Public Safety Memorial Fund

Supplemental Application for Benefits

The Public Safety Memorial Fund Board (Board) must consider the facts contained in this application and the amount of funds available in the Public Safety Memorial Fund, any anticipated claims against those funds when determining award amounts. The Board may request additional information be provided to assist with eligibility determinations. [ORS 243.959 & 243.962]

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Deceased/Disabled Public Safety Officer's Name: _____

DPSST #: _____

Date of Initial PSMF Eligibility Determination: _____

Applicant's Name: _____

Relationship to the Deceased/Disabled Officer: _____

Applicant's Occupation/Employer: _____

Applicant Salary: _____

Applicant's Current Marital Status: _____

Discretionary Benefits requested: (Select all that apply)

☐ **Mortgage Payments:** [ORS 243.956(7)]

- ✓ *Application for mortgage assistance must be made within the first 12 months following the date of initial eligibility determination.*
- ✓ *Proof of mortgage amount must be provided.*

1. Is the mortgage for the home of the deceased/disabled officer listed above? ☐ YES ☐ NO
2. Is there insurance on the mortgage? ☐ YES ☐ NO
3. Amount of mortgage payment: _____ per month
4. Number of payments requested: _____ (up to 12)

□ Health/Dental Reimbursement: [ORS 243.956(5)]

- ✓ *Timelines for reimbursement eligibility:*
  - *Officer: Five years*
  - *The Spouse of officer: Five years or until the spouse remarries, whichever occurs first.*
  - *Children/Dependents of the officer: Until 18 or 23 if attending school full-time (proof of enrollment required).*
- ✓ *Alternate health and dental coverage includes health and dental insurance provided by:*
  - *A current employer;*
  - *A government health care program such as Medicare of the Oregon Health Plan;*
  - *An insurance policy obtained through the Affordable Care Act exchange in effect at the time of application, is subsidized by a federal or state program and that provides coverage for the applicant at the time of the application;*
  - *An educational institution; or*
  - *Any other source that insures the applicant at the time of the application.*
- ✓ *Proof of costs and coverages for health and dental benefits for which reimbursement is being requested must be provided.*
- ✓ *Proof of coverage provided at the time of the officer's death/disability must be provided.*

1. List the eligible family members reimbursement is being requested for: (Attach additional pages if necessary)

   a. Name: _____ DOB: _____
   Relationship to Officer: _____ Age: _____
   Cost of Insurance: Health: _____ per _____
   Dental: _____ per _____
   Requested Reimbursement Amount: _____

   b. Name: _____ DOB: _____
   Relationship to Officer: _____ Age: _____
   Cost of Insurance: Health: _____ per _____
   Dental: _____ per _____
   Requested Reimbursement Amount: _____

2. Is alternate health and dental coverage available for any of the above listed family members? □ YES □ NO

□ Scholarship: [ORS 243.956(8)]

- ✓ *Proof of application and exhaustion or denial of the following benefits is required:*
  - *USDOJ Public Safety Officers' Educational Assistance Program;*
  - *Scholarships available through the Higher Education Coordinating Commission; and*
  - *US Department of Education (Free Application for Federal Student Aid)*

1. Eligible family member requesting scholarship:

   Name: _____ DOB: _____

   Relationship to Officer: _____ Age: _____

   Date of High School Graduation: _____

2. Type of Program: □ Graduate □ Undergraduate

3. Name of School Attending? _____

4. Has the student applied for and exhausted all other available education benefits? □ YES □ NO

List of other benefits applied for, expected to be received and previously awarded as a result of this death/disability, to include organization, award date and award amount. (Attach additional pages as necessary.)

_____

_____

_____

_____

List any other information relating to applicant's income or expenses that may be relevant to the Board's consideration. (Attach additional pages as necessary.)

_____

_____

_____

_____

By signing below, I swear and affirm that the information contained in this application, including all supporting documentation and information is true and correct to the best of my knowledge and belief. I understand that any and all information provided will be used by the Public Safety Memorial Fund Board (Board) to determine the award of Public Safety Memorial Fund benefits. I understand that all information submitted becomes public record under ORS 192.410 and is open to public inspection unless the Board determines that the information should be kept confidential. I understand that the Board may request additional information in order to make an eligibility determination.

_____ _____
Applicant Signature Date

_____ _____
Phone Number E-mail Address

Applicant Address: _____

_____

_____

Applicant Social Security Number*: _____

* Beneficiary Social Security Numbers (SSN) are required to be provided to DPSST. The authority for this requirement is USC 405(c)(2)(C)(i). Beneficiary SSN will be used for tax purposes only.

Please send completed form to:

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