Need of Aid
Charitable Foundation
Application for Benefit Assistance

Please fill out the below form completely and email to needofaid@slcpa.org.

Officer/Professional Staff Information

Last Name _____ First Name _____ MI _____

DOB _____ Marital Status _____

Home Address _____ City _____ Zip Code _____

Phone (_____) - _____ - _____ Personal Email _____

Rank _____ DSN _____ Assignment _____

Spouse/Partner Information

Last Name _____ First Name _____ MI _____

Employer _____ Occupation _____

Dependent Information

Dependent Name	DOB	Relationship

Benefit Assistance Amount Requested _____

If dollar amount exceeds $1500, please also fill out *Application for Additional Benefit Assistance.*

Person Needing Assistance is Member of SLCPA FOP (circle one) YES NO

Reason for Assistance

_____

_____

_____

_____

_____

Person Making Request

If a representative, do you request your identity remain unknown to applicant? (circle one) YES NO

Last _____ First _____ Cell Phone (_____) _____ - _____

Information provided is confidential and will not be shared outside Need of Aid