

**FINANCIAL ASSISTANCE APPLICATION FOR ESSEX COUNTY &
UNION COUNTY RESIDENTS ONLY.**

OTHER SERVICES OPEN TO ALL NEW JERSEY RESIDENTS

Date Submitted:

Amount Requested _____ Amount Awarded _____



CONTACT AND EMPLOYMENT INFORMATION

Name	
Address, Phone & Email	
Are you receiving disability insurance payments? If yes, Start Date, End(ing) Date:	
Employer	
Employer Address	
Employer Phone/Email	

ASSISTANCE YOU ARE REQUESTING

Please check all that apply, and the amount(s) requested. We will need a copy of current bills, last 2 pay stubs (for rent/utility support), and all receipts for transportation/childcare.

Utilities (Electric/Gas/Water/Sewer) _____ Telephone/Cable _____	Insurance copay/Prescription _____
Transportation _____ Child Care _____	Rent/Mortgage _____
Grocery _____	Misc. _____ (must explain)

MEDICAL CONTACTS

PLEASE LIST ALL YOUR DOCTOR' S CONTACT INFORMATION AND DATES OF SERVICE IF POSSIBLE.

MEDICAL CIRCUMSTANCES:

Please list the date of diagnosis of the patient, treatments and/or date completed.

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DESCRIBE THE REASON(S) YOU ARE REQUESTING THIS ASSISTANCE:

SUMMARIZE YOUR SUPPORT REQUEST OR FINANCIAL NEED

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ALL PERSONS LIVING IN YOUR HOME

Please include full name, age, and employment information if employed

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AGREEMENT AND SIGNATURE

BY SUBMITTING THIS APPLICATION, I AFFIRM THAT THE FACTS SET FORTH IN IT ARE TRUE AND COMPLETE. I UNDERSTAND THAT IF I AM GRANTED ASSISTANCE, ANY FALSE STATEMENTS, OMISSIONS, OR OTHER MISREPRESENTATIONS MADE BY ME ON THIS APPLICATION MAY RESULT IN IMMEDIATE CRIMINAL CHARGES.

Name (printed)	
Signature	
Date	

OUR POLICY

IT IS THE POLICY OF THIS ORGANIZATION TO PROVIDE EQUAL OPPORTUNITIES WITHOUT REGARD TO RACE, COLOR, RELIGION, NATIONAL ORIGIN, GENDER, SEXUAL PREFERENCE, AGE, OR DISABILITY.

CHECK LIST: _____ APPLICATION COMPLETED & SIGNED

ALL required documents are attached: YES _____ NO _____

Information Missing:

Application approved or rejected (please circle one) By _____

Date _____ Amount approved _____

Comments _____



Post Office Box 150, Montclair, NJ 07042

(p) 1-888-589-8035 (f) 1-888-552-8437

info@aangelsnj.org www.aangelsnj.org