EMORY HEALTH CARE VETERANS PROGRAM
Financial Assistance Application

Please note when completing the application:

- The application must be complete. On a separate sheet of paper, include any other information you feel is pertinent to your situation. ***An incomplete application cannot be processed***.
- A legible copy of your DD214 must accompany the completed application
- **Your military Point-of-Contact information must be complete, including the phone number and email address. This person should be your VA case worker or mental/physical health counselor. The Point-of-Contact must understand your history and current situation, and have written consent from you to discuss your case.**
- Copies of bills for which you are requesting payment assistance. **W9 required for all rental payments.*

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

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

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

Ethnicity- Please circle one: American Indian/Alaskan Native | Asian | Hispanic/Latino
Black/ African American | Native Hawaiian or Pacific Islander | Multi Ethnic

Are you employed? _____ **Marital Status**: Single Married Divorced Separated
If married, what is your spouse's name: _____ **Is spouse employed**? _____
Do you have children? _____ **How many?** _____

Branch of Service: US Army ___USN ___USAF___ USMC___ USCG___

Began active duty date ____/____/____ **Ended active duty date** ____/____/____

After your discharge, which of the following applies?
___ I am not injured.
___ I am service connected and currently rated @ _____%
___ I am currently being evaluated/re-evaluated for service connection rating
___ I have a permanent disability.
___ I have been rated unemployable
___ I am currently undergoing a rehabilitation or recuperation program

Have you received financial assistance from any other organizations? If so, please list the sources and amount of aid. _____
_____
_____

Mandatory Point of Contact Information

Emory Mental Health Counselor Point of Contact:

Name: _____Title:_____

Telephone: _____Email _____

The verification & release of all case information must be provided before application can be processed.

FINANCIAL RECORD

MONTHLY INCOME

LES-Separation Leave of Earnings Statement	
Veterans Compensations/ Pension from VA	
Social Security Benefits	
Food Stamps/ State Aide	
Work Income	
Child Support	
Unemployment	
Earnings of Spouse	
Loans/GI Bill	
Caregivers Pay	
Additional Income	
TOTAL	

MONTHLY NEEDS

Mortgage/Rent	
Car Payment	
Car Insurance	
Utilities	
Phone	
Other	
TOTAL	

Goals & Objectives

What are you requesting help with? Please list the most critical needs in order of importance.

How will your situation be financially improved in 3-6 months assuming Salute gives you financial assistance?

If requested by SALUTE, INC. I am willing and able to provide documentation to support this claim.

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 *Date - Required*
(Must be signed not printed or typed)

If application is submitted on behalf of the intended recipient, the representative should complete the following additional information:

Name of Representative: _____ *Relationship:* _____

Address of Representative: _____
(Street Address & Apt. #- City, State, Zip Code)

_____ _____

(Telephone Number) *(E-Mail Address)*

_____ _____

Signature of Representative – (Must be signed not printed or typed) *Date – Required*

Three ways to submit applications:

- ***Fax:*** *847-359-8818 (preferred way to submit)*
- ***Scan & Email****: gethelp@saluteinc.org* * Pictures of application and documents taken from a phone or camera are not acceptable.*
- ***Mail*** *to: SALUTE, INC./ P.O. Box 2663 / Palatine, IL 60078*

If you have any questions, please call the SALUTE, INC. main office at 847-359-8811