Application for the Delaware Accessibility Needs Program

Paralyzed Veterans of America
Colonial Chapter

This application does not cover the cost of medication, eyeglasses, or any other items we determine unacceptable.

The requested item may be funded solely by the Colonial Chapter's Accessibility Needs Fund or you may be responsible for a percentage of the total cost; based upon your income and ability to raise funds from other sources.

Application must be fully completed, and you MUST include: 2 most recent bank statements for each household member as proof of income and a note from your doctor stating your disability, or the application will be returned to you.

Return completed Applications to our office.

700 Barksdale Road, Unit 2 Newark, DE 19711

Phone: (888)-963-6595 Fax: (302)-861-6675

Name:_____ Date:_____

Address:_____ Town:_____ Zip Code:_____

Home Phone #:_____ Cell Phone #:_____

DOB:_____ Marital Status:_____

Your Disability: _____

Wheelchair User? Y/N If yes, what type? **Manual / Power / Scooter**

What do you need? 1 Item (Lift, ramp, wheelchair,etc):_____

Are you a Veteran? **Y/N** Service Connected/Non-SC: _____

Do you receive Veterans Pension or Compensation? **Y/N** If yes, what amount? _____

# of Dependents:_____

Are you currently employed? **Y/N** If yes, state Annual Income? _____

Employer Address: _____ Town:_____ Zip Code:_____

Phone #: _____

Rent or Own a home:_____

Do you live with Parents or Guardian? **Y/N** If yes, state parent/guardian income: _____

Spouse's Income: _____ Other Household Income: _____

Have you applied to any other organization regarding this claim: **Y/N** If yes, who? _____

Name of Social Worker or another individual who may assist us with your claim:

Name: _____Phone #: _____

Monthly Household Income

Social Security (SDDI, SSI):_____Pension/Retirement:_____

Workman's Comp:_____Stocks, Bonds:_____

Annuity, Interest:_____Aid for dependent children:_____

Other: _____**TOTAL:**_____

Monthly Household Expenses

Rent/Mortgage:_____Food:_____

Utilities:_____Insurances:_____

Insurances:_____Medical Expenses: _____

Other (List each separate): _____**TOTAL:**_____

Savings Account Amount:_____

As a recipient of this program, I agree to hold harmless and discharge the association, namely, Colonial Chapter of the Paralyzed Veterans of America; a Delaware non-profit organization, their assigns, lessees, agents, employees, directors, volunteers; any and all claims, damages, demands, actions, costs and/or expenses on our behalf arising out of personal injury, property damage, and/or accidents which may be incurred by you upon acceptance of said item received. I hereby certify the given information is correct to the best of my knowledge.

Name (signature) _____ Date: _____

FOR OFFICIAL USE ONLY

Approved:_____

Not Approved:_____

Date: _____