



UNITED WAY EMERGENCY & HOMELESSNESS PREVENTION FUND

 Name of Applicant Age Marital Status Phone Number Email Address

 Address City Zip Code

 Place of Employment Address Phone Number

 Spouse's Place of Employment Address Phone Number

FAMILY MEMBERS LIVING IN THE HOME

OTHERS IN HOUSEHOLD

<u>Spouse</u>			
Name	age	Name	Relation
<u>Children</u>			
Name	age	Name	Relation
_____	_____	_____	_____
Name	age	Name	Relation
_____	_____	_____	_____
Name	age	Name	Relation
_____	_____	_____	_____
Name	age	Name	Relation
_____	_____	_____	_____
Name	age	Name	Relation

INCOME FROM ALL SOURCES	AMOUNT	Weekly__ Monthly__	AMOUNT
Wages, Salary, Tips, Commissions		Pensions	
Self-Employment		Unemployment Insurance	
Child Support Payments		Social Security Disability	
Income from lodgers/boarders		S.S.I.	
N.Y.S. Disability Payments		Survivor's Benefits	
Social Security/Retirement		Veteran's Benefits	
Contribution for Shelter/Utilities		Worker's Compensation	
Temporary Assistance		Other (Specify)	

TOTAL INCOME _____



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EXPENSES	WEEKLY	MONTHLY	ANNUALLY	IN ARREARS
Rent__ Mortgage__				
Utilities Heat				
Phone				
Electric				
Taxes				
Medical Bills				
Car Payment/Upkeep				
Life Insurance .				
Health Insurance				
Loans				
Food				
Clothing				
Child Care				
Other (Specify)				

TOTAL EXPENSES _____

Information provided below is not used to determine eligibility for receipt of grant funds.

Does anyone in your household smoke? Yes ___ No ___

Have you ever applied for Temporary Assistance? Yes ___ No ___

Have you ever received Temporary Assistance? Yes ___ No ___

Are you presently receiving Temporary Assistance? Yes ___ No ___

If yes, name of your Case Worker and phone number: _____

DO YOU HAVE ANY OF THESE PROBLEMS?



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Date: _____

Fuel or Power Shut-off	Yes___ No___	No food	Yes___ No___
Pending Eviction	Yes___ No___	Serious Medical Problem	Yes___ No___
Recently Lost Income	Yes___ No___	Urgent Family Problems	Yes___ No___
No Place to Stay	Yes___ No___	Other	Yes___ No___

ESTIMATED AMOUNT NEEDED: _____

REASON FOR APPLICATION FOR ASSISTANCE: (print clearly or attach type-written response)

PRINT CASE MANAGER/INTAKE WORKER NAME

CONTACT INFORMATION (TELEPHONE/E-MAIL)

Grant Approved: _____ Amount: \$ _____ Date: _____

PRINT NAME, ADDRESS, AND PHONE # OF PAYEE/VENDOR: _____

Grant Denied: _____ Reason: _____

Revised 4/20/2020