# ***APPLICATION FOR ASSISTANCE***

***NAME:_____*** ***DATE:_____***

***ADDRESS: _____***

***TOWN: _____***

***TELEPHONE #: _____***

***SOCIAL SECURITY #: _____-_____-_____***

***NATURE OF DISABILITY AND/OR NEED FOR ASSISTANCE:***

_____
_____
_____
_____
_____

***MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED***

***NUMBER OF DEPENDENTS AND RELATIONSHIP (including yourself)***
***(indicate sex, age and whether a member of your immediate household):***

_____
_____
_____
_____
_____
_____

***A. FINANCIAL STATUS:***

***PRESENT INCOME:***

***SALARY: $_____*** ***PENSION: $_____***

***SOCIAL SECURITY: $_____*** ***DISABILITY: $_____***

***INTEREST/DIVIDENDS: $ _____*** ***OTHER: $_____***

# *APPLICATION FOR ASSISTANCE*

## *ASSETS:*

***BANK ACCOUNTS: $_____*** ***STOCKS & BONDS: $_____***

***REAL ESTATE: $_____*** ***LOCATION: _____***

***AUTOMOBILES: $_____*** ***YEAR & MAKE: _____***

***$_____*** ***YEAR & MAKE: _____***

***INDIVIDUAL RETIREMENT ACCOUNTS $ _____***

***OTHER: $_____***

## *LIABILITIES:*

***MORTGAGE: $_____*** ***MONTHLY PAYMENT: $_____***

***AMOUNT OF MORTGAGE PAYMENTS PRESENTLY DELINQUENT: $_____***

***LOANS: $_____*** ***LENDER:_____***

***$_____*** ***LENDER:_____***

***CHILD SUPPORT: $ _____***

***OUTSTANDING BILLS:***

***1. _____*** ***$ _____***

***2. _____*** ***$ _____***

***3. _____*** ***$ _____***

***CREDIT CARD BILLS:***

***1. _____*** ***$ _____***

***2. _____*** ***$ _____***

***3. _____*** ***$ _____***

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## *B. MEDICAL STATUS*

***OUTSTANDING BILLS:***

_____

_____

_____

_____

***HOSPITAL:*** _____ ***$*** _____

_____ ***$*** _____

***DOCTORS:*** ***NAME:*** _____ ***$*** _____

***NAME:*** _____ ***$*** _____

***NAME:*** _____ ***$*** _____

***NAME:*** _____ ***$*** _____

***HEALTH INSURANCE PLAN:*** _____

***WILL ANY OF THE ABOVE MEDICAL BILLS BE REIMBURSED THROUGH HEALTH INSURANCE COVERAGE?*** _____.

***IF YES, AMOUNT OF COVERAGE: $*** _____

***ARE YOU ELIGIBLE FOR MEDICARE?*** _____

***ARE YOU ELIGIBLE FOR MEDICAID?*** _____

***LIST BELOW THE TYPE AND AMOUNT OF ASSISTANCE YOU ARE REQUESTING:***

_____

_____

_____

_____

_____

_____

_____

## ***APPLICATION FOR ASSISTANCE***

***GENERAL INSTRUCTIONS:***

***All requests and claims for assistance on this application must be fully documented with bills and other proof of need. Requests for assistance will be subject to investigation, and will become the property of a confidential file of the Volunteer and Exempt Firemen's Benevolent Association of Wantagh, Nassau County, New York.***

## ***PLEASE ATTACH A COPY OF LAST YEAR'S 1040 FEDERAL INCOME TAX FORM***

***This application must be given to an Officer or Trustee of this Association two (2) weeks prior to a scheduled meeting of the association in order to be processed. Emergency requests can be made at any time to a Board member or Trustee.***

***The undersigned hereby affirms that all of the foregoing information is true and correct, made for the sole purpose of obtaining aid and assistance form the Volunteer and Exempt Firemen's Benevolent Association of Wantagh, Nassau County, New York.***

***APPLICANT'S SIGNATURE:*** _____

***DATE OF SIGNATURE:*** _____

***The undersigned also grants permission for this association to request a credit check from an authorized supplier.***

***APPLICANT'S SIGNATURE:*** _____

***DATE OF SIGNATURE:*** _____

* * * * * * * * * * * * * * * * * * * * * * * * * * * * *

### ***ACTION BY THE BOARD OF TRUSTEE'S***

***AMOUNT PAID: $*** _____ ***DATE:*** _____

***CHECK #'S:*** _____ ***SIGNED:*** _____