Request For Assistance & Release

Please Print This Form To Complete.

INSTRUCTIONS: Please read the WeAreAlive 'Assistance' page on this website for assistance guidelines. A complete and valid application under the guidelines saves time in processing the request. Print this form and complete. Please print clearly. If the print out is more than one page long, be sure to sign the bottom of all pages. If you have a case worker helping you with this package, give the completed form to him or her to submit for you. If you do not have a case worker, then submit this form with the required attachments to WeAreAlive. If you have a scanner, you can scan the documents and email them to requests@WeAreAlive.org. If you do not have access to a scanner, you can mail the documentation to We Are Alive, Inc., 14427 Brook Hollow, #165, San Antonio, Texas 78232. (Note: Processing takes longer when the documentation is mailed.) If you need help completing this form, please email your questions to requests@WeAreAlive.org.

Last Name:_____ First Name:_____ MI:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:(____)____-_____ Fax Number:(____)____-_____
Cell Phone:(____)____-_____ Pager:(____)____-_____
Work Phone:(____)____-_____ Extension #:_____ Work Hours:_____-_____
Email Address:_____@_____
Social Security #:_____-____-_____ Birth Date:___/___/___ (month/date/year)
Valid Picture ID #:_____ ID Type:_____ Issuing State:_____
Do You Have A Social Worker? _Yes _No
...If Yes: Name:_____ Agency Name:_____
.....Agency Phone #:(____)____-_____ Extension #:_____
...If No: Why don't you have a social worker?
.....
Primary Assistance Amount Requested:$_____ Describe Request Below:
_____
_____
Secondary Assistance Amount Requested:$_____ Describe Request Below:
_____
_____
Have You Applied For The Requested Assistance With A Government Agency?
..._ Yes _ No - If Yes List Result Or If No List Why Not:
_____
Have You Applied For The Requested Assistance With A Charity Specific To Your Illness Or Specific To Your Need?
..._ Yes _ No - If Yes List Result Or If No List Why Not:
_____
List Any Health Insurance:_____
Number Of Persons In Your Household: Age 18 & Over:_____ Under Age 18:_____
Number Of Persons In Your Household Who Are Employed:_____
Your Employer:_____ Contact:_____
...Employer Phone Number:(____)____-_____ Extension #:_____

ASSETS:
Value Of House(s) Owned:$_____ Value Of Real Estate Owned:$_____
Checking Account Balance:$_____ Other Bank Account Balances:$_____
Stocks & Bonds:$_____ Vehicles:$_____
List The Policy Value Death Benefit And Cash Value Of All Life Insurance Policies:
_____
List All Other Assets:_____
_____
INCOME:
Your Total Gross Monthly Income Before Taxes: $_____
Your Net Monthly Income After Taxes:$_____
Social Security Income: $_____ Income From Dividends:$_____
List Other Income:_____
Gross Monthly Income Of All Household Members Without Yours: $_____
Net Monthly Income Of All Household Members Without Yours: $_____
MONTHLY EXPENSES FOR ENTIRE HOUSEHOLD:
Rent:$_____ -OR- Mortgage:$_____
Electricity:$_____ Gas Utilities:$_____ Water:$_____ Phone:$_____
Transportation Expenses:$_____ -OR- Gasoline:$_____ + Car Pmt:$_____
Food:$_____ Clothing:$_____ Out Of Pocket Medical Expenses: $_____
Other Necessary Living Expenses (List Each Item With Monthly Amounts.):
_____
_____
Any Other Information That You Would Like To Tell Us About (Attach If Necessary):
_____
CHECK LIST FOR ATTACHMENTS REQUIRED:
_1) Letter from your physician within the past six (6) months stating that you have a terminal illness or a life threatening severe chronic illness that is an ongoing serious disability and what the illness is and what type of care you need.
_2) Copy of your social security card.
_3) Copy of your valid state or federal picture identification or the photo & name page of your US Passport.
_4) Any back up that you may have for the assistance that you are requesting, for example; lease & rent statement, utility bills, prescription costs, etc.
_5) Copies of your sources of income (payroll check stub, W-2, 1099, etc.
_6) Copies of requests and denials from other sources for the assistance that you are requesting.

RELEASE:
I hereby give We Are Alive, Inc. permission to contact and discuss my case with anyone listed on this request, on the documents I provide, that I verbally provide or that is necessary to contact to process my request. I understand that if my request is approved, that We Are Alive, Inc. does not pay me directly, but pays my vendors or providers. I understand that We Are Alive, Inc.'s name and logo on their checks, stationary, forms, etc. as well as their check memo which will reference my name, social security number and type of assistance, will more than likely make it known to my vendors or providers that I have a terminal or severe chronic illness. I understand that We Are Alive, Inc. does what it can within reason to keep my medical information confidential outside the area of providing assistance to me, but that We Are Alive, Inc. can not guarantee that my information will remain confidential. By signing this document and requesting assistance I hereby release We Are Alive, Inc., its board members, its officers, its volunteers, its staff, its consultants and its members from any liability or claims whatsoever that I may have now or in the future. I certify that the information that I have provided to We Are Alive, Inc. is complete and correct. If I fax or email this form, I agree that my faxed or scanned signature is to be treated as my original signature.

Signature:X_____ Date:___/___/___ (month/date/year)

If the recipient above is not able to sign or is under the age of 18, the recipient's legal guardian must sign below, hereby confirming the statements made hereon and agreeing to the terms and conditions stated hereon.

Signature:X_____ Date:___/___/___ (month/date/year)