

APPLICATION FOR ASSISTANCE

ADAM KLEIN CHAPTER #, DISABLED AMERICAN VETERANS
P.O. Box 915
Bismarck, ND 58502-0915
email: aklein3dav@gmail.com

(PLEASE TYPE OR PRINT LEGIBLY)

GENERAL

ASSISTANCE NEEDED:	AMOUNT REQUESTED:	DATE:
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APPLICANT INFORMATION

Name			Social Security Number		
Address			Telephone Number		
City	State	Zip Code	Relationship to Veteran		

VETERAN INFORMATION

Name	Social Security Number	VA disability rating %
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FAMILY INFORMATION

Marital Status	Name of Spouse	Spouse Date of Birth
Names of Dependent Children		Dates of Birth
Child Support	Receiving-List Amount:	Paying-List Amount:

APPLICANT INCOME

Present Employer	Employer Telephone	Net Salary/Month
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SPOUSE INCOME

Present Employer	Employer Telephone	Net Salary/Month
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PARENT INCOME (Dependent Children Only)

Name of Parent	Present Employer	Employer Telephone	Net Salary/Month
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PARENT INCOME (Dependent Children Only)

Name of Parent	Present Employer	Employer Telephone	Net Salary/Month
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OTHER INCOME

Benefit	Applicant	Spouse/ Parents	Total	Benefit	Applicant	Spouse/ Parents	Total
VA S/C Compensation				Workers Compensation			
VA NSC Pension				Unemployment Comp.			
VA Education				Retirement			
Social Security				Pension			
SSI				Public Assistance			
Other (rental, alimony, etc.)				Other (rental, alimony, etc.)			

ACCOUNTS/ASSETS

Type of Account (checking, savings, investments, etc.)	Name of Institution	Balance
TOTAL ASSETS:		

MEDICAL LIABILITIES

	Name	Monthly Payment	Balance
Hospital Insurance/Medicare			
Prescriptions			
Monthly Medical bills			
Total Monthly Medical Expenses Being Paid			
Monthly Income			
Subtract Medical			
Add/Subtract Child Support			
Net Income			

APPLICANT ACKNOWLEDGMENT

I hereby certify that all of the answers herein made are true and that I have not withheld any information regarding income or other resources. I do further certify that I have no means of support beyond those stated herein. I FURTHER UNDERSTAND THAT ANY FALSE STATEMENT OF MATERIAL FACT MADE BY ME IN THIS APPLICATION MAY RESULT IN DENIAL OF ASSISTANCE. I further understand that I may receive monies from the Veterans Aid Fund only once in my lifetime.

I hereby authorize the U.S. Department of Veterans Affairs, Job Service of North Dakota, North Dakota State Tax Department, North Dakota Workforce Safety and Insurance, financial institutions and any other credit sources to disclose to Adam Klein Chapter #3, Disabled American Veterans any information contained in their files and records concerning myself upon request.

Applicant Signature	Date
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APPLICATION FOR ASSISTANCE

ADAM KLEIN CHAPTER #3, DISABLED AMERICAN VETERANS

*****NOTICE TO APPLICANTS*****

Applications will be considered monthly, or at other appropriate times as determined by the Chapter Finance Committee.

Applications must be complete, including proper supporting documentation. No action will be taken on incomplete applications.

Decisions will be made based on various factors. Decisions of the Chapter Finance Committee are final. Individuals may receive assistance from the Veterans Aid Fund only one time. If an application is denied, the individual may apply and be considered for assistance in the future.

DOCUMENTATION CHECKLIST

Residency (All Applicants)

Copy of ND Driver License or ID Card showing address

OR

Copy of monthly expense bill or bank statement verifying address, i.e. utility, phone, or cable bill

Veteran Status (All Applicants)

Copy of DD 214 or equivalent documentation

Unremarried Widow

Copy of marriage certificate

AND

Copy of death certificate

Spouse

Copy of marriage certificate