



AMERICAN LEGION AUXILIARY

Department of California

Temporary Financial Assistance - Hospital Representative/CBOC Deputy Investigation Report

Hospital Social Worker Name _____

Address _____

Phone _____ Date of Application _____

Name of Veteran _____

Veteran's Wife/Husband (or Widow/Widower) _____

Dependents: Age of Wife/Husband _____

Number of Children _____

Ages of Children _____

Other Dependents _____

War Service: Date of Enlistment _____

Date of Discharge _____

Serial Number _____

Branch of Service _____

Present condition of veteran's health _____

If hospitalized, location of hospital and reason for hospitalization _____

Is disability Service connected? _____

Is the veteran a member of the American Legion? _____

Post Name _____ Number _____

List other organizations in which he/she holds membership: _____

Present Residence _____

Street

City

State

Zip

Previous Residence _____

Street

City

State

Zip

How long has the veteran resided in the city? _____ State? _____ County? _____

What is the veteran's occupation or trade? _____

Is he/she presently working? _____ If so, at what wage? _____

Name of present employer _____

Source of Present Monthly Income		Estimated Monthly Needs	
Government Compensation Disability allowance	\$ _____	Rent	\$ _____
From Earnings	\$ _____	Food	\$ _____
.	\$ _____	Clothing	\$ _____
From Relatives	\$ _____	Fuel Supplies	\$ _____
.	\$ _____	List Other	\$ _____
State Aid	\$ _____	\$ _____
.	\$ _____	\$ _____
County Aid	\$ _____	\$ _____
.	\$ _____	\$ _____
Red Cross	\$ _____	\$ _____
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Community Agencies From The American Legion Post or Unit			
Miscellaneous			
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What effort has been made to secure aid from county, state, local agencies, church, other organizations, and family?

What is the veteran's particular need? _____

What temporary financial assistance is recommended to temporarily assist the veteran? _____

VAMC Social Services Worker - Forward this Investigation Report to the Hospital Representative or CBOC Deputy

Hospital Representative/CBOC Deputy - Review this report, make recommendations, and forward to Department VA&R Chairman

Signature _____ Date _____

Department Chairman _____

Date Received _____

Case Number _____

Date Forwarded to Department _____

Amount of Assistance _____

If denied, reason _____