



## NEURO COMMUNITY CARE 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	
<b>TOTAL</b>	

##### MONTHLY NEEDS

Mortgage/Rent	
Car Payment	
Car Insurance	
Utilities	
Phone	
Other	
<b>TOTAL</b>	



## 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](mailto: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***