Be Well My Friends (BWMF) specific purpose is to raise money for people, organizations, and charities of Downriver which require financial assistance by creating and hosting unique fundraising events.

Anyone requesting financial support must complete this form to be eligible for BWMF's services. Please print clearly or type. Completed forms should be mailed to Be Well My Friends at 2435 15th, Wyandotte, MI 48192 or emailed to bewellmyfriends501c@gmail.com. Please call (734) 530-1569 and ask for Brian if you have any questions.

Today's Date (MM/DD/YYYY): | **ALL FIELDS ARE REQUIRED**

APPLICANT'S INFORMATION (IF DIFFERENT THAN DONATION RECIPIENT)

Last Name:	First Name:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone: ( )	Cell Phone: ( )	Email:	Can our administrative team text your cell phone? ❑ Yes ❑ No

Preferred Contact Method: (multiple selections okay) Home Phone ❑ Cell Phone ❑ Email ❑	Birth date: / /	Age:	Sex: ❑ M ❑ F	Person in need of help is: Child ❑ Adult ❑

Street Address\Apt.:	City:	State:	Zip:

Michigan County of Residence:

Race:

❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

❑ Hispanic or Latino ❑ Middle Eastern or Arab American

❑ Native American or Other Pacific Islander ❑ White or Caucasian ❑ Prefer Not to Answer

Employment:

❑ Employed- Employer Name________________________________ ❑ Unemployed ❑ Retired ❑ Disabled

❑ Student ❑ Other_________________________________

Veteran Status: ❑ Yes ❑ No Comments: ____

TOTAL HOUSEHOLD INCOME

Mark below your **total income,** including alimony and child support, of **all** persons living in the household. You must provide copies of the following for anyone in the household with income: **1.)** past 3 months checking and savings, Venmo, CashApp, PayPal and any other banking sources and **2.)** your most recent Federal 1040 Income Tax Return. Medical bill invoices or utility statements may be requested to support your outstanding debt. To determine eligibility for financial assistance, BWMF uses the Michigan ALICE Survival Budgets Annual Totals [**https://www.unitedforalice.org/state-overview/Michigan**], not the Federal Poverty Level.) Please mark below your total household income:

❑ $0-$10,000 ❑$10,000-$20,000 ❑ $20,000-$30,000 ❑ $30,000-$40,000 ❑ $40,000-$50,000

❑ $50,000-$60,000 ❑ $60,000-$70,000 ❑ $70,000-$80,000 ❑ $80,000-$90,000 ❑ $90,000-$100,000

❑ Over $100,000

REFERRAL INFORMATION

How did you hear about BWMF's services?

❑Facebook ❑ Internet search ❑ Social Media, which ___________________________
❑ Family Member or Friend, name ___________________________
❑Newspaper, which paper___________________________
❑Other ____

DONATION RECIPIENT'S INFORMATION (IF DIFFERENT THAN APPLICANT'S)

Donation recipient is same as applicant: Yes ❑ No ❑

Last Name:	First Name:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone: ( )	Cell Phone: ( )	Email:	Can our administrative team text your cell phone? ❑ Yes ❑ No

Preferred Contact Method: (multiple selections okay) Home Phone ❑ Cell Phone ❑ Email ❑ Mail ❑	Birth date: / /	Age:	Sex: ❑ M ❑ F	Person in need of help is: Child ❑ Adult ❑

Street Address\Apt.:	City:	State:	Zip:

Michigan County of Residence:	Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino ❑ Middle Eastern or Arab American ❑ Native American or Other Pacific Islander ❑ White or Caucasian ❑ Prefer Not to Answer

Employment:

❑ Employed- Employer Name________________________________ ❑ Unemployed ❑ Retired ❑ Disabled

❑ Student ❑ Other_________________________________

Veteran Status: ❑ Yes ❑ No Comments: ____

ADDITIONAL FAMILY INFORMATION

Total Number of People in Household:

_____ Children _____ Adults

List Names/Birthdates of Children Still Living in Home of Recipient:

Name____________________ DOB___/____/____ Sex___ Name_____________________ DOB___/____/____ Sex___

Name____________________ DOB___/____/____ Sex___ Name_____________________ DOB___/____/____ Sex___

Name____________________ DOB___/____/____ Sex___ Name_____________________ DOB___/____/____ Sex___

Name____________________ DOB___/____/____ Sex___ Name_____________________ DOB___/____/____ Sex___

ADDITIONAL INFORMATION/COMMENTS

Please provide any additional information on your current needs (add another page or write on back if more space is needed:

____

____

I certify that this information is true to the best of my knowledge, and I agree to the terms listed above as of the date indicated below. I understand that Be Well My Friends is a non-profit, community organization. Provision of services is subject to approval by the BWFM Board of Directors and may be discontinued at any time with or without notice. BWMF will contact me upon receipt of my completed application.

Signature________________________________ Relationship to Patient _______________ Date: __/__/_____