



## Correctional Professionals Assistance Fund of Indiana Application

Applicant's name: \_\_\_\_\_ Primary phone number: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail address, if applicable: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current facility and job title: \_\_\_\_\_ Date of hire: \_\_\_\_\_

Name of spouse, children's names and ages, and any other dependents including name, age and relationship who may reside with the IDOC employee

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of the incident and resulting loss, including applicable photos and documentation.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is applicant able to continue working? \_\_\_\_\_

If not, please describe, including last day worked and estimate date of return.

Describe any immediate family need:

\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have access to any other assistance, financial aid, insurance, or other type of help to cover the need? \_\_\_\_\_

If approved, to whom would the assistance be delivered? \_\_\_\_\_

Fill out application and send to your Superintendent  
Or fax it to;  
Correctional Professionals Assistance Fund of Indiana  
Fax #317-232-6798