The purpose of Rose McGill Grants is to provide confidential aid to deserving Kappa Kappa Gamma alumnae who findthemselves suddenly and unexpectedly in need. Depending on available funds, this aid is given for care and support during a one-time emergency or for an extended period of time.

Use the checklist below and complete the application. Retain a copy for your records.

|  |  |
| --- | --- |
| ☐ | Write a personal letter describing your need in detail. The letter should be specific and also detail past and current Kappa activities (e.g., adviser, alumnae association officer, etc.). |
| ☐ | Provide verification of all income and expenses listed, including Form 1040 from last year's tax return. You may send photocopies of pay stubs, checking/savings account statements, checks, bills, payment books, premium notices, etc., as verification of income and expenses. |
| Any questions may be directed to the Kappa Kappa Gamma Foundation at 866-KKG-1870 or [rosemcgill@kappa.org](mailto:rosemcgill@kappa.org). | |

Send all application materials to:

**Kappa Kappa Gamma Foundation**

6640 Riverside Drive, Suite 200

Dublin, Ohio 43017

866-KKG-1870 (toll-free)

614-228-6515

614-228-7809 (fax)

[rosemcgill@kappa.org](mailto:rosemcgill@kappa.org)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **For Kappa Kappa Gamma Headquarters Use Only** | | | | |
| Letter |  |  | Application received |  |
|  |  |  |  |  |
| Income verification |  |  | Approved by |  |
|  |  |  |  |  |
| Expense verification |  | Financial Assistance Chairman | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | |  |  | | | |  |  | | |  |  |
|  | *First* | |  | *Middle* | | | |  | *Maiden* | | |  | *Last* |
|  |  |  | |  |  |
| Marital status: | | | | | | | | Birthday: | | | | | |
|  | | | | | | | |  | | | | | |
| Address: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| City: | | | | | | State: | | | | ZIP: | | | |
|  | | | | | |  | | | |  | | | |
| Phone: | | | | | | | | Email: | | | | | |
|  | | | | | | | |  | | | | | |
| Chapter: | | | | | | | | Initiation date: | | | | | |
|  | | | | | | | |  | | | | | |
| Number of persons in household: | | | | | | | | Adults: | | | Children: | | |
|  | | | | |  | |  | | | | Ages: | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **Monthly source of income** | | | | |
| Gross income | $ | | Pension | $ |
| Net income after taxes | $ | | Alimony | $ |
| Social Security per month | $ | | Insurance | $ |
| Savings/investment income | $ | | Workers’ compensation | $ |
| Assets: balance in bank, savings and loans, etc. | $ | | Child support:  ☐ Parent ☐ Family ☐ Friends | $ |
| Other (specify) | $ | | **Total monthly income** | **$** |
|  |  | |  |  |
| **Current or most recent employer** | |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Address: | | | | | | |
|  | | | | | | |
| City: | | State: | | | ZIP: | |
|  | |  | | |  | |
| Brief job description: | | | | | | |
|  | | | | | | |
| Dates of employment: | | | | | | |
|  | | | | | | |
| **Source of debt per year** | | | | | | |
| Credit card debt | $ | | Other debt | | | $ |
| List credit cards with the amount of debt on each. (Use back if needed.) | | | | | | |
|  | | | | | | |
|  | | | |  | |  |
|  | | | | **Total debt** | | **$** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Monthly expenses** | | | | | | | |
| Rent/mortgage | | $ | | Home maintenance | | | $ |
| Taxes (other than payroll) | | $ | | Car maintenance | | | $ |
| Car payment | | $ | | Car insurance | | | $ |
| Property insurance | | $ | | Medical/dental insurance | | | $ |
| Gas/electric | | $ | | Phone/long distance | | | $ |
| Cable TV | | $ | | Computer | | | $ |
|  | | | | |  | |  |
| **Health expenses not covered by insurance** | | | | |  | |  |
| Hospital/nursing home | | $ | | Doctor/dentist | | | $ |
| Home care | | $ | | Prescriptions | | | $ |
|  | |  | |  | | |  |
| **Other** | |  | |  | | |  |
| Food | | $ | | Clothing | | | $ |
| Other (list) | | $ | | **Total monthly expenses** | | | $ |
|  | |  | |  | | |  |
| **Estimated period of time that assistance will be needed** | | | | | | | |
| ☐ Repeating | Length of time: | | | | | Amount per month: | $ |
| ☐ One time |  | |  | | | One-time gift amount: | $ |
|  |  | |  | | |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Have you received financial aid from the Kappa Foundation before? ☐ Yes ☐ No | | | | | | | | | | |
| If yes, when? | | | | | | | | How much? | | $ |
|  | | | | | | | |  | |  |
| A reference we may contact (preferably local): | | | | | | | | | | |
|  | | | | | | | | | | |
| Address: | | | | | | City: | | | | |
|  |  | | | | | | | | | |
| State: | | | | ZIP: | | Phone: | | | | |
|  | | | | | | | | | | |
| Email: | | | | | | Relationship: | | | | |
|  | | |  | | | | | | | |
| Is your reference a member of Kappa Kappa Gamma? ☐ Yes ☐ No | | | | | | | | | | |
|  | | | | | | | | | | |
| I agree to report to the Rose McGill Confidential Aid Alumnae Chairman if my financial circumstances change and/or I no longer need confidential aid. I certify that all information provided in this application is true and complete. | | | | | | | | | | |
|  | | | | | | | | | | |
| Signature: | |  | | |  | | Date: | |  | |