Women Marines Association

Matching Funds and Grants Program

Veteran's Name ____

Address: ____

Phone: ____________________ Email: ____________________

Complete this form and return to MFG@womenmarines.org. All dollars should be entered on a MONTHLY basis (average if needed).

1. Provide a copy of your latest paystub and/or proof of other income such as Social Security Income/Disability or Disability Compensation from the Department of Veterans Affairs.
2. Amount requested ____________. Proved a copy of the bill/invoice to be paid to include address to mail payment. (You will be contacted to get account number for payment, if needed.)
3. Provide the following information.

   (Net amount refers to the amount you receive after taxes, not your gross salary or total monthly Social Security benefit before taxes are taken out.)

INCOME, LIVING & TRANSPORTATION EXPENSES (MONTHLY)

MONTHLY INCOME:

Net pay from job ____________
Net pay of spouse ____________
Child Support ____________
VA Disability ____________
VA Education Benefits ____________
Social Security (net amount) ____________
SNAP/WIC (Yes/No) ____________
Unemployment Benefits ____________

TRANSPORTATION:

Vehicle(s) Payment ____________
Vehicle Insurance ____________
Vehicle Registration ____________
Parking/Tolls/Public Transportation ____________
Other: ____________

HOME EXPENSES:

Rent/Mortgage ____________
Electric/Natural Gas ____________
Water/Sewage/Garbage ____________
Homeowners/Renters Insurance ____________

HEALTH EXPENSES:

Insurance (life, other) ____________
Medical (co-pays, dentist, orthodontist) ____________
Other ____________

HOA Fees/Taxes	____________	***CONTRIBUTIONS:***	
Security Systems	____________	Family	____________
Cell Phone	____________	Religious/Charities	____________
Phone/Internet/Cable	____________		
Other (Tuition)	____________		

TOTAL MONTHLY EXPENSE: _____________________

4. Provide the following additional documents:
   a. SIGNED letter stating the reason for the request and the amount.
   b. A copy of last DD214. (redact SSN)
   c. A letter of recommendation from their Chapter President if a member of WMA and Chapter.
   d. A letter of recommendation from a VA Counselor, Pastor or Docter, depending on the reason to substantiate the request.
5. I give WMA permission to share my story (anonymously) on WMA's social media.

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I, ___________________________________, certify that the above information is accurate and true and I understand that providing false information will result in the disapproval of my request for a grant.

____
Applicant's Printed Name

____
Applicant's Signature

____
Date

Save and rename this file to your PC and then attach to an email to send to WMA's Emergency Grant Fund at MFG@womenmarines.org