



Application for Respite Care

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: _____