



HCDO FOP #39 - ASSIST THE DEPUTY FOUNDATION

Request for Assistance

The Assist the Deputy (“ATD”) is a 501(c)(3) non-profit organization established to provide financial assistance to members of the Harris County Deputies’ Organization FOP #39 who have been injured in the line of duty, suffering a critical health illness, or who have been impacted by natural disaster or other unforeseeable condition that affects you or a current dependent.

The ATD will review and evaluate this application based solely on the information provided by the applicant. All requests for assistance will be evaluated based on need and circumstances, without regard to race, national origin, religion, gender, or sexual orientation. **No part of the application process should be considered a guaranty of benefits.** Each application must be considered and adjudicated on its own merits.

Any intentional misrepresentation or withholding of requested information may be grounds for dismissal of an application. **This form must be completed, in its entirety, and all requested information must be provided as a prerequisite for consideration of an application.** Submission of a completed application is not a guarantee of payment of benefits.

Please submit the completed application to ATD Office at 3130 North Freeway Houston, Texas 77009 or Email to assistthedeputy@hcdo.com.

The maximum amount awarded at this time is \$1,000. If anyone feels a higher amount is warranted, the application will be presented to the entire board for discussion. Awards are made at the sole discretion of the HCDO ADF board.

Privacy Policy – Each application for benefits, and all information submitted therewith, is legally privileged and confidential information which is gathered and maintained only for the consideration of the application in question. The information submitted with each application is kept confidential and any use, dissemination, distribution, or reproduction of such information is strictly prohibited.

B. Illness

Description of Illness and Financial Impact:

Estimated Recovery Time: _____

Last Day Worked: _____ Date to Return to Work: _____

C. Natural Disaster or Other Condition

Description of Loss and Financial Impact:

Estimated Recovery Time: _____

Member Signature

Date

FOR OFFICE USE ONLY

Date Received: _____ Vote of Committee: _____

Amount Awarded: _____ Check # _____

Signature

