

DCVMF Grant Application

Applicant Information			
Full Name:			
Date of birth:	Phone:	Email:	
Current address:			
City:	State:	ZIP Code:	
Amount of funds requested:			
Have you contacted other sources for this need:		If Yes, who:	
Have you received assistance for this need:		If Yes, how much:	
Service Information			
Branch of Service:		Rank:	
Date entered:	Date Discharged:	DD214: Yes No	
Veteran Compensation <i>(please circle those that apply)</i>		Retirement Pension	Disability Compensation
Percentage of Disability:	Amount of compensation:		
Employment Information			
Current employer:			
Employer address:			How long?
Phone:	E-mail:	Fax:	
City:	State:	ZIP Code:	
Position:	Annual Income:	Annual Household Income:	
Family Information			
<i>Please circle one:</i> Married Divorced Never Married		Number of Children:	
Do you pay child support:		Monthly amount of child support:	
Describe program or special need for which the grant is sought <i>(attach a separate sheet if necessary):</i>			
References			
Name:	Address:	Phone:	
I certify that the answers are true and complete to the best of my knowledge and I authorize DCVMF to verify the information provided on this form.			
Signature of applicant:			Date:

(Office Use Only)

Date Application Received: _____

Date of Board Approval: _____ Amount: _____

Checks to: _____