Reference #_____

Individual/Family Application for Assistance

Date of Request: _____

Recommended by: _____ Phone #(_____) _____

Applicant Name (First, MI, Last): _____

Marital Status: _____ Gender: M F Race: _____ Ethnicity: _____

Address: _____

City, State Zip: _____ County: _____

Mailing Address (if different from above): _____

_____

Phone # (_____) _____ Secondary Phone # (_____) _____ Email:_____

FAMILY/HOUSEHOLD INFORMATION

of people in household (including yourself): _____ Are you/your spouse employed? Y N If yes, please list below, including telephone number of employer: _____

_____

Are you currently receiving assistance from any other program? Y N If yes, please list below: _____

_____

ASSISTANCE REQUEST

Using the space below, give a brief description of the assistance requested:

_____

_____

_____

_____

_____

_____

Reference #_____

REFERENCES

Please list below the name, phone number, and relationship to you of three people we may contact to verify the information given above. At least one of these must be unrelated. Social workers, pastors, and employers are acceptable references.

1. _____
2. _____
3. _____

Are any references from out of state? Y N If so, which one(s): _____

PROGRAM REQUIREMENTS

Please read each statement below carefully. Initial each line after you have read and agreed to the requirements of this program.

_____ 1. A valid photo ID is required for each person (one per family) receiving assistance from What Would Bob Do, Inc. A copy of this ID will be kept on file with each application. Additional information may also be requested based on need.

_____ 2. All information submitted on this application is subject to verification by the board of directors and its appointed agents of What Would Bob Do, Inc.

_____ 3. If after investigation the board of directors deems it necessary, drug testing may be required by one or more members of the household before any awards will be made.

_____ 4. If after investigation the board of directors deems it beneficial, a social work referral may be made to ensure assistance is given that reaches beyond the scope and mission of What Would Bob Do, Inc.

I certify under penalty of perjury that the statements on this application are true and correct and that I have read and understand the program requirements.

Signature: _____ Printed: _____ Date: _____

Signature of Witness: _____ Printed: _____ Date: _____

WWBD STAFF USE ONLY

Date application rcvd: _____ Initials of WWBD rep: _____ Case File #:_____

APPROVED: _____ _____ _____ _____ DENIED: ____ Date: _____ Reason for denial: _____