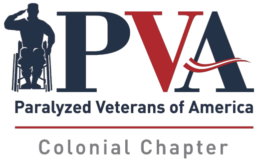

Application for Financial Assistance for Attendant Care in DE

This application is renewable once a year, for up to $500 and is only available to members of the Colonial Chapter of Paralyzed Veterans of America. The request assistance maybe funded solely by the Colonial Chapter of the Paralyzed Veterans of America 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

Date:__________________

Member ID:______________________________Name:____

Address:______________________________ Town:_________________________ Zip Code:________________

Home Phone #:__________________ Cell Phone #:____________________DOB:___________________________

Email:____________________Marital Status:_____________ Your Disability:______________________________

Are you Service Connected? Y / N

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:________________

Position:______________________________Phone #: ____

Are Other Household Members currently employed? **Y/N** If yes, state Annual Income? ___________________

Employer Address: ___________________________ Town:___________________ Zip Code:________________

Position:______________________________Phone #: ____

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

Health Insurance & Policy #:____

Have you applied to insurance provider for this Request? : **Y / N**

If Yes, attach documentation. If no, please explain why you have not applied: ________________________

____

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: ________________________

Social Security #:____________________________

FOR OFFICIAL USE ONLY

Approved:______________________________________

Not Approved:__________________________________

Date:_________________________