Be Well My Friends (BWMF) specific purpose is to raise money for people, organizations, and nonprofits 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 **chobbs@bewellmyfriends.org**. Please direct questions and applications to **Mrs. Charlotte Hobbs**, President of Be Well My Friends.

ALL FIELDS ARE REQUIRED

GRANT RECIPIENT'S INFORMATION

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:

What County do you live in: _____

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's Name_____ ☐ Unemployed ☐ Retired ☐ Disabled

☐ Student ☐ Other_____

Veteran Status: ☐ Yes, I am a Veteran ☐ No, I am not a Veteran 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 annual 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 _____

TOTAL NUMBER OF PEOPLE IN HOUSEHOLD	
Number of Children under 18:	Number of Adults over 18:

Name	D.O.B.	☐ M ☐ F	Name	D.O.B.	☐ M ☐ F
Name	D.O.B.	☐ M ☐ F	Name	D.O.B.	☐ M ☐ F
Name	D.O.B.	☐ M ☐ F	Name	D.O.B.	☐ M ☐ F
Name	D.O.B.	☐ M ☐ F	Name	D.O.B.	☐ M ☐ F
Name	D.O.B.	☐ M ☐ F	Name	D.O.B.	☐ M ☐ F

COMPLETE THIS SECTION ONLY IF YOU ARE SUBMITTING THE APPLICATION ON BEHALF OF ANOTHER PERSON

I am the grant recipient:
☐ No (complete this section)
☐ Yes (do not complete this section)

Last Name:	First Name:	Middle Initial:

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

Home Phone:	Cell Phone:
( )	( )
Email:	Relationship to the grant recipient:
Can our administrative team text your cell phone?	Preferred Contact Method: (multiple selections okay)
☐ Yes ☐ No	☐ Home Phone ☐ Cell Phone ☐ Email ☐ Mail

ADDITIONAL INFORMATION OR COMMENTS

Please provide the amount of money that you are needing and details about what your needs are (add another page if more space is needed.) BWMF will do our best to meet your needs if your grant is approved, but we make no guarantees on the amount or timing of when the funds or items will be made available.

I understand that only 1 grant per household is allowed, and that applications are reviewed at the sole discretion and timing of BWMF and not the applicant, and 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. I certify that the information that I provided is true and that false statements of income will result in denial of my request. I agree to all terms listed here as of the date indicated below.

Printed Name:_____ **Signature:**_____ **Date:** _____/_____/_____