LAWN CARE, HOSEHOLD ITEMS, ETC. | | | | | | | $ | |
| RECREATION | | | | DINING OUT, MOVIES, CD’S, CABLE, ALCOHOL, TOBACCO, ETC. | | | | | | | $ | |
| CONTRIBUTIONS | | | | CHURCH, GIFTS, DONATIONS | | | | | | | $ | |
| OTHER | | | |  | | | | | | | $ | |
|  | | | | **MONTHLY EXPENSES TOTAL** | | | | | | | $ | |
|  | | | | | | | | | | | | |
| **DISABILITY RELATED EXPENSES** | | | | | | | | | | | | |
| PLEASE PROVIDE INFORMATION ABOUT DISABILITY RELATED EXPENSES (I.E., ADAPTIVE AIDS, ASSISTIVE TECHNOLOGY, MEDICAL SUPPLIES, AND PERSONAL ASSISTANCE SERVICES) FOR ALL INDIVIDUALS IN THE HOUSEHOLD WHO EXPERIENCE A DISABILITY. LIST ONLY THOSE EXPENSES PAID FOR OUT OF POCKET, NOT THOSE COVERED BY PROGRAMS AND BENEFITS. | | | | | | | | | | | | |
| **NAME OF PERSON UTILIZING DISABILITY AIDS OR SERVICES** | | | | **SOURCE** | | | | | | | **AMOUNT** | |
|  | | | |  | | | | | | | $ | |
|  | | | |  | | | | | | | $ | |
|  | | | | **DISABILITY RELATED EXPENSE TOTAL** | | | | | | | $ | |
|  | | | | | | | | | | | | |
| **TOTAL EXPENSES FROM ALL SOURCES** | | | | | | | | | | | | |
| PLEASE ENTER THE TOTALS FROM ALL **EXPENSE** SOURCES IN THE SPACES PROVIDED | | | | | | | | | | | | |
| **SOURCE** | | | | | | | | | | | | **AMOUNT** |
| MONTHLY EXPENSES TOTAL | | | | | | | | | | | | $ |
| DISABILITY RELATED EXPENSES TOTAL | | | | | | | | | | | | $ |
|  | | | | **TOTAL MONTHLY EXPENSES** | | | | | | | | $ |
| **Residual income** | | | | | | | | | | | | |
| TO FIND RESIDUAL INCOME, SUBTRACT YOUR TOTAL MONTHLY EXPENSES FROM YOUR TOTAL MONTHLY INCOME. IF APPROVED, YOUR RESIDUAL INCOME TOTAL WILL BE USED TO DETERMINE YOUR LOAN’S MONTHLY PAYMENT PLAN.  **NOTE**: RESIDUAL INCOME MUST NOT BE EQUAL TO OR LESS THAN ZERO FOR LOAN CONSIDERATION. | | | | | | | | | | | | |
| **SOURCE** | | | | | | | | | | | | **AMOUNT** |
| TOTAL MONTHLY INCOME | | | | | | | | | | | | $ |
| TOTAL MONTHLY EXPENSES | | | | | | | | | | | | $ |
|  | | | | | | | **RESIDUAL INCOME** | | | | | $ |

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| --- | --- | --- | --- |
| **assets** | | | |
| PLEASE ENTER THE AMOUNTS IN YOUR SAVINGS OR CHECKING ACCOUNTS, ANY MONETARY GIFTS THAT YOU MAY RECEIVE AND ANY OTHER BENEFITS IN THE SPACES PROVIDED. | | | |
| **APPLICANT: ASSETS** | | **CO-APPLICANT: ASSETS** | |
| SOURCE | AMOUNT | SOURCE | AMOUNT |
| SAVINGS ACCOUNT | $ | SAVINGS ACCOUNT | $ |
| CHECKING ACCOUNT | $ | CHECKING ACCOUNT | $ |
| GIFTS FROM RELATIVES | $ | GIFTS FROM RELATIVES | $ |
| OTHER BENEFITS | $ | OTHER BENEFITS | $ |
| OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ | OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |
| **APPLICANT ASSETS** | $ | **CO-APPLICANT ASSETS** | $ |

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| --- | --- | --- |
| **certification** | | |
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| APPLICATION COMPLETED BY: | | DATE: |
| RELATIONSHIP TO APPLICANT: | | |
| I (WE) CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I (WE) UNDERSTAND THAT ANY OMISSIONS OR DISCREPANCIES FOUND LATER MAY BE GROUNDS FOR DISQUALIFICATION FOR ASSISTANCE FROM THE ‘DOUBLE-CLICK’ PROJECT LOAN PROGRAM. I (WE) AUTHORIZE THE ‘DOUBLE-CLICK’ PROJECT LOAN PROGRAM TO VERIFY ANY AND ALL OF THE INFORMATION PROVIDED. I (WE) AGREE TO ADHERE TO ALL ‘DOUBLE-CLICK’ PROJECT LOAN RULES, POLICIES AND PROCEDURES.  I (WE) UNDERSTAND THAT FINANCIAL LITERACY COUNSELING MAYBE REQUIRED TO ACCESS THE FINANCIAL ASSISTANCE OFFERED THRU THE ‘DOUBLE-CLICK’ PROJECT LOAN. | | |
| APPLICANT’S SIGNATURE: | DATE: | |
| CO-APPLICANT’S SIGNATURE: | DATE: | |