UESF HEALTH & WELFARE APPLICATION

Applications Ongoing from January 1st through November 15, 2023

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 } Out of pocket $_____
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 winnings: ***(only if selected for funding).***

Mail or Email complete application to:	
Health & Welfare Fund c/o UESF **2310 Mason St., 2nd Floor** **San Francisco, CA 94133**	**galmanza@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.