SALUTE, INC.
Tampa Polytrauma Financial Assistance Application

- **Assistance is limited to post 9/11 (2001) Veterans, Active Duty Service Members, including Reservists and National Guard members in VA hospitals as well as mental health, rehabilitation or substance abuse programs.**
- **Must provide letter from a doctor, therapist, or case manager confirming participation in ongoing inpatient or outpatient program.**
- **Reason for financial assistance must be medical or military related due to VA service connected rating.**
- Must show proof of **VA service connection rating**.
- Must provide a valid and legible copy of your **DD214** or Statement of Service Letter for Active Duty, Reserves or National Guard.
- Must reside in the United States and provide a **state-issued ID** (Driver's License or State ID).
- Must include the monthly billing statement for the payment assistance you are requesting. *Screenshots are NOT accepted*.
- Rental assistance requires copy of lease and the landlord's W9 tax form.

IMPORTANT NOTES:

- **One time assistance only.**
- Allow 3-4 weeks for processing
- Any altered or falsified documentation is considered a felony.
- *Disclaimer: Meeting these requirements does not guarantee assistance.*

Applicant Name:_____ **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, spouse's name: _____ **Is spouse employed**? _____
Do you have children? _____ **How many?** _____

Branch of Service: Army ____ Navy ____ Air Force____ Marines____ Coast Guard____

Reservist_____ National Guard _____

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

Briefly list the injuries incurred during your time in service.

Which of the following applies to your current situation?
___ 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.

Do you require a caregiver? _____ Caregiver's Name _____

Mandatory Point of Contact Information

Doctor/Therapist/Case Manager 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 EXPENSES

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.

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

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:

- ***Scan & Email***: gethelp@saluteinc.org * *Pictures of application and documents taken from a phone or camera are not acceptable.*
- ***Fax:*** *847-359-8818* ***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