



PROGRAM FINANCIAL ASSISTANCE APPLICATION FORM

Applicant's Information			
First Name	MI	Last Name	Home Phone
Street Address		Apartment/Unit Number	Work Phone
City	State	Zip Code	Cell Phone
E-mail Address			

Eligible Family Members <i>(residing in the same household and listed on documentation)</i>			
First Name	Last Name	First Name	Last Name
First Name	Last Name	First Name	Last Name
First Name	Last Name	First Name	Last Name
First Name	Last Name	First Name	Last Name

Please fill in the bubble for the type of services you receive. You must provide proof of services received.

- Supplemental Nutrition Assistance Program
- Arizona Health Care Cost Containment System (AHCCCS)
- Temporary Assistance to Needy Families (TANF)
- General Assistance (GA)
- Income Guidelines (Must provide either most recent tax return or 4 most recent paychecks from each employer for all persons in household. Any receipts must show gross wages.)

Please check the type of personal identification and proof of Coconino County residency presented with this application:

- AZ Driver's License
- Utility Bill
- Other (list type) _____

I hereby certify that all of the above information is true and correct. I understand deliberate misrepresentation will result in permanent denial of eligibility in the future.

Signature of Applicant

Date

For Office Use Only	
Review by: _____	Date: _____
Status: _____	Reduction: _____ %