Hope Foundation
Of Iranian-American Jewish Communities

P.O. Box 18280
Beverly Hills, California 90209-4280
Telephone 310-535-7744

Date:_____

Application

This application must be fully completed before you can be eligible for assistance.

Applicant: _____, _____, _____
Last Name First Name Middle Name or Initial

Home Address, including City and Zip Code Mailing Address (if different)

_____ _____

_____ _____

Home Telephone (____)_____ Birth date: _____/_____/_____

Message Phone (____)_____ Place of Birth: _____

With whom do you live at your home address?

Name	Age and Relationship to you
1._____	_____ _____
2. _____	_____ _____
3. _____	_____

Marital Status: Single ___ Married ___ Separated ____ Widowed ____ Divorced ___

If separated or married, your spouse's name. _____

Number and current age(s) of children: Number _____ Ages _____, ____,_____, _____

Are you or your spouse citizens of the United States?

You Yes …__ No … ----------___----------_____----------_ _____
Immigration status Social Security Number Medi-Cal Number

Spouse Yes …__ No ….__ ---------- __----------_____----------_____
Immigration status Social Security Number Medi-Cal Number

Do you own or rent the home address indicated above? Own ____ Rent ____

Landlord _____ _____
Name Phone
_____ $_____
Address Rent/Mortgage
_____

Highest level of education you have completed? High School_____College_____Other_____

By who are you employed?

Name _____ Position: _____
Address _____ Monthly Salary: $_____
_____ Hours/Week _____

Are you in need of a job? _____ If so, what type of job are you searching for? _____

State your monthly income by type of income:

	Self	Spouse/child/ Parent	Claim Number
Social security	$_____	$_____	_____
State disability	$_____	$_____	_____
SSI	$_____	$_____	_____
Government Pension	$_____	$_____	_____
AFDC (welfare)	$_____	$_____	_____
Alimony	$_____	$_____	_____
Child Support	$_____	$_____	_____
Private help	$_____	$_____	_____
Other sources	$_____	$_____	_____

Health Insurance Available to You or Your Spouse:

Insurer:	Named Insured	Policy/Claim Number
Medi-Cal	_____	_____
MediCare	_____	_____
Others (specify)	_____	_____

How much monetary assistance are you requesting? _____

For how long are you requesting assistance? _____

I, the Applicant, hereby acknowledge and agree that:

1. The Hope Foundation of Iranian-American Jewish Communities, Inc. (the "Hope Foundation") is a non-profit charitable organization which is support by private donations and is not related, affiliated or connected with any governmental entity or agency.

2. The Hope Foundation reserves the right to ask the Applicant for additional information or documents as it determines necessary at its sole and absolute discretion.

3. The Hope Foundation has the right to deny the Applicant's application for any reason whatsoever at its sole and absolute discretion, and the Applicant shall have no right, and hereby waives any right the Applicant may have, to object, appeal the decision or in any way or manner make any claims against the Hope Foundation to the extend allowed by law.

4. The Hope Foundation may deny, or fully or partially grant the Applicant's request and may suspend, or terminate the assistance at any time, for any reason, at its sole and absolute discretion. If the Hope Foundation granted a request of the Applicant in whole or in part, there is no obligation for the Hope Foundation to continue said assistance, and the Hope Foundation may at any time and for any reason, suspend or terminate the assistance.

5. The Hope Foundation may use the Applicant's story and the changes the Hope Foundation's help made in the Applicant's life at any of its marketing or advertising programs, without divulging the name of the Applicant.

6. The Hope Foundation makes no warranty or guarantee that any benefit granted to the Applicant will in fact benefit the Applicant to the Applicant's satisfaction.

7. The Hope Foundation reserves the right to grant a request for assistance through payments directly to third parties or entities.

8. The Applicant hereby represents, warrants, and certifies that the information provided in this Application is true and correct.

9. The Applicant has enclosed a valid copy of his/her social security card (and Spouse's if applicable).

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____

(Print Name) Date

_____

(Signature)