



UESF HEALTH & WELFARE APPLICATION



Applications Ongoing from October 1st through November 26, 2021

ONE TIME ONLY ASSISTANCE UP TO \$1,000.00
ONLY CURRENT UESF MEMBERS MAY APPLY

Name of Applicant: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Years in San Francisco School District: _____ From: _____ To: _____

Position Held: _____

School of Current or Last Assignment: _____

Age: _____ Marital Status: _____ SFUSD ID# _____

Financial Status / Assets: (Please state amounts)

Savings: _____

Checking: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION

I. MONTHLY INCOME:

1. All Monthly Household Wages \$ _____

2. Social Security \$ _____

3. Disability Income \$ _____

4. Other (please specify) \$ _____

Total Household Monthly Income \$ _____

II. MONTHLY EXPENSES:

- 1. Rent / Mortgage \$ _____
- 2. Property Taxes \$ _____
- 3. Utilities \$ _____
- 4. Telephone/cell/internet/cable \$ _____
- 5. Medical } Out of pocket \$ _____
- 6. Dental } \$ _____
- 7. Food \$ _____
- 8. Transportation \$ _____
- 9. Other (please specify) \$ _____

Total Monthly Expenses \$ _____

- III. **Brief Statement of Need:** *(please attach statement)*
- IV. **Provide proof of medical or dental urgency, if applicable.**
- V. **Please include copies of pages 1 and 2 of your most current IRS 1040 tax form.**
- VI. **Paraeducators and Substitutes will have a \$6.00 application fee deducted from any awards:** *(no fee necessary if not selected for funding).*

Email completed application to:	
Bracha Israel UESF Administrator	bisrael@uesf.org

Under penalty of perjury, I certify that the above statement is true and complete to the best of my ability, and I have not omitted any assets, nor have I excluded any sources of income from this statement.

Date

Signature of Applicant

The Committee will keep all information on the application strictly confidential.