



VETERANS INNOVATIONS PROGRAM APPLICATION

COUNTY: _____

APPLICATION DATE: _____

PROGRAM USE ONLY

PERSONAL INFORMATION

_____		_____	
Full Name (last, first, middle)		Social Security Number	
_____	_____	_____	
Phone Number	Message Number	Email	
_____		_____	_____
Home Address		City	Zip Code
_____		_____	_____
Mailing Address (if different)		City	Zip Code

MILITARY SERVICE

Active Duty Military Service (regular not Title 10 activation):

Date of Entry: _____ Date of Discharge: _____ Type of Discharge: _____

Branch of Service: Army USN USAF USMC Coast Guard

Guard/Reserve Service:

National Guard Air Guard Which State? _____

Army Reserves USN Reserves USAF Reserves USMC Reserves Coast Guard Reserves

Date Activated -Title 10 _____ **Date De-Activated -Title 10** _____

Campaign or Expeditionary Medal:

Vietnam Southwest Asia Kosovo Afghanistan Iraq New Dawn Armed Forces Navy/Marine GWOT

Military Occupational Skill(s) _____

VA Benefits & Entitlements Status:

Have you filed a claim for VA Disability (*SC Compensation*)? Yes No

If yes, date filed: _____ Who is your Representative (*POA*) _____

Award granted? Yes No If yes, percentage: _____%

List disabilities: _____

Have you accessed other VA Benefits & Entitlements? Yes No

If yes, which? Health Care Education & Training Life Insurance Home Loan

DEMOGRAPHICS

Gender: Male Female

Marital Status: Single Married Divorced Separated Widowed

Ethnicity:

- Asian/ Asian American American Indian/Native Alaskan Black /African American
 Hispanic / Latino Native Hawaiian/Pacific Islander White/Caucasian
 Other: _____

FAMILY INFORMATION

List all individuals who currently live with you (*Spouse, friend, partner, roommate, etc.*)

Name	Age	Relationship	Employed
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYMENT

Employment (Self): Full-Time Part-Time Unemployed Retired Unable to Work

Employer Name/Address: _____

Hours per week _____ Hourly Wage \$ _____

Job Title: _____ Job Duties: _____

Have you registered with your Local Veterans Employment Representative (LVER) or Disabled Veterans Outreach Program (DVOP) specialist at the Work Source Center (Employment Security)?

Yes No If No, why not? _____

Are you currently receiving Unemployment Insurance (UI)? Yes No

If yes, date UI Benefits began? _____ Date UI benefits expire? _____

Employment (Spouse, if applicable): Full-Time Part-Time Day Labor Unemployed Retired Unable to Work

Employer Name/Address: _____

Hours per week _____ Wage \$ _____

Job Title: _____ Job Duties: _____

If not employed, are you a full-time student? Yes No If yes, where: _____

If yes, are you receiving VA Education Benefits? Yes No

If yes, which benefit: MGIB MGIB-R Post 9/11 GIB Voc Rehab Other: _____

If not employed, is your spouse a full-time student? Yes No If yes, where: _____

If yes, are you receiving VA Education Benefits? Yes No

If yes, which benefit: MGIB MGIB-R Post 9/11 GIB Voc Rehab Other: _____

If yes to Post 9/11 GIB or Voc Rehab, are you in receipt of: BHA Stipend

Are you participating in the VA Work-study Program? Yes No

If yes, where: _____

HEALTH CARE

Are you enrolled in a Health Care plan? Yes No

Is your family enrolled in a Health Care plan? Yes No

If yes, which one: _____

IMMEDIATE NEEDS

I am applying for the following type(s) of assistance:

- Food
- Utilities (gas, electric)
- Transportation
- Other, please list: _____
- Rent / Mortgage
- Child care
- Employment Support Services
- Tuition / Books / Fees

Are you homeless? Yes No If yes, how long? _____

Do you have an eviction or foreclosure notice? Yes No

If yes, date issued: _____ Effective date: _____

Do you have or expect to receive a utility shut-off notice? Yes No

If yes, date issued: _____ Effective date: _____

What other resources have you applied for?

- County Veterans Assistance Fund
- Minuteman
- American Legion -Temp Family Assistance
- Soldier's Angels
- Local Faith Based Organization or Church
- Salvation Army
- Other

Describe assistance received: _____

EXPENSES

Total Household Expenses (Monthly):

Rent/Mortgage _____

Utilities _____

 Water _____

 Gas _____

 Electrical _____

Telephone _____

Car Payment _____

Car Insurance _____

Fuel, oil, parking _____

Food _____

Household Supplies _____

Day Care _____

Child Support _____

Other: _____

INCOME

Total Household Income (Monthly):

Employment (*self*) _____

Employment (*spouse*) _____

Guard/Reserve Pay _____

VA Comp / Pension _____

VA MGIB / VocRehab _____

VA Work-Study/Stipend _____

Unemployment _____

L& I _____

SSI / SSDI _____

GA-U / GA-X _____

Food Stamps _____

Child Support _____

Other: _____

DECLARATION AND SIGNATURE

I declare under penalty of perjury that the information I gave in this application is true, correct, and complete to the best of my knowledge. I understand that I can be criminally prosecuted if I incorrectly receive financial assistance because I have willfully made a false statement or willfully failed to report something I should report.

Signature of Applicant or Legal Representative _____
Date

Case Manager

Telephone

Location

E-Mail

SUPPORT SERVICE REQUEST FORM

Supportive services shall be provided only when the service is reasonable, allowable, and justifiable and is **not** available through another resource. If the support needed is an emergency request, staff must document emergency in the justification. Lack of support documents will result in denial of application.

Participant Name: _____

Assistance Requested:

- | | | |
|--|--|--|
| <input type="checkbox"/> Food | <input type="checkbox"/> Rent / Mortgage | <input type="checkbox"/> Employment Support Services |
| <input type="checkbox"/> Utilities (gas, electric) | <input type="checkbox"/> Child care | <input type="checkbox"/> Tuition / Books / Fees |
| <input type="checkbox"/> Transportation | | |
| <input type="checkbox"/> Other _____ | | |

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JUSTIFICATION FOR SUPPORT SERVICE

- | | | | | |
|---|-------------------------------------|--|---|---|
| <input type="checkbox"/> Transition to Employment | <input type="checkbox"/> Job Search | <input type="checkbox"/> Job Retention | <input type="checkbox"/> OJT Program | <input type="checkbox"/> Retraining Program |
| <input type="checkbox"/> Transition to Education | <input type="checkbox"/> MGIB | <input type="checkbox"/> MGIB-R | <input type="checkbox"/> Formal Skills Training Program | |
| <input type="checkbox"/> Other _____ | | | | |

Justification: _____

Case Manager

Date