GOOD FRIENDS
OF THE
FIRST STATE
Inc.

Monetary Request Form

POST OFFICE BOX 424
HOCKESSIN DELAWARE 19707
302 / 455 8534

www.goodfriendsofthefirststate.org

Monetary Request Form

Request Date: _____

Consumer Full Name: _____

Consumer Phone Number: _____

Consumer Social Security Number: _____

Consumer Date of Birth: _____

Consumer Age: _____

Consumer Address (Street, City, State, Zip): _____

_____

_____

List all other adults living in the household, along with their ages: _____

_____

_____

List all children living in the household, along with their ages: _____

_____

_____

Monthly household income: _____

Please check all that apply:

❒ Food Stamps ❒ SSI/Social Security ❒ Medicare/Medicaid

❒ TANF ❒ Wages ❒ Health Insurance

❒ Other (please explain): _____

Requested Item/Amount: _____

Describe requested need and use, along with justification: _____

_____

_____

_____

_____

_____

How was need verified: _____

Checks are written and mailed based on the information below:

Vendor: _____

Vendor Contact Name: _____

Address (Street, City, State, Zip): _____

_____

_____

Phone: _____

Account Name (if applicable): _____

Account # (if applicable): _____

Please attach all price verifications and invoices along with the request application.

Submitter name: _____

Submitter phone: _____

Submitter email: _____

Submitter signature: _____

Supervisor name: _____

Supervisor phone: _____

Supervisor email: _____

Supervisor signature: _____

Incomplete applications will not be processed.

Please email to: goodfriendsdistributions@gmail.com

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