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

---

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 doctors 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:

____

____

____

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. State Pension Plan or Programs:	$______________
6. Military Benefits: Specify: ___________________________	$______________
7. Individual Retirement Account Withdrawals: (IRA, SEP/IRA, Keogh, etc.)	$______________
8. Business or Government Retirement Payments:	$______________
9. Annuities:	$______________
10. Worker's Compensation:	$______________
11. Rental Income:	$______________
12. Interest:	$______________
13. Dividends:	$______________
14. Disability Insurance Payments:	$______________
15. Spouse's Income, if any: Sources: _________________________	$______________
16. Other (specify source and kind, including income from trusts, oil or gas leases, income in kind, etc.):	
_________________________________	$_____________
_________________________________	$_____________
_________________________________	$_____________
17. 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

WAIVER OF CONFIDENTIALITY AND AUTHORIZATION

I authorize my physicians and all health care providers to disclose information as to my physical and mental condition to the Administrators, Waterman Trust Fund, or their representatives, hereby waiving the physician-patient privilege of confidentiality.

This information may be sent directly to the Administrators, Waterman Trust Fund, Denver Bar Association, 1900 Grant Street, Suite 950, Denver, CO 80203-4309.

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

Date: ________________

____
Signature

____
Name Printed or Typed

____
Address

____

____
Telephone

____
Social Security Number

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)		**$_____________**