



## **Warren Lupel Lawyers Care Fund**

The Illinois Bar Foundation's Warren Lupel Lawyers Care Fund offers economic aid to lawyers and/or their spouses or dependents who because of age, illness or other circumstances find themselves in financial distress. The Lawyers Care Fund seeks to ensure that its recipients have adequate housing, food and basic medical care. Funding from the IBF should be considered short-term and supplemental, and it is not intended to be a recipient's primary or long-term method of support. Monthly payments are generally in the range of \$200-\$1,000. The Fund is considered a program of last resort. Please apply for any government assistance prior to submitting this application.

The Lawyers Care Fund Committee supports individuals and/or families of individuals (1) who are or were admitted to practice law in Illinois by the ARDC and primarily practiced law in Illinois and (2) who are seeking aid for reasons other than unemployment as an attorney. For more details on the Lawyers Care Fund Guidelines for Support, see page 2. If you have any questions about whether or not you qualify for support, please contact Illinois Bar Foundation staff in advance of filling out this application.

**Application Process:** Once your application has been received in full and reviewed to ensure it meets the baseline criteria for support, one or two members of the Committee will reach out to you to arrange an in-person or phone interview. After the interview, the Committee will review the case in detail and make a determination on support. IBF staff or your assigned Committee member will then notify you of the funding decision. Please note that this process generally takes two (2) months or more. We appreciate your patience during the process. Should you have an emergency requiring expedited consideration, please advise IBF staff as soon as possible. This application and supporting documentation must be completed in its entirety. Failure to supply the information requested may result in the application being denied or returned to you and will delay its processing. The information that you provide in this application will remain confidential and is only discussed by the Lawyers Care Fund Committee.

If you have any questions regarding this application or the approval process, please contact Jessie Reeves at 312.726.6072 or [jreeves@illinoisbarfoundation.org](mailto:jreeves@illinoisbarfoundation.org).

Please submit this application and all required attachments to:

Illinois Bar Foundation  
Lawyers Care Fund  
20 South Clark, Suite 910  
Chicago, IL 60603

Or by email to: [jreeves@illinoisbarfoundation.org](mailto:jreeves@illinoisbarfoundation.org)

## **Lawyers Care Fund Guidelines for Support**

The Illinois Bar Foundation's Lawyers Care Fund is intended to provide support for Illinois lawyers and their families who have fallen on hard times. Funding is not unlimited and meeting the following criteria is essential.

### The following criteria apply in order to qualify for support:

- Applicants must have had a meaningful practice in Illinois. A meaningful practice means the applicant:
  - Was registered with the ARDC during their years of practice AND
  - Represented Illinois clients on a regular basis OR
  - Worked for the federal government and were not required to register with the ARDC and had a meaningful practice in Illinois
  - NOTE - Non-attorney immediate family members (dependents and/or spouses) of deceased attorneys who meet the criteria above are eligible to apply for support
- Applicants must be registered with the ARDC if they are practicing law in Illinois
- Absent a compelling situation, applicants must live in Illinois during the time they apply for and receive support
- There is a preference for applicants that were / are members of the ISBA and who are / were donors to the IBF

### Applicant / Applicant Family Need

- Applicants must have sufficient need to justify support. Need may include:
  - Serious, diagnosed physical, mental or emotional health issues, whether temporary or permanent, which reduce or eliminate the ability of the applicant to support him/herself or to support his/her family
  - NOTE - The Foundation does not require that applicants be destitute or near-destitute before they are eligible. However, in recognition of the charitable nature of our mission the Foundation will consider lifestyle of the applicant during a determination of eligibility or level of support
  - Applicants may be eligible for support when providing for care to spouses, dependent children or dependent parents with severe physical, mental or emotional health issues

### Funding Considerations

- Funding is reviewed at least yearly and sometimes more frequently, as determined by the Lawyers Care Fund Committee or its representatives
- Applications are considered on a case-by-case basis
- Funding is not unlimited and, even when granted, is subject to revision at the sole discretion of the Committee
- Funding is not intended to provide indefinite support and, absent compelling reasons, will not exceed three years
- Recipients should demonstrate progress toward self-sufficiency
- Support may be contingent upon conditions deemed appropriate by the Committee, including but not limited to supplying additional financial information; participation in counseling programs; consultation with attorneys, financial or tax professionals, etc.

### Additional Considerations

IBF generally will not consider funding attorneys who have had their law license involuntarily suspended or revoked by the ARDC. Funding in these cases may be conditioned upon participation by the applicant in the Lawyers Assistance Program or some other counseling or assistance program.

For applicants with a history of substance abuse or mental health issues, the IBF has a preference for those who have undertaken a treatment program with licensed professionals and have an established track record of success in such a recovery program. Support may be conditioned on participation in such a program and may require the signing of appropriate waivers to allow regular compliance checks by IBF staff.

**I. Applicant (Please note if you are filling out this application on another's behalf)**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

E-mail address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age at Application \_\_\_\_\_

Name of Individual Completing Application (if different than applicant): \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Legal Guardian/Caretaker (if applicable) \_\_\_\_\_

Legal Guardian/Caretaker Phone/Email \_\_\_\_\_

**II. Attorney Status**

☐ I am an attorney licensed in Illinois with the ARDC

☐ I was an attorney licensed in Illinois with the ARDC

☐ I am an attorney, but not licensed in Illinois

☐ I was an attorney, but never licensed in Illinois

Date of Bar Admission \_\_\_\_\_

☐ I am a member of the Illinois State Bar Association

☐ I was a member of the Illinois State Bar Association

If applicable, describe your bar activities \_\_\_\_\_

\_\_\_\_\_

☐ I am a spouse or dependent of an attorney licensed in Illinois

☐ I was a spouse or dependent of an attorney licensed in Illinois

☐ I am a spouse or dependent of an attorney not licensed in Illinois

☐ I was a spouse or dependent of an attorney not licensed in Illinois

Attorney's name \_\_\_\_\_

Years of active practice in Illinois \_\_\_\_\_

**III. Employment Status**

☐ I am currently employed

Current Employer \_\_\_\_\_

☐ I am currently unemployed

Previous Employer \_\_\_\_\_

☐ I am unable to work due to health reasons

Current or Former Employer Information:

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Immediate Supervisor \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

(3) \_\_\_\_\_

[illegible]

## VII. Treating Physicians

Please list the name and address of any treating physicians

Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## VIII. Medical Waiver

Periodically, the Illinois Bar Foundation verifies conditions with treating physicians. Please indicate whether or not you give the IBF permission to contact your treating physician(s). Should the IBF need to contact your treating physicians, you may be required to sign additional appropriate waivers.

☐ I give the Illinois Bar Foundation staff or elected member of its committee permission to verify my condition(s) with my treating physician(s) listed in section VII and am willing to sign additional appropriate waivers as needed.

☐ I do not give the Illinois Bar Foundation staff or an elected member of its committee permission to contact my treating physician.

## IX. Request

☐ I am requesting a single lump sum payment of \$ \_\_\_\_\_

☐ I am requesting short-term monthly support in the amount of \$ \_\_\_\_\_ for \_\_\_\_\_ months

☐ I am requesting ongoing monthly support in the amount of \$ \_\_\_\_\_

Reason for request (please use an additional page if need be)

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If support is provided by the Foundation, will any other sources of income be discontinued? ☐ YES ☐ NO

Describe \_\_\_\_\_  
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### **X. Additional Information**

Please provide any pertinent information bearing on the needs of the applicant (please use an additional page if need be)

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### **XI. Attachments**

Please complete and attach the following documents:

- (1) Copy of your most recent tax return OR IRS Form 4506T Request for Transcript of Tax Return for a Verification of Non-Filing

### **XII. Certification**

The undersigned applicant hereby affirms the validity of the matters asserted on this application.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please submit this application and all required attachments to:**

Illinois Bar Foundation  
Lawyers Care Fund  
20 South Clark, Suite 910  
Chicago, IL 60603

Or by email to [jreeves@illinoisbarfoundation.org](mailto:jreeves@illinoisbarfoundation.org)

If you have any questions, please call the IBF at 312.726.6072.

# Illinois Bar Foundation

## Lawyers Care Income & Expense Statement

Please provide as much information as possible. If any information is not applicable, please leave that field blank.

### PERSONAL FINANCIAL STATEMENT

ASSETS	TOTAL VALUE	LIABILITIES	TOTAL VALUE
Cash on Hand and in Banks	<hr/>	Credit Cards (Detail in Schedule)	<hr/>
Stocks and Bonds	<hr/>	Notes and Accounts Due to Others (Detail in Schedule)	<hr/>
401(K) or Other Retirement Accounts	<hr/>	Taxes Due	<hr/>
Life Insurance (Face Value)	<hr/>	Rent Due	<hr/>
Real Estate (Detail in Schedule)	<hr/>	Real Estate Mortgages (Detail in Schedule)	<hr/>
Household Furniture (Market Value)	<hr/>	Leins on Real Estate	<hr/>
Jewelry, Art, Silver, China, Etc. (Market Value)	<hr/>	Medical or Hospital	<hr/>
Automobile (Market Value)	<hr/>	Note on Auto	<hr/>
Accounts Receivable from Firm	<hr/>		
Other Assets/Anticipated Windfall		Other Liabilities	
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
TOTAL ASSETS	<hr/>	TOTAL LIABILITES	<hr/>



SCHEDULES					
<div>REAL ESTATE</div> <p>Title to all real estate listed should be in your name solely, jointly, or in common expect as shown hereon.</p>					
LOCATION & SIZE	TITLE HELD IN NAME OF	PURCHASE PRICE	ASSESSED VALUE	MONTHLY PAYMENTS	MORTGAGE BALANCE
<div>DEBTS</div>					
NAME OF LENDER		COLLATERAL	MONTHLY PAYMENTS	BALANCE	

## ACCOUNTS

Please list all checking accounts, saving accounts, certificates of deposit, mutual funds, or any other accounts or investments which you own or have rights in such.

INSTITUTION	TYPE OF ACCOUNT OR INVESTMENT	AMOUNT
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## STOCKS AND BONDS

All securities should be your's solely, and are in your possession except as shown, hereon.

ISSUING CORPORATION AND TYPE OF SECURITY	NO. OF SHARES/FACE VALUE	ANNUAL INTEREST OR DIVIDEND	MARKET VALUE	REGISTERED IN NAMES OF
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APPLICANT INCOME

ITEM	AMOUNT PER MONTH
Professional fees	
Salary, bonuses, or commission	
Spouse's salary	
Rents	
Social Security	
Pension, 401(K), or otherretirement benefits	
Disability benefits	
Other Public Aid (please list)	
Other support/recipients	
TOTAL	

## APPLICANT EXPENSES

ITEM	AMOUNT PER MONTH
Mortgage (including taxes) or Rent Payment	<hr/>
Homeowners/Rental Insurance	<hr/>
Child Support Payments	<hr/>
Utilities	
Electric	<hr/>
Gas	<hr/>
Water	<hr/>
Telephone	<hr/>
Refuse Disposal	<hr/>
House Maintaince	
Landscaping	<hr/>
Repairs and Decorating	<hr/>
Auto	
Car Payment	<hr/>
Insurance	<hr/>
Gas	<hr/>
Maintenance/Repairs	<hr/>
Medical	
Insurance	<hr/>
Doctor/Dentist	<hr/>
Prescriptions	<hr/>
Groceries	<hr/>
Meals Eaten Out	<hr/>
Clothing	<hr/>
Recreation	<hr/>
Other (please list)	
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
TOTAL	<hr/>

## EXPENSES FOR SPOUSE, MINOR, OR DEPENDENTS

### SPOUSE

ITEM	AMOUNT PER MONTH
Clothing	<hr/>
Grooming	<hr/>
Insurance	<hr/>
Medical Care	<hr/>
Auto/Transportation Expenses	<hr/>
TOTAL	<hr/>

### MINOR CHILD(REN)

ITEM	AMOUNT PER MONTH
Clothing	<hr/>
Education	<hr/>
School Lunch	<hr/>
Medical Care	<hr/>
Personal Allowance	<hr/>
TOTAL	<hr/>

### DEPENDENT(S)

ITEM	AMOUNT PER MONTH
Clothing	<hr/>
Grooming	<hr/>
Medical Care	<hr/>
Other Expenses	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
TOTAL	<hr/>