Do Not Fax

Assisting Holocaust Survivors in Need

RECERTIFICATION FORM FOR EXISTING CLIENTS ONLY

Please include a cover letter from your agency's letterhead stating the following:

1. A brief Holocaust history for the client covering the years 1933-1945 with dates and places of Nazi oppression.
2. Your recommendation for The Blue Card services for the client, why you believe the service is necessary for that person, and any relevant medical or financial history regarding the client's need for assistance.
3. Statement as to why the client is not eligible for government or agency assistance and proof of any government, agency and family funding they are receiving.
4. Our forms do not replace the cover letter.

Please enclose the following proofs of income and expenses:

- *Photo ID, if we do not already have one on file*
- *Most updated award letter from SSI, SSA, SSD (any and all that are applicable)*
- *Most updated Lease/Rental agreement, Rent Increase Exemption Letter (SCRIE), (if applicable)*
- *Most updated SNAP award letter (if not receiving, please provide current asset information)*
- *Last 3 months bank statements*
- *Provide supporting documentation for the request, such as x-rays (if applicable), treatment plan, invoices or receipts, statements from a doctor, estimate from the vendor, etc.*
- *Confirmation of client's Diamond approval through your agency*

If the client is approved for a Claims Conference funded program, which includes but is not limited to medical expenses, dental expenses, rent, or funeral costs, they will receive a check in the mail. Once the check arrives, please confirm that the services for the client have been provided and the payment, funded by the Claims Conference has been allocated as requested.

Please e-mail completed recertification with subject line
2025 Blue Card Recertification
to only ONE of the below emails:

bogdana@bluecardfund.org
iliana@bluecardfund.org

All TERS requests to maya@bluecardfund.org

The Blue Card – 2025 Recertification Form for Existing Clients

SURVIVOR INFORMATION **SPOUSE INFORMATION**

Last Name: _____ First Name_____ Spouse_____

Address: _____Apt. _____City_____ST._____Zip_____Phone: _____

Social Security Number: _____ Spouse: _____

Date of Birth: _____ Spouse: _____

Place of Birth: (City, Country): _____ Spouse: _____

Single □ Married □ Widowed □ (Date of death of spouse:_____) Divorce Date _____ Separated Date _____

Number of other dependents living with you: _____

Financial Aid Request _____

Money Your Household Receives (include all living with you)

Monthly Income Survivor Spouse

Salary/Welfare **$**_____ **$**_____

SSA/SSI/SSD **$**_____ **$**_____

Nazi Restitution/ Claims Conference? **$**_____**$**_____

Pension from other countries $_____ **$**_____

Other Pensions/IRA **$**_____ **$** _____

Funds from your Agency, Family Support: **$**_____ **$**_____

Food Stamps **$**_____ **$**_____

Section 8 or SCRIE (rent subsidy) **$**_____

Medicare/Part D/Medicaid/Epic (circle)

Total of all bank accts, investments, and assets **$**_____

Did you file income taxes in 2024? Yes: ____ No: ____

Expenses (For Household)

Monthly Recurring Expenses

Health Ins/Life (circle) **$**_____

Home Ins. **$**_____

Auto Ins.$_____

Gas/Elec./Phone/Cable **$**_____

Medical/Rx **$**_____

Food **$**_____

Monthly Loan Payments (Explain) **$**_____

Rent/Mortgage (you pay after Sect 8/SCRIE) **$**_____

Other (please explain) **$**_____

Credit card(s) $_____

For Office Use Only:

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☐ **Check this box if you would like to receive phone calls from volunteers**.

Please list names, addresses & phone numbers of all your children (Use back of this form if needed):

_____

_____

_____

Name of case worker completing application: _____ **Signature:** _____

Name of agency: _____ **Phone Number:** _____

Case Worker's Email Address: _____

Applicant Signature:_____**Spouse:**_____**Date:** _____