Application for Assistance

Date: _____

Last Name:	**First Name:**	**DOB:**

Address:		**Apt. #:**
City:	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	
Email Address:		
Physician's Name:	**Are you currently covered by Health Insurance, Medicare, or Medicaid?** **Yes** ☐ **No** ☐	

HOUSEHOLD INCOME

Net Employment Income *(After Taxes)*
Welfare, SSI, SDI, Etc.
Unemployment Compensation
Other Income *(Child Support, Etc.)*
Total Income:

Women Rock, Inc. may require verification of income such as paystubs, income tax returns, etc. You must provide this verification when requested. If you fail to provide the requested documentation upon request, or have falsified information in order to obtain financial assistance from Women Rock, Inc., you will be required to repay the full cost of the services provided through Women Rock, Inc.

HOUSEHOLD COMPOSITION

Please indicate the number of persons supported by this income

Adults (18+)	**Children (Under 18)**

Please list any extraordinary circumstances that might affect your ability to pay

I verify that all of the information on this application is true and correct. I understand that a false answer to any portion of this application may jeopardize any benefits I am receiving or will receive from Women Rock, Inc.

_____ _____

SIGNATURE **DATE**

Applications May Be Mailed To: Women Rock, Inc. 225 E. Houston Street - Sherman, Texas 75090 - (903) 487-2528