

**WESCO INTERNATIONAL CHARITABLE FOUNDATION**  
**Emergency Financial Assistance Needs Assessment Form**

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***WESCO EMPLOYEE INFORMATION***

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<b>Last Name</b>	<b>First Name</b>	<b>M. I.</b>	<b>Date of Birth</b>
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Occupation: \_\_\_\_\_

Branch Location: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Current Address: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Back-up Contact Phone: \_\_\_\_\_

**Name, age, and relationship of dependent family members:**

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**Description of injury, illness, or loss:**

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**Brief description of critical needs (e.g., food, clothing, shelter, medical care, etc.):**

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**Employee Name:** \_\_\_\_\_

***HEALTH NEEDS***

**(Duplicate form as needed for each family member with health needs.)**

Name of Family Member: \_\_\_\_\_

Describe injury or medical condition. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treated by & where: \_\_\_\_\_

\_\_\_\_\_

Is treatment complete? If not, please describe ongoing treatment/care. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does family member have access to medicine that he/she needs on a regular basis? \_\_\_\_\_

If not, what does he/she need? \_\_\_\_\_

\_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Phone #: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_

Any health needs not covered by insurance? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other relevant information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Employee Name:** \_\_\_\_\_

***DAMAGE TO RESIDENCE***

Describe damage to your home and contents.  
\_\_\_\_\_  
\_\_\_\_\_

Is your home able to be repaired? Explain.  
\_\_\_\_\_  
\_\_\_\_\_

Are any contents salvageable? Explain.  
\_\_\_\_\_  
\_\_\_\_\_

What are your current living conditions?  
\_\_\_\_\_

What are your current housing needs?  
\_\_\_\_\_

Insurance? \_\_\_\_\_ Contents only?  
Any deductibles or policy limits?  
\_\_\_\_\_

Insurance Company: \_\_\_\_\_

Agent Name and Phone Number: \_\_\_\_\_

Have you been in contact with the insurance company? \_\_\_\_\_

Are they meeting your needs? Explain.  
\_\_\_\_\_  
\_\_\_\_\_

When do you expect to receive insurance proceeds? \_\_\_\_\_

Amount recovered and/or expected to be recovered from insurance:  
\_\_\_\_\_  
\_\_\_\_\_

Employee Name: \_\_\_\_\_

***FAMILY CLOTHING NEEDS***

**(Please list sizes. Duplicate form as needed.)**

Male – Name \_\_\_\_\_  
Shirt \_\_\_\_\_ Sleeve length \_\_\_\_\_ Neck \_\_\_\_\_  
Trousers – waist \_\_\_\_\_ Length \_\_\_\_\_ Belt \_\_\_\_\_  
Shoes – size \_\_\_\_\_ Width \_\_\_\_\_

Female – Name \_\_\_\_\_  
Dress \_\_\_\_\_ Shoes – size \_\_\_\_\_ Width \_\_\_\_\_  
Skirt \_\_\_\_\_ Slacks \_\_\_\_\_ Jacket \_\_\_\_\_ Blouse \_\_\_\_\_

Child – Name \_\_\_\_\_ Sex \_\_\_\_\_  
Child clothing Size \_\_\_\_\_ Shoe – size \_\_\_\_\_

Child – Name \_\_\_\_\_ Sex \_\_\_\_\_  
Child clothing Size \_\_\_\_\_ Shoe – size \_\_\_\_\_

Child – Name \_\_\_\_\_ Sex \_\_\_\_\_  
Child clothing Size \_\_\_\_\_ Shoe – size \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

***DAMAGE TO VEHICLES***

Vehicle #1 \_\_\_\_\_

Describe damage. \_\_\_\_\_

Is it insured? \_\_\_\_\_

Vehicle #2 \_\_\_\_\_

Describe damage. \_\_\_\_\_

Is it insured? \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Agent Name and Phone Number: \_\_\_\_\_

Have you been in contact with the insurance company? \_\_\_\_\_

Are they meeting your needs? Explain. \_\_\_\_\_

When do you expect to receive insurance proceeds? \_\_\_\_\_

Amount(s) recovered and/or expected to be recovered from insurance: \_\_\_\_\_

\_\_\_\_\_

***OTHER NEEDS***

Describe any losses and/or needs not otherwise addressed. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employee Name: \_\_\_\_\_

**FINANCIAL INFORMATION**

MONTHLY FAMILY INCOME	Current	Projected	AVERAGE MONTHLY EXPENSES	Current	Projected
Salary			Social Security (FICA)		
Spouse's Salary			Inc. Tax Withheld-Fed		
Social Security Benefits			Inc. Tax Withheld-State		
Child/Family Support			Medicare		
Interest/Dividends			Alimony/Child Support		
Rental Income			Rent/Mortgage		
Other (specify all sources)			Car Payments		
			Utilities		
			Telephone		
			Cable TV		
			Food & Household Items		
			Clothing		
			Life Insurance		
			Homeowners/Rental Ins.		
			Vehicle Insurance		
			Other Insurance		
			Fuel/Vehicle Maintenance		
			Child Care		
			Medical/Dental		
			Savings/401(k)		
			Other (Specify)		
<b>TOTAL</b>			<b>TOTAL</b>		

INDEBTEDNESS							
Creditor Name	Purpose	Date Incurred	Original Amount	Balance Owed	Past Due Amount	Months Remain.	Monthly Payment

ASSETS			
Description (e.g., cash, savings, etc.)	Approximate Value	Description	Approximate Value

**Employee Name:** \_\_\_\_\_

***FINANCIAL INFORMATION (cont.)***

Would disposal of any of your assets to cover your losses cause further personal hardship? Explain.

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Please summarize losses not expected to be covered by insurance.

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Have you applied for and/or received assistance from any other sources (e.g., other charitable organizations or relief agencies, other insurance policies, etc.)? If so, please describe.

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**Employee Name:** \_\_\_\_\_

**CERTIFICATION**

*By my signature below, I certify that (i) all of the foregoing information is true and correct to the best of my knowledge; (ii) I will notify WESCO International Charitable Foundation of any material changes to such information prior to receiving a grant from WESCO International Charitable Foundation; and (iii) I will comply with the terms and conditions of any emergency financial assistance that may be granted to me by WESCO International Charitable Foundation.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Employee Name:** \_\_\_\_\_

**For Internal Use Only:**

**Name of Grantee:** \_\_\_\_\_

**Place of Current or Former Employment:** \_\_\_\_\_

**Relationship (if any) of the grantee to the directors and officers of the Foundation:**

\_\_\_\_\_

**Type and amount of assistance provided:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Purpose of grant:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Grant No.** \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date