APPLICATION FOR ASSISTANCE

DISABLED AMERICAN VETERANS, DEPARTMENT OF NORTH DAKOTA
3812 Lakewood Dr. SE
Mandan, ND 58554
email: DeptofNorthDakota@davnd.org

(PLEASE TYPE OR PRINT LEGIBLY)

GENERAL

ASSISTANCE NEEDED:	AMOUNT REQUESTED:	DATE:

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 %

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

SPOUSE INCOME

Present Employer	Employer Telephone	Net Salary/Month

PARENT INCOME (Dependent Children Only)

Name of Parent	Present Employer	Employer Telephone	Net Salary/Month

PARENT INCOME (Dependent Children Only)

Name of Parent	Present Employer	Employer Telephone	Net Salary/Month

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:	$0.00

MEDICAL LIABILITIES

	Name	Monthly Payment	Balance
Hospital Insurance/Medicare			
Prescriptions			
Monthly Medical bills			
Total Monthly Medical Expenses Being Paid		$0.00	$0.00

Monthly Income	$0.00
Subtract Medical	$0.00
Add/Subtract Child Support	$0.00
Net Income	$0.00

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 the Disabled American Veterans, Department of North Dakota any information contained in their files and records concerning myself upon request.

Applicant Signature	Date

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NOTICE TO APPLICANTS

Applications will be considered monthly, or at other appropriate times as determined by the Department 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 Department 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 Drivers 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