



A 501C(3) Non-profit Women's Organization

WOV FINANCIAL ASSISTANCE REQUEST APPLICATION

INSTRUCTIONS: Please read the entire application form including the attached "Criteria For Financial Assistance". Print your answers clearly. MAIL TO: WOV; P.O. BOX 513; Temple Hills, MD 20757. This becomes a valid application once you enter your name and address, sign the form. You may have someone help you complete this form for you or on your behalf. We may have to meet with you in order to process your application. If you need additional space, attach a separate sheet of paper and identify which question(s) you are answering.

If you need us to provide an interpreter, check here What language: _____

WHAT KIND OF ASSISTANCE ARE YOU REQUESTING? Check all that apply:

- Groceries Utilities(Gas, Heat, Electric, Water) Medical (Hosp/Dr. Bills/RX) Insurance Premium (Auto or Health)
 Childcare Clothing Other _____

What Assistance Period are you applying for: 1 Month 2 Consecutive Months (max. per calendar year)

"Only 1 Creditor/Provider of Service per month will be paid, but you can list up to 3 for us to consider (\$200 maximum payout for 1-Month and \$400 maximum payout for 2 consecutive months)."

(1) Who is the specific creditor/provider of service the funds would be paid to:

Name: _____

Full Billing Address: _____

Amount of Bill: \$ _____ Your Account/Billing Number: _____

If late, please give a brief explanation:

(2) Who is the specific creditor/provider of service the funds would be paid to:

Name: _____

Full Billing Address: _____

Amount of Bill: \$ _____ Your Account/Billing Number: _____

If late, please give a brief explanation:

(3) Who is the specific creditor/provider of service the funds would be paid to:

Name: _____

Full Billing Address: _____

Amount of Bill: \$ _____ Your Account/Billing Number: _____

If late, please give a brief explanation:



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WHY DO YOU NEED ASSISTANCE FROM WOV'S FUND? Due to Medical Illness/Treatment Due to Family Crisis
After checking which reason, please elaborate on your condition:

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Do you have the supporting documents for your request: Yes No

What supporting documents are being attached to this application:

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First Name	Middle Initial	Last Name	
Home Address	City	State	Zip Code
Mailing Address (if different)	City	State	Zip Code
Home Phone Number ()	Cell Phone/Pager Number ()		
Maiden Name or Previous Names Used	Name and Phone Number of Emergency Contact		
Are you currently Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes-Name of Employer:	Employer Location (only City and State):		

OPTIONAL - Indicate the race. Select all that apply. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. This information will not be used in determining eligibility for assistance. If you do not provide this information, it will not affect your application. We ask for the information to assure that benefits are distributed without regard to race, color or national origin. If you do not enter any information the worker will enter an answer to the race and ethnicity questions.

- American Indian or Alaska Native Asian Black or African American
- Native Hawaiian or Other Pacific Islander White Other
- Do you also consider yourself Hispanic/Mexican American? Yes No

COMPLETE THE FOLLOWING IF YOU HAVE AN EMERGENCY

Do you have an eviction notice? Yes No

Have your utilities been shut off or do you have a shut off notice? Yes No

Are you out of heating fuel (propane, oil)? Yes No

Do you need immediate assistance with food? Yes No

Do you have another kind of emergency which threatens your health or safety? Yes No If yes, explain:

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HAVE YOU APPLIED FOR/RECEIVED ANY ASSISTANCE FROM OTHER SOURCES SUCH AS:

Applied For	Rece		Unearned Income Type	Paid To	How Much? How Often?	Claim Number Address
	Yes	No				
			Contributions or Gifts/Money from Friends or Relatives			
Assistance Payments FROM (List below, if previously from WOV, please list as well):						

FOR OFFICE USE ONLY

After careful consideration of the Financial Assistance Board, we have unanimously approved to provide financial assistance for the following:

Creditor/Provider of Service Name	Mailing Address	Account #	Check # & Date	Amount
				\$
				\$

Approval Signatures:

Name: _____ Title: _____ Date: _____

Name: _____ Title: _____ Date: _____

Name: _____ Title: _____ Date: _____

Action	Date	By
Mailed to Creditor/Provider of Service on		
Copy of Approved Application		
Letter of Denial		