THE DENVER BAR ASSOCIATION
WATERMAN TRUST FUND
1900 Grant Street, Suite 950
Denver, Colorado 80203-4309

☐ INITIAL APPLICATION (or)
☐ PERIODIC REVIEW APPLICATION

This Application is being made for financial assistance under the Will of Anna Rankin Waterman, deceased

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Date: _____

Name: _____
First Middle Last

Residence: _____
Number and Street City State Zip code

Own or Rent?_____. Landlord's Name:_____; Telephone: _____

Applicant's Telephone: _____; Fax: _____; e-mail: _____

Applicant's Age: _____ Birth date: _____

Date Admitted to Practice (Colorado): _____ Registration Number: _____

I have engaged in the practice of law in Colorado during the following times, with the firms listed and at the addresses shown:

The following Colorado lawyers have knowledge of my circumstances and may be contacted for information as to my circumstances:

Name	Address	Telephone

My federal and state income tax returns for the previous year are attached (This is Required).

Where did you learn about the Waterman Fund? _____

Please state why you are applying for assistance from the Waterman Fund:

Are any disciplinary proceedings pending against you through the Colorado Supreme Court Office of Regulatory Counsel? _____ If "yes" please explain:____

_____

If you are ill, disabled, or otherwise incapacitated, please describe your physical or mental condition, supported by a current doctor's report, which is attached. If this is a Periodic Review Application, please state any changes in condition since the last application):

The following persons are dependent upon me for support:

Name	Relationship	Age

The names, office addresses and telephone numbers of my primary care providers and specialists are:

_____

_____

Have you applied for SSDI or any other government or private assistance programs? If so, what is the current status of those applications? If not, please explain.

How long beyond this application period do you anticipate continuing to ask for Waterman Fund support? Please explain.

MY ASSETS:

My Assets and Their Approximate Market Value	**Applicant**	**Spouse**	**Joint**
1. Cash:	$_____	$_____	$_____
2. Bank accounts:			
Location: _____	$_____	$_____	$_____
Location: _____	$_____	$_____	$_____
3. Automobiles:			
Description: _____			
Value: $_____			
Lien:$_____			
Equity:	$_____	$_____	$_____
Description: _____			
Value: $_____			
Lien:$_____			
Equity:	$_____	$_____	$_____
4. Residence:			
Value: $_____			
Liens: $_____			
Equity:	$_____	$_____	$_____
5. Other real estate:			
Description: _____			
_____			
Value: $_____			
Liens: $_____			
Equity:	$_____	$_____	$_____
6. Individual Retirement Accounts:			
(IRA, SEP IRA, Keogh, etc.)	$_____	$_____	$_____
7. Business or Government Retirement Accounts:			
Specify:_____	$_____	$_____	$_____
8. Stocks, Bonds, Securities:	$_____	$_____	$_____
9. Life Insurance Cash Value:			
(Please complete Attachment A)	$_____	$_____	$_____
10. Law Practice or Business Assets:	$_____	$_____	$_____
11. Receivables	$_____	$_____	$_____
12. Other:_____ Specify	$_____	$_____	$_____
	Applicant	**Spouse**	**Joint**
TOTAL ASSETS:	**$**_____	**$**_____	**$**_____

MY INCOME:

My Sources of Income	**Monthly Amount**
1. Salary	$_____
2. Law Practice or Business: (Please complete Attachment B)	$_____
3. Other self-employment income:	$_____
4. Social Security Benefits:	$_____
5. SSDI/Government Assistance	$_____
6. State Pension Plan or Programs:	$_____
7. Military Benefits: Specify: _____	$_____
8. Individual Retirement Account Withdrawals: (IRA, SEP/IRA, Keogh, etc.)	$_____
9. Business or Government Retirement Payments:	$_____
10. Annuities:	$_____
11. Worker's Compensation:	$_____
12. Rental Income:	$_____
13. Interest:	$_____
14. Dividends:	$_____
15. Disability Insurance Payments:	$_____
16. Spouse's Income, if any: Sources: _____	$_____
17. Other (specify source and kind, including income from trusts, oil or gas leases, income in kind, etc.):	
_____	$_____
_____	$_____
_____	$_____
18. All other contributions to household expenses or income, including from roommates, relatives and friends:	$_____
TOTAL MONTHLY INCOME	**$**_____

MY ACTUAL EXPENSES (PERSONAL/NON BUSINESS EXPENSES):

My Personal (non-business) expenses	Monthly Amount
1. Rent or Mortgage Payment (PITI):	$_____
2. R.E. Taxes & Insurance (Not included above)	$_____
3. Utilities:	
Gas & Electric	$_____
Telephone, cell phone	$_____
Water & Sewer	$_____
Internet & Cable	$_____
4. Insurance Premiums (Attachment A):	
Health:	$_____
Life:	$_____
Long Term Care:	$_____
5. Medical/Dental not covered by insurance:	$_____
6. Prescription Drugs not covered by insurance:	$_____
7. Hospitalization not covered by insurance:	$_____
8. Nursing Home not covered by insurance:	$_____
9. In Home Care Providers not covered by insurance:	$_____
Provider:_____	
9. Clothing:	$_____
11. Food:	$_____
12. Transportation:	
Public Transportation:	$_____
Automobile Expenses:	
Payment:	$_____
Auto Insurance:	$_____
Maintenance & Repair:	$_____
13. Maintenance or Child Support	$_____
14. Credit Cards (Specify):	
_____	$_____
_____	$_____
15. Other Installment obligations:	
_____	$_____
16. Other Expenses:	
_____	$_____
TOTAL MONTHLY EXPENSES	**$**_____

RECAPITULATION

MONTHLY AMOUNT REQUEST

TOTAL MONTHLY INCOME: $_____

TOTAL MONTHLY ACTUAL EXPENSES: $_____

EXCESS OF MONTHLY ACTUAL EXPENSES OVER MONTHLY INCOME: $_____

MONTHLY AMOUNT REQUESTED FROM WATERMAN FUND: $_____

SINGLE AMOUNT REQUEST

AMOUNT REQUESTED FROM WATERMAN FUND: $_____

ADDITIONAL COMMENTS: _____

_____

_____

APPLICANT'S CERTIFICATION AND AGREEMENT

I certify that the information provided in this Application is correct. I understand that the Waterman Fund Administrators (the "Administrators") will rely on the information in this Application in determining whether any benefits will be awarded to me under the Waterman Fund (the "Fund").

I understand and agree that the Fund is established for the sole and only purpose of relieving the financial necessities, assuaging the hardships and lightening the financial burdens of aged, infirm or otherwise incapacitated members of the Colorado Bar, in good repute and standing, and who shall have practiced law in Colorado for a period of at least ten years prior to being a recipient of any of the benefits of the Fund.

I understand and agree that the Fund, the Administrators, the Denver Bar Association, and the officers and trustees of the Denver Bar Association, have no legal obligation to me or to any of my creditors, or to my spouse or dependents, if any, or to any of their creditors.

I understand and agree that all benefits under the Fund are paid solely at the discretion of the Administrators, not as a matter of legal right capable of enforcement by me.

I understand and agree that the benefits of the Fund are not in lieu of any other public or governmental assistance that I may be entitled to receive. I certify that I have made proper applications, where applicable, for all federal and state public assistance programs, including but not limited to Social Security benefits, Social Security Disability Income, Medicare, Medicaid, Military or Veterans Administration benefits, and any appropriate state assistance.

I understand and agree that all benefits awarded shall be subject to review, and to reduction, cancellation, reapplication, or increase by the Administrators at any time, and in making such review the Administrators shall give consideration to any new evidence brought to or coming to their attention, to total demands on the Fund, and to any and all other relevant evidence, knowledge or facts.

I agree that I will inform the Administrators of the Fund of any additional income received after the submission of this Application, whether one-time or continuing, within one month of receipt of the income.

I consent to be interviewed by the Administrators or their representatives. Any representative is fully authorized to report to the Administrators all communications between such representative and myself.

Date: _____ _____

Signature of Applicant

MEDICAL RELEASE (HIPAA Compliant)
(Release records to Administrators, Waterman Trust Fund, or Their Representatives)

Patient Name	Date of Birth

The following health provider is authorized to provide medical records and disclose patient identifiable health information:

The above named health provider is authorized to discuss my medical treatment and health information with:
The Administrators, Waterman Trust Fund, or their representatives

The above named health provider is NOT authorized to discuss my medical treatment or health information with:.
___Unknown_____ INSURANCE COMPANIES

The scope of the health information to be provided or disclosed is as follows:
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

The health information is authorized to be provided to:
ADMINISTRATORS, WATERMAN TRUST FUND Denver Bar Association 1900 Grant Street, Suite 950 Denver, CO 80203-4309 Telephone: 303-824-5319; Facsimile: 303-861-5274; Email: jmbauer@cobar.org

The patient identifiable health information received pursuant to this release authorization is to be used for the following purpose.
Application to the Waterman Trust Fund for financial assistance under the Will of Anna Rankin Waterman, deceased.

RIGHT OF REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to the Administrators, Waterman Trust Fund, or their representatives. The revocation will not apply to records and information that have already been provided.

EXPIRATION: Unless earlier revoked, this authorization will expire six months after the date of this release.

PATIENT RIGHTS: I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in CFR 164.528.

My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care, or my ability to enroll for benefits will not be affected.

RE-DISCLOSURE: I understand that there is a potential for unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules.

PHOTOCOPIES OF THIS RELEASE ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

DATE:_____ BY:_____

Name: _____

Supreme Court Office of Attorney Regulation
Attn: John S. Gleason
Regulation Counsel
Dominion Plaza Building
600 – 17th Street, Suite 3055
Denver, CO 80202

WAIVER OF CONFIDENTIALITY AND AUTHORIZATION

I have made application to the Waterman Trust Fund for financial assistance under the Will of Anna Rankin Waterman, deceased.

I waive all rights of confidentiality of the disciplinary records of the Colorado Supreme Court, as maintained by the Supreme Court Office of Attorney Regulation and do hereby give permission to the Office of Attorney Regulation to respond to inquiries by the Administrators of the Waterman Trust Fund, or their representatives, pertaining to my good repute and standing at the bar.

I authorize the Supreme Court Office of Attorney Regulation to forward to the Administrators of the Waterman Trust Fund all information concerning any pending or completed disciplinary actions against me. This information should be sent directly to the Administrators as follows:

Administrators
Waterman Trust Fund
Denver Bar Association
1900 Grant Street, Suite 950
Denver, CO 80203-4309.

This waiver of confidentiality is made pursuant to Rule 251.31 of the Colorado Rules of Procedure Regarding Attorney Discipline and Disability Proceedings.

A photocopy of this waiver and authorization will have the same force and effect as an original executed copy.

Date: _____

_____
Attorney Signature

_____
Attorney Name Printed or Typed

_____
Attorney Registration Number

ATTACHMENT A

INSURANCE POLICIES

LIFE INSURANCE POLICIES

Company:
Date Purchased:
Insured:
Beneficiary:
Term/Whole Life/Group:
Face Value: $ (i.e. amount paid at death of insured)
Cash Value: $ (i.e. amount paid if policy were cashed in now)
Annual Premium: $

Company:
Date Purchased:
Insured:
Beneficiary:
Term/Whole Life/Group:
Face Value: $ (i.e. amount paid at death of insured)
Cash Value: $ (i.e. amount paid if policy were cashed in now)
Annual Premium: $

Company:
Date Purchased:
Insured:
Beneficiary:
Term/Whole Life/Group:
Face Value: $ (i.e. amount paid at death of insured)
Cash Value: $ (i.e. amount paid if policy were cashed in now)
Annual Premium: $

Company:
Date Purchased:
Insured:
Beneficiary:
Term/Whole Life/Group:
Face Value: $ (i.e. amount paid at death of insured)
Cash Value: $ (i.e. amount paid if policy were cashed in now)
Annual Premium: $

HEALTH OR LONG TERM CARE INSURANCE POLICIES

Company and Address:
Policy Number:
Family Members Covered:
Monthly Premium: $

Company and Address:
Policy Number:
Family Members Covered:
Monthly Premium: $

ATTACHMENT B

STATEMENT OF INCOME AND EXPENSE
LAW PRACTICE OR OTHER BUSINESS
_____, 20__ to _____, 20__.

(Note: Your most recent business tax return
may be submitted in lieu of this statement)

GROSS RECEIPTS **$**_____

EXPENSES:

Rent	$_____
Telephone	$_____
Internet Services	$_____
Other Utilities	$_____
Library, Subscriptions	$_____
Professional Liability Insurance	$_____
Office Supplies and Equipment	$_____
Secretarial/Staff	$_____
Dues	$_____
Continuing Education	$_____
Advertising	$_____
Automobile (mileage)	$_____
Other (Specify):	
_____	$_____
_____	$_____
Taxes	$_____
TOTAL EXPENSES:	**$**_____

NET PROFIT (NET LOSS) **$**_____