**COVID-19 Relief Funding Application**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total # of Adult household Members: \_\_\_\_\_\_\_\_\_\_

Total # of Children (<18) household members: \_\_\_\_\_\_\_\_\_\_

I need help paying for the following:

How did COVID cause this?

I have attached documentation to verify the information I provided above yes\_\_\_ no \_\_\_

I understand that my request must be related to the COVID-19 Pandemic and that I am required to provide verification to that effect prior to any funds being disbursed.

By signing below, I authorize a representative from the Shenandoah County Department of Social Services to contact any entity required to verify the information I provided above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Application received on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Representative from the SCDSS

FAX application to 540.459.1970 / Mail or drop off completed application and verifications to:

SCDSS / 494 N Main Street S-200 / Woodstock. VA 22664 / ATTN: COVID Relief Fund