HOME BASE VETERAN & FAMILY CARE PROGRAM
Financial Assistance 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

Home Base 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

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