We Are Alive Application for Assistance

NAME:_____ SOCIAL SECURITY#:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE #:_____

DRIVER'S LICENSE OR OTHER GOVERNMENT ISSUED PICTURE ID#:_____

MEDICAL USED FOR CARE NAME:_____

DOCTORS NAME:_____

REASON FOR MEDICAL CARE OR HOSPITALIZATION:_____

_____

ARE YOU ABLE TO WORK, IF NOT, WHY?_____

_____

DO YOU HAVE ANY INCOME?_____

IF NOT, HOW ARE YOU PAYING YOUR BILLS?_____

_____

WHAT IS YOUR REQUEST FOR?_____

HOW MUCH IS THE REQUEST FOR?_____

WE ARE LIMITED TO $300 ONCE A YEAR AT THIS TIME. THIS CAN BE BROKEN UP INTO SMALLER AMOUNTS FOR SEVERAL PAYMENTS IF NEEDED. WE ONLY ASSIST THOSE WITH MEDICAL CONDITIONS, HOWEVER, WE CAN REFER YOU IF WE ARE UNABLE TO ASSIST.

SIGNED BY THE REQUESTER:_____

PRINT YOUR NAME:_____

DATE OF REQUEST:_____

EMAIL OF REQUESTOR:_____

IF ADDITIONAL INFORMATION IS NEEDED TO EXPLAIN YOUR SITUATION, PLEASE SUBMIT ALONG WITH YOUR FORM.

- ***INCLUDE A COPY OF YOUR PHOTO ID TO YOUR REQUEST.***
- ***INCLUDE A MEDICAL INFOMRATIN PAGE TO YOUR REQUEST.***
- ***INCLUDE A COPY OF THE BILL YOU NEED PAID TO YOUR REQUEST.***

IMPORTANT INFORMATION
NO FUNDS ARE GIVEN DIRECTLY TO THE CLIENT, SOCIAL WORKER OR ORGANIZATION. FUNDS GO DIRECTLY TO THE VENDOR, LANDLORD OR LADY, PHARMACY OR OTHER PERSON REQUESTING PAYMENT.

SIGNATURE:_____ DATE:_____

MAIL TO:
WE ARE ALIVE, INC.
2400 MCCULLOUGH AVE #12273
SAN ANTONIO, TX 78212
PHONE NUMBER 210.737.1411