



APPLICATION FOR UNMET NEEDS FINANCIAL ASSISTANCE

City and County of Broomfield Senior Services



The Unmet Needs Financial Assistance Program is designed to support low-income older adults by addressing small, essential expenses that are not typically covered by other financial aid or benefit programs. This program fills critical gaps by providing limited, one-time assistance for necessity-based needs that can significantly impact a senior's health, safety, or well-being.

This program is **NOT** intended for ongoing or recurring expenses (such as rent, utilities, or groceries). Each request is reviewed on a case-by-case basis to determine eligibility and urgency.

Incomplete applications will not be processed. Please return the application to Broomfield Senior Services, Attn: Resource Coordinator, at 280 Spader Way, Broomfield, CO 80020. For questions, please call 303-464-5529 or email lclemesen@broomfield.org.

APPLICANT INFORMATION

Last Name _____ First Name _____ MI _____
Street Address _____ Apt/Lot # _____
City _____ Zip _____
Phone _____ Email _____
Date of Birth _____ Age _____

REQUEST DETAILS

Describe the need for assistance (what is needed and why is it essential?):

Total Amount Requested: \$ _____

Is this a one-time expense? Yes No (This program does *not* cover ongoing or recurring expenses.)

PAYMENT INFORMATION

Please note: If approved, payment will be issued via check or debit card directly to the medical provider or vendor. Payments cannot be made payable to the applicant.

Vendor Name (Name to make the check payable to) _____
Vendor Mailing Address _____ Apt/Lot # _____
City _____ State _____ Zip _____
Vendor Phone _____ Email _____

CURRENT ASSISTANCE PROGRAMS

Please check all programs you are currently enrolled in:

- | | |
|--|---|
| <input type="checkbox"/> Social Security Benefits (SSI/SSDI) | <input type="checkbox"/> SNAP (Food Stamps) |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Veteran Benefits (VA) |
| <input type="checkbox"/> Medicare Savings Program | <input type="checkbox"/> Medicaid Waiver Services |
| <input type="checkbox"/> Housing Assistance (Voucher, TBRA) | <input type="checkbox"/> Other: _____ |

FINANCIAL ELIGIBILITY

This program is for seniors whose **gross household income is at or below 40% of the Area Median Income (AMI)** for Broomfield County. For eligibility purposes, “household” refers to the applicant and any individuals they are financially responsible for.

MONTHLY INCOME LIMITS

COUNTY	1 PERSON	2 PERSON	3 PERSON	4 PERSON	5 PERSON
BROOMFIELD	\$3,270	\$3,737	\$4,203	\$4,670	\$5,047

Please complete the section below to help determine your eligibility:

Number of household members you are financially responsible for (including yourself): _____

Total gross monthly income for all household members listed above (before taxes): \$_____

Sources of income (check all that apply): Social Security SSI/SSDI Pension

Employment VA Benefits Other: _____

OTHER RESOURCES

This program is intended only for needs **not covered** by insurance or other benefit programs.

Have you contacted other programs or agencies to try to meet this need?

Yes No

If yes, list where you applied and the outcome (denied, not eligible, no response, etc.):

Why are you unable to pay for this expense yourself?

Is this expense covered or reimbursed by any insurance, benefit, or organization?

Yes No

If yes, please explain:

DOCUMENTATION

Please include any supporting documentation that will help us review your request including, but not limited to:

- Estimate or invoice for the item/service - **REQUIRED**
- Doctor's note or referral (if applicable)
- Proof of efforts to seek other help (denial letters, emails, notes)
- Proof of income (optional but helpful)

AGREEMENT & SIGNATURE

I, the applicant, understand that if I am approved for financial assistance from Senior Resources of Broomfield, Inc., the funds will be paid directly to the vendor providing services, not to me personally.

I, the applicant, understand the vendor **MUST** agree to provide the services fully and completely, **PRIOR** to payment, and that it is my responsibility to coordinate the services with the vendor.

I, the applicant, indemnify and hold City and County of Broomfield and Senior Resources of Broomfield, Inc. harmless from any and all claims, disputes, liabilities, or causes of action arising out of the agreement to provide assistance or the providing of financial assistance, or arising out of services and goods sold or provided to recipients of financial assistance.

My signature below indicates my agreement to these statements and attests that the information provided in this application is true and accurate to the best of my knowledge.

I understand that submitting an application does not guarantee approval, and that this program is for one-time, urgent needs not covered by other resources.

SIGNATURE: _____ **DATE:** _____

FOR STAFF USE ONLY
Request Approved Y N
Approved Amount: _____
Approved By: _____
Date: _____
Comments: _____