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 Dependents:
Wife/Husband (or Widow/Widower) _____
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	$_____	Rent	$_____
Disability allowance	$_____	Food	$_____
From Earnings	$_____	Clothing	$_____
From Relatives	$_____	Fuel Supplies	$_____
State Aid	$_____	List Other	$_____
County Aid	$_____	. . . . .	$_____
Red Cross	$_____	. . . . .	$_____
Community Agencies	$_____	. . . . .	$_____
From The American Legion	$_____	. . . . .	$_____
Post or Unit	$_____	. . . . .	$_____
Miscellaneous	$_____	. . . . .	$_____

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 _____