Application for Assistance from the Committee for the Families of War Veterans Program

Dear Applicant

We ask that you fill out this application to help us determine if you qualify for monetary assistance from our organization. Please fill out this application completely and as accurately as possible. If you need assistance we will provide help for you. All information obtained in this application will be kept confidential.

Person applying for applicant [if not Applicant]: _____

Applicants Name: _____

Street Address: _____

City: _____ **State:** _____

Zip Code: _____ **Email Address:** _____

Cell Phone: _____ **Home Phone**: _____ **DOB:** _____

Current Employment: _____ **Marital Status**: _____

Dependents/People who reside with you: [Names, relationship to applicant, age]

_____
_____
_____
_____
_____

Please explain your need:

_____
_____
_____
_____
_____
_____
_____
_____
_____

PHONE: 800-221-4742
FAX: 845-271-3446
EMAIL: DANO@OKANEENTERPRISES.COM & FRONTDESK@OKANEENTERPRISES.COM

MAIL: COMMITTEE FOR THE FAMILIES OF WAR VETERANS
55 WEST RAILROAD AVE., BLDG. 24C – FIRST FLOOR, GARNERVILLE NY 10923

Please forward copies of debts/income, supporting current bills/documents, and DD214 with application.

Expenses	*Weekly/ Month*	*Gross Income*	*Weekly/Monthly*
Rent/ Mortgage	_____	**SSI**	_____
Electricity	_____	**Disability**	_____
Gas	_____	**Comp & Pen**	_____
Heating Fuel	_____	**Child Support**	_____
Car Payment	_____	**Wages Applicant**	_____
Car Insurance	_____	**Wages Spouse**	_____
Health Insurance	_____		
School Lunches	_____		
Food	_____		
Child Care/Support	_____		
Credit Card debt	_____		
Student Loans	_____		
Medical	_____		
Other (Please specify)	_____		
	_____		
	Total Monthly Expenses:		***Total Monthly Income:***
	_____		_____

Please include signature to verify that the information contained in this application is valid.

Signature: _____ Date: _____

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