Black River Good Neighbor Services, Inc.

APPLICATION FOR ASSISTANCE

All Information must be filled in on this sheet, front and back.
We will not pay Overdue Bills, Telephone, Cable TV, or Satellite TV Bills.
Only One Member of a Household is Eligible to Apply for Assistance at a time.
Every application for assistance will be reviewed every six months to see if you are still eligible.

Date_________________ Name of Client _______________________________________

Address ____Phone _________________
(Entire Street Address including Zip)

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Name of any other adults/children living in same household:

First and Last Name; Age

________________________________ ____________________________________
First and Last Name; Age First and Last Name; Age

________________________________ ____________________________________
First and Last Name; Age First and Last Name; Age

Referred by: ______________________________ Why: ____________________________

Type of assistance needed: ____
(Rent , Fuel, Food, Etc. Please include dollar amount.)
For Rent Assistance we need to know the name, address and phone number of the landlord:

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For Fuel/ Utility assistance we need a copy of a current bill. (No Past Due Bills Will Be Paid)

Regular Monthly Expenses: Propane _______ Lights________ Fuel Oil ________ Other_________
All payments are made directly to the provider of the service you are asking for assistance with.
We are an emergency food shelf. We will supply enough food for four days for each person in the household. Food can only be obtained once a month and only for six months. At the end of six months your file will be reviewed to see if you are eligible for further assistance.
Food Given On:

Date Signature of Client Date Signature of Client

Date Signature of Client Date Signature of Client OVER>

Financial Statement Must Be Completed In Full for Assistance

Employed By: ____
(Full name and mailing address including phone and zip)

Income From above Employer $__________________________ (Weekly/Monthly)
Aid to Dependent Children $__________________________ (Weekly/Monthly)
Food Stamps or Other Public Assistance $__________________________ (Weekly/Monthly)
Unemployment Compensation $__________________________ (Weekly/Monthly)
Workers Compensation $__________________________(Weekly/Monthly)
Court Ordered Support – Child or Spousal $__________________________(Weekly/Monthly)
Social Security or SSI/Disability $__________________________ (Weekly/Monthly)
Pensions, Dividends, Annuities $__________________________(Weekly/Monthly)
Any other income from a member of the household? $ _________________________(Weekly/Monthly)
WIC Yes______ NO______

Total Income: Client/family/household: $__________________________ (Weekly/Monthly)

Do you own or Rent your residence? ___________- Monthly Rent/Mortgage______________

Show any pertinent information below that applies to your request for help

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I agree by signing this application and affirm that all the above information is true and complete to the best of my knowledge. I also give my permission to the Director or a Board Member to consult with other agencies as an advocate on my behalf.

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Signature of Client

The information below will be filled in by the Director or whoever reviews this application,

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____________________________________ ________________________________

Signature of Reviewer Date