

Friends In Need

F O U N D A T I O N

APPLICATION FOR ASSISTANCE – PART 1

Please complete the following questionnaire for review by the Friends in Need (FIN) Benefits Committee. Also, complete financial information requested in Parts 2 and 3. Please mail completed forms to the post office box listed at the bottom of the page.

Date of application: _____

Family/individual in need of assistance: _____

Contact person's name: _____

Contact person's address: _____

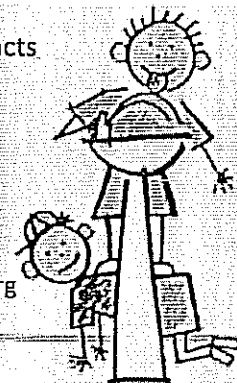
Contact person's phone: cell: _____ other: _____

Contact person's e-mail address: _____

Please describe applicant's medical condition in detail (attach additional pages if necessary). Include any other documents that may assist FIN in reviewing your application (reports or letters from physicians listing short-term and long-term prognosis are helpful).

List items and amounts for which grant applicant is seeking financial assistance (attach additional pages if necessary). Attach supporting documents.

Friends in Need reserves right to request additional information or to independently verify the facts stated above with physicians or other professionals.



FRIENDS IN NEED FOUNDATION, INC.
APPLICATION FOR ASSISTANCE - PART 2
MONTHLY INCOME AND EXPENSES (attach additional pages if needed)

APPLICANT'S NAME: _____

**LIST AMOUNTS AS OF DATE OF
APPLICATION**

COMMENTS

MONTHLY HOUSEHOLD INCOME:		
Wages (after taxes)		
Interest, dividends		
Other investment income (net of expenses)		
Retirement income		
Social security income		
Other income (list type and amount):		
TOTAL MONTHLY INCOME		
MONTHLY HOUSEHOLD EXPENSES:		
Mortgage or rent payments		
Property taxes		
Homeowners/renters insurance		
Electricity		
Gas		
Telephone		
Water		
Cable TV		
Cellular phone		
Car payments		
Car insurance		
Other transportation		
Groceries		
Medical/dental/vision care and insurance		
Personal care (clothing, hair care, etc.)		
Credit card payments		
Child care expenses		
Tuition expenses:		
Elementary education		
Secondary education		
Higher education		
Other expenses (list type and amount):		
TOTAL MONTHLY EXPENSES		

By signing below applicants certify accuracy of above information:

Applicant: _____ Applicants spouse: _____

FRIENDS IN NEED FOUNDATION, INC.
APPLICATION FOR ASSISTANCE - PART 3
PERSONAL/FAMILY FINANCIAL STATEMENT (attach additional pages if needed)

APPLICANT'S NAME: _____

SECTION 1:

LIST AMOUNTS AS OF DATE OF APPLICATION

ASSETS:

Cash in banks (checking and savings)		
Investments in stocks, bonds		
Estimate of fair market value of home		
Estimate of fair market value of vehicles		
Retirement savings value		
Other assets (list type and amount):		

TOTAL ASSETS

LIABILITIES:

Home loan debt (amount owed on mortgage)		
Vehicle loan debt (amount owed on vehicle loan)		
Credit card debt		
Other liabilities (list type and amount):		

TOTAL LIABILITIES

SECTION 2:

List below cost of medical care anticipated over the next twelve months net of insurance coverage. Please provide details of the type of care, special medical equipment needed and the expected date of need:

By signing below applicants certify accuracy of above information:

Applicant: _____ Applicants spouse: _____