UNITED EDUCATORS OF SAN FRANCISCO
AFT/CFT #61, AFL-CIO, NEA/CTA
2310 Mason Street San Francisco, CA 94133 415-956-8373 www.uesf.org UESF61 @UESF @UnitedEducatorsofSF

UESF HEALTH AND WELFARE FUND APPLICATION

ONE-TIME PER DECADE ASSISTANCE UP TO **$1,000**
ONLY CURRENT UESF MEMBERS MAY APPLY

*In order for the Health & Welfare Committee to review your application, please submit **ALL requirements** listed below. The Committee may take **up to a month** to review all applications after submission.*

1. **This completed application** (Please fill out *all* sections to the best of your ability.)
    a. UESF members of at least *6 months* are eligible to apply.
2. **Statement of Need** (can be submitted as a separate document)
    a. If you would also prefer to speak to us about your situation in addition to submitting a separate document, please contact the UESF Office at 415-956-8373 and ask for Geri Almanza.
    b. If applicable, please provide proof of medical or dental urgency.
3. **Copies of pages 1 and 2 of your most recent IRS 1040 tax form**.

TELL US MORE ABOUT YOUR EMERGENCY.

A. Rate the severity of your situation from 1 to 5: _____
Examples:
    - 1 - You are behind on paying off your credit card bills.
    - 5 - Your house burned down.

B. Check all that apply:
    - ☐ Medical or dental emergency (yours or a loved one)
    - ☐ Divorce or separation
    - ☐ Car problems

APPLICANT INFORMATION

Full Legal Name: _____

Address: _____

City: _____ Zipcode: _____

Cell Phone: _____ Home Phone: _____

Personal Email Address: _____

SFUSD ID#: _____

Years in SFUSD: _____ From: _____ To: _____

Current Position: _____

School of Current or Last Assignment: _____

Age: _____

Marital Status: _____

FINANCIAL STATUS/ASSETS: (Please state amounts or write 0 if none.)

Savings: _____

Checking: _____

INCOME: Check which payroll schedule applies to you.

- ☐ Monthly
- ☐ Biweekly

A. All Household Wages: $_____

    1. Number of People You are Financially Responsible for: _____

B. Social Security: $_____

C. Disability Income: $_____

D. Other (please specify): $_____

TOTAL MONTHLY INCOME: $_____

MONTHLY EXPENSES:

E. Rent / Mortgage: $_____

F. Property Taxes: $_____

G. Utilities: $_____

H. Telephone/Cell/Internet/Cable: $_____

I. Medical (Out-of-Pocket): $_____

J. Dental (Out-of-Pocket): $_____

K. Food: $_____

L. Transportation: $_____

M. Other (please specify): $_____

TOTAL MONTHLY EXPENSES: $_____

Before you submit, do you have all requirements listed:

- ☐ This completed application
- ☐ Statement of Need
- ☐ Copies of pages 1 and 2 of your most recent IRS 1040 tax form

If **yes**, please:

Mail or Email complete application to:	
Health and Welfare Fund % UESF 2310 Mason St., 2nd Fl 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.