

**Dossier de demande de soutien financier**

Dossier à faire remplir par un.e assistant.e social.e

et à retourner à l’adresse ci-dessous ou par email

**Fédération Leucémie Espoir**

23 Rue de Versailles Beaupréau 49600

BEAUPREAU-EN-MAUGES

Présidente : Françoise TILLIER

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**DEMANDE DE SOUTIEN FINANCIER**

Enquête présentée par ---------------------------, assistant.e social.e.

Hôpital/Service ----------------------------

Téléphone/Email ----------------------------

Chèque à émettre à l’ordre de ---------------------------- en cas de virement transmettre un RIB (joindre justificatif ou facture)

MOTIF DE LA DEMANDE D’AIDE

Alimentaire  Hébergement

Transport  Prestation non remboursable ou partiellement remboursée

Frais d’obsèques  Autre (préciser) --------------------------------------

DEMANDEUR

Nom Prénom -----------------------------------------------------------------------------------------------------------

Adresse --------------------------------------------------------------------------------------------------------------

Nationalité ------------------------ Sécurité Sociale (N°) --------------- Mutuelle ------------------------

**BENEFICIAIRE**

Nom Prénom ---------------------------, Date de naissance      /     /

Adresse -----------------------------------------------------------------------------------------------------------

Nationalité ------------------------ Sécurité Sociale (N°) --------------- Mutuelle ------------------------

COMPOSITION FAMILIALE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Nom** | **Prénom** | **Parenté** | **Date de Naissance** | **Activité** |
| ----------------------------  ----------------------------  ----------------------------  ----------------------------  ---------------------------- | ------------------------  ------------------------  ------------------------  ------------------------  ------------------------ | ---------------------  ---------------------  ---------------------  ---------------------  --------------------- | --/--/----  --/--/----  --/--/----  --/--/----  --/--/---- | --------------------------------  --------------------------------  --------------------------------  --------------------------------  -------------------------------- |

**--------*PARTIE RESERVEE A LA FEDERATION LEUCEMIE ESPOIR*--------**

AVIS FAVORABLE  DEFAVORABLE  MONTANT ACCORDÉ : ------------ €

CHEQUE  VIREMENT  AUTRE

N° chèque: ------------------------------

BENEFICIAIRE: ------------------------------------- AIDE ACCORDEE PAR: -------------------------------------

DATE: --/--/---- SIGNATURE:

**RENSEIGNEMENTS**

Ressources et charges

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **RESSOURCES (AVANT IMPOT)** | **MONTANT**  **AVANT LA**  **MALADIE** | | **MONTANT PENDANT LA MALADIE** | **CHARGES** | **MONTANT MENSUEL** |
| Salaire 1 | | ------ € | ------ € | Loyer / crédit immobilier | ------ € |
| Salaire 2 | | ------ € | ------ € | Charges | ------ € |
| Salaires des enfants au foyer | | ------ € | ------ € | EDF-GDF | ------ € |
| Revenus des ascendants au foyer | | ------ € | ------ € | Eau | ------ € |
| Indemnités maladie | | ------ € | ------ € | Impôts sur le revenu | ------ € |
| Pension vieillesse | | ------ € | ------ € | Taxe dhabitation / redevance | ------ € |
| Prestations familiales | | ------ € | ------ € | Taxes foncières | ------ € |
| Aide au logement | | ------ € | ------ € | Téléphone | ------ € |
| A.E.E.H. | | ------ € | ------ € | Frais liés à la scolarité | ------ € |
| A.A.H. / Pension invalidité | | ------ € | ------ € | Frais de garde | ------ € |
| RSA | | ------ € | ------ € | Assurances (habitation, scolaire, voiture) | ------ € |
| Pension alimentaire reçue | | ------ € | ------ € | Pension alimentaire versée | ------ € |
| Autres | | ------ € | ------ € | Mutuelle | ------ € |
|  | |  |  | Crédits autres | ------ € |
|  | |  |  | Frais liés à la maladie | ------ € |
|  | | TOTAL A | TOTAL B |  | TOTAL C |

Ressources mensuelles nettes avant la maladie (A - C) = ------ €

Ressources mensuelles nettes après la maladie (B - C) = ------ €

Montant du soutien financier demandé = ------ €

Autres organismes sollicités ----------------------------------------------------------------------------------------------------------------------------------------------------------------

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| --- |
| Observations :  ------------------------------------------------------------------------------------------------------------------------------------------------------------------------  ------------------------------------------------------------------------------------------------------------------------------------------------------------------------  ------------------------------------------------------------------------------------------------------------------------------------------------------------------------  ------------------------------------------------------------------------------------------------------------------------------------------------------------------------  ------------------------------------------------------------------------------------------------------------------------------------------------------------------------ |

**RENSEIGNEMENTS**

Compléments de la page ressources si besoin

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**RAPPORT SOCIAL**

Compte rendu de l’enquête sociale

Joindre le certificat médical sous enveloppe

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