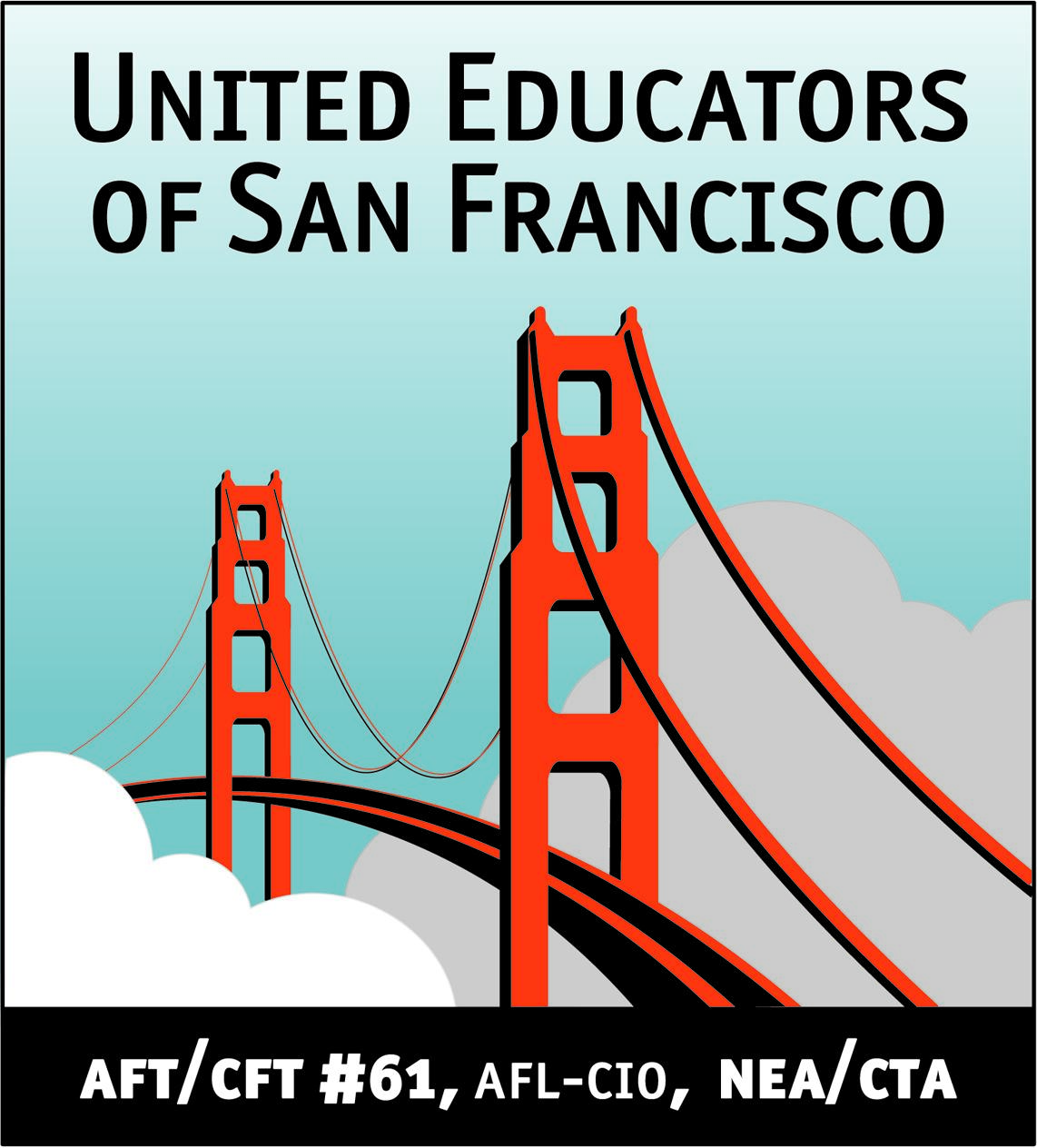
UESF HEALTH & WELFARE APPLICATION 

**ONE TIME ONLY ASSISTANCE UP TO $1,000.00**

**ONLY CURRENT UESF MEMBERS MAY APPLY**

Please allow for a month for the Health & Welfare Committee to review all applications received in a month.

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.**

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