

The Friends Foundation Dripping Springs, Texas

Application for Financial Assistance

Name _____ Sex: Male _____ Female _____ Date of Birth _____

Social Security No. _____ Medicare No. _____ Medicaid No. _____

Supplemental Insurance Policy _____

Telephone No. (Home) _____ (Work) _____ (Other) _____

Address _____

(Must be in D.S.I.S.D or greater Dripping Springs Area)

City _____ Zip Code _____

Address of domicile _____

Spouse Name _____ Sex: Male _____ Female _____ Date of Birth _____

Social Security No. _____ Medicare No. _____ Medicaid No. _____

Telephone No. (Home) _____ (Work) _____ (Other) _____

Do you receive financial assistance from anyone? _____

Closest relative not living with you _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

Who is responsible for you? _____

In what way are they responsible for you? _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

Total Yearly Income \$ _____

Source(s) of this income _____

Please attach a copy of your most recent tax return.

Other agency benefits now receiving _____

Church affiliation _____

Would you consent to a home visit to assess need? Yes _____ No _____

Have you requested help from another source? If so, who _____

Response from that source _____

Reason for financial request? _____

Amount requested _____

I hereby certify that the information above is true to the best of my knowledge. I will cooperate fully with verification of my application. I will not sell any of the supplies that I may receive.

Applicant Signature _____ Date _____

Witness Signature _____ Date _____

CONSENT TO RELEASE INFORMATION

I, the undersigned, hereby give my consent for The Friends Foundation to obtain any and all personal information which they deem necessary in order to process my Application for Financial Assistance.

Signature

Date

Printed name

Social Security Number