Shirley Ryan AbilityLab Financial Assistance Application

Name of Veteran Applicant: _____ **Date of Birth** ___/___/___

Address: _____
(Street Address, including Apartment Number, if applicable) (City, State, Zip Code)

Phone (with Area Code):_____ **Email** _____

Marital Status: Single Married Divorced Separated **Spouse's Name** _____

Is spouse employed? _____ **Children?** _____ **How many?** _____

Branch of Service: US Army ___USN ___USAF___ USMC___ USCG___

Began active duty date ____/____/____ **Ended active duty date** ____/____/____ **Active now?**___

Caregiver Information

Caregiver's Name _____ **Relationship** _____

Address: _____
(Street Address, including Apartment Number, if applicable) (City, State, Zip Code)

Phone (with Area Code):_____ **Email** _____

Area of Need (Check all that apply)

___ Housing ___ Travel ___ Communications ___ Financial Aid ___ Dental ___Pastoral Care
___ Other (Please be specific)

_____
_____
_____

I certify the above information to be true and correct. I authorize verification/release of the information that I am providing on this application. Disclosure of information on this form is voluntary. Failure to provide the requested information, however, will prohibit the processing of this application. In accordance with applicable laws, SALUTE, INC. will maintain confidentiality regarding the application and any aid given or denied except as required to process this or subsequent applications, or an otherwise required by law.

_____ _____
Signature of Applicant Recipient – Required (Must be signed not printed or typed) *Date - Required*