

GRAND CHAPTER OF MASSACHUSETTS  
ORDER OF THE EASTERN STAR  
ISADORE FORBES BENEVOLENT FUND BOARD

APPLICATION FOR TEMPORARY ASSISTANCE

Please, fully read the application before completing. Incomplete applications will be returned. Please use ballpoint pen when completing the application.

Chapter Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Town/City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone/Cell Phone Number: \_\_\_\_\_, E-Mail Address: \_\_\_\_\_

Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed/Widower: \_\_\_\_\_

If married, name of spouse: \_\_\_\_\_

Is applicant or spouse a member of a Masonic Lodge? \_\_\_\_\_ Where? \_\_\_\_\_

Own Home: \_\_\_\_\_ Rent: \_\_\_\_\_ Board: \_\_\_\_\_ Live with relatives: \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Number in Family: \_\_\_\_\_ List age of each dependent:

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

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

Name of Primary Doctor: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

Medical or Hospital Insurance: \_\_\_\_\_ If yes, Name of Company: \_\_\_\_\_

If married, answers to the following questions should include spouse:

Currently employed: \_\_\_\_\_ Employer: \_\_\_\_\_ Retired since (year): \_\_\_\_\_

Financial Status: Indicate sources of monthly income and amount(s): (\*include written proof of all income) (\*\* include latest 2 statements or last 2 pages of pass book)

Employment: \$ \_\_\_\_\_ \* Pension: \$ \_\_\_\_\_ \* Annuities: \$ \_\_\_\_\_ \* Social Security: \$ \_\_\_\_\_ \*

401K: \$ \_\_\_\_\_ \* (\*if direct deposit, last 2 bank statements must accompany the Application)

Unemployment Compensation: \$ \_\_\_\_\_ \* Savings Account(s): \$ \_\_\_\_\_ \*\* Checking Account(s): \$ \_\_\_\_\_ \*\*

Family Contributions: \$ \_\_\_\_\_ \* Other: \$ \_\_\_\_\_ \* (please explain) \_\_\_\_\_

**If your answer is yes to any or all of the following questions, please explain on the reverse side of this page.**

Has Applicant ever applied to any other O.E.S. fund for assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

Has Applicant received assistance from this Board or the Charitable Foundation Board in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

Is Applicant eligible for assistance from any government agency or agencies? Yes \_\_\_\_\_ No \_\_\_\_\_

Is Applicant receiving aid or assistance from any other source? Yes \_\_\_\_\_ No \_\_\_\_\_

**PLEASE LIST ALL MONTHLY EXPENSES**  
Include either originals or copies of all bills or statements

Monthly Rent or Mortgage payment: \$ \_\_\_\_\_

Utilities: Gas: \$ \_\_\_\_\_ Electric: \$ \_\_\_\_\_ Propane: \$ \_\_\_\_\_

Home Phone: \$ \_\_\_\_\_ Cell Phone: \$ \_\_\_\_\_

Medical Insurance: \$ \_\_\_\_\_ Life Insurance(s): \$ \_\_\_\_\_

Child Care: \$ \_\_\_\_\_ Doctor Bills (List all, if more than one): 1: \_\_\_\_\_  
2: \_\_\_\_\_, 3: \_\_\_\_\_ If necessary, continue of reverse side.

Medication(s): \$ \_\_\_\_\_

Hospital Bills: (Total of all outstanding bills) \$ \_\_\_\_\_

Itemized Credit Card Receipts (include copies of credit card bills): \$ \_\_\_\_\_

Other Expenses: (please explain on the reverse side of this page, if needed): \$ \_\_\_\_\_

\_\_\_\_\_  
**Signature of Applicant**

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**To be completed by the Chapter Representative:**

I have contacted the Applicant. My letter and the Applicant's letter are enclosed.

**Chapter Representative's Signature:** \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Tel. No.: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Town/City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**To be completed by the Chapter Secretary certifying the Applicant's FIVE YEARS OF CONTINUOUS MEMBERSHIP (IN GOOD STANDING) in the Order of the Eastern Star in Massachusetts:**

I certify that the Applicant was initiated on (date) \_\_\_\_\_ in \_\_\_\_\_ Chapter

No. \_\_\_\_\_ and that she/he is a member in good standing of \_\_\_\_\_ Chapter No. \_\_\_\_\_

**Chapter Secretary's Signature:** \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Tel. No.: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Town/City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**Note: Application MUST be accompanied by a letter from the Applicant and the Chapter Representative (if not mailed separately).**