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

Virginia Scatena Memorial Fund Application

ONE TIME ONLY ASSISTANCE TO UESF MEMBERS OF 6+ MONTHS, GRANT VARIES

Applications Due by 5:00 p.m. on **Friday, November 13, 2026**

In order for your application to be reviewed by the Scatena Committee, please include **all** requirements:
1. **This completed application** (Please fill out *all* sections to the best of your ability.) 2. **Statement of Need** (can be submitted as a separate document) a. Describe your current situation that requires you to apply for this fund. Feel free to include any details you deem necessary to support your statement. 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**.

APPLICANT INFORMATION

Name of Applicant: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone #:_____

SS#: _____

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 or write 0 if none.)

Savings: _____ Bonds:_____

Real Estate:_____ Stocks: _____

Checking:_____

Liabilities: (Please state amounts) _____

Notes: _____

Charge Accounts: _____ Mortgages: _____

Other: _____

Total Monthly Income (from reverse) $_____

Total Monthly Expense (from reverse) $ _____

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

I. **MONTHLY INCOME**:

1. Monthly Wage $_____
2. STRS/City Pension $_____
3. Other Pension $ _____
4. STRS Supplemental $_____
5. Social Security $ _____
6. Disability Income $_____
7. Investments $ _____
8. Spouse/partner household income $ _____
9. Other (please specify) $_____

Monthly Total: $_____

II. **MONTHLY EXPENSES**:

1. Rent / Mortgage $ _____
2. Property Taxes $_____
3. Utilities $ _____
4. Telephone/cell/internet/cable $_____
5. Medical $ _____
6. Out-of-Pocket Dental $_____
7. All insurance (including medical & dental) $ _____
8. Food $ _____
9. Transportation $_____
10. Other (please specify) $_____

Monthly Total: $ _____

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 _____

Mail or Email complete application to:	
Scatena Memorial Fund c/o UESF 2310 Mason St., 2nd Floor San Francisco, CA 94133	epaningbatan@uesf.org