## Application for Assistance from the Committee for the Families of War <u>Veterans Program</u>

## Dear Applicant

We ask that you fill out this application to help us determine if you qualify for monetary assistance from our organization. Please fill out this application completely and as accurately as possible. If you need assistance we will provide help for you. All information obtained in this application will be kept confidential.

Person applying for appli	cant [if not Applicant]:		
Applicants Name:			
Street Address:			
		State:	
Zip Code:	Home Phone:		
Cell Phone:	DOB:	Marital Status:	
Current Employment:_			
	ationship to applicant, age]		
Please explain your need	l:		

PHONE: 800-221-4742 FAX: 845-271-3446

EMAIL: DANO@OKANEENTERPRISES.COM & FRONTDESK@OKANEENTERPRISES.COM

MAIL: COMMITTEE FOR THE FAMILIES OF WAR VETERANS

55 WEST RAILROAD AVE., BLDG. 24C – FIRST FLOOR, GARNERVILLE NY 10923

<u>Please forward copies of debts/income and DD214 with application.</u>
Assistance excludes personal transportation vehicles and credit card debt.

Expenses	Weekly/ Month	Gross Income	Weekly/Monthly
Rent/ Mortgage		SSI	
Electricity		Disability	
Gas		Comp & Pen	
Heating Fuel		Child Support	
Car Payment		Wages Applicant	
Car Insurance		Wages Spouse	
Health Insurance			
School Lunches			
Food			
Child Care			
Credit Card debt			
Student Loans			
Medical			
Other (Please specify)			
	Total Expenses:		Total Income:
Please include signature	e to verify that the inf	 Formation contained in	n this application is va
Signature:		Date:	

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