EMORY HEALTHCARE VETERANS PROGRAM
Financial Assistance Application

- **Must have served in the US military, discharged in 2013 or later, and be 50% or more service connected.**
- **Assistance could take 3-4 weeks. Cases are handled on a first come, first serve basis.**
- Must include a valid & legible copy of your DD214.
- Must include photo copy of state issued ID (driver's license or state ID).
- Must include VA documentation of injuries & disability rating.
- A mandatory Point-of-Contact including phone number and email address is required. This person should be VA case worker or mental/physical health counselor who understands your history and current situation, and has your written consent to discuss your case.
- Include copies of bills in which you are requesting assistance and/or equipment estimates. **W9 required for all rental payments*
- Applications will be accepted via fax (preferred) or scanned and emailed. **No cell phone or camera pictures of application or additional documents will be accepted.**
- The application must be complete. **An incomplete application cannot be processed.**

***Any altered or falsified documentation is considered a felony**

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 | White

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

Briefly list the injuries incurred during your time in service _____

_____

Does veteran require a caregiver? ____ **Caregiver's Name** _____

Caregiver Phone # _____ **Caregiver Email** _____

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

_____

Mandatory Point of Contact Information

Military/VA Case Worker/Mental or Physical Health Counselor Point of Contact:

Name: _____Title:_____

Telephone: _____Email _____

The verification & release of all case information must be provided in order to process application.

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 this assistance improve the quality of your life?

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*

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