

WOMEN IN ACTION
FAMILY HEALTH CARE & EDUCATION ASSISTANCE APPLICATION

Applicant Name: _____ Date of Birth: _____

SSN: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Parents Name (If different than applicant): _____

Date of Birth: _____

SSN: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Annual Gross Household Income: below \$15,000 _____ \$15,000-\$25,000 _____ \$25,000-\$35,000 _____ \$35,000-\$45,000 _____

\$45,000-\$55,000 _____ \$55,000-\$65,000 _____ \$65,000-\$75,000 _____ above \$75,000 _____

Family Size: _____ Ages and Names of dependent Children: _____

Do you currently have any insurance? YES / NO (circle one)

If yes, please provide company name _____

On the back of this application please describe your total request for assistance as well as any additional information that you feel would support your request for assistance