



## Department of California California Disaster Fund Supplemental Data

*To determine financial need, Units are asked to complete this supplemental data form. Please work with the impacted member to fill in as much information as possible. This information will be maintained with utmost privacy and sensitivity by the Department Community Service Chairman.*

Impacted Member: \_\_\_\_\_ Date of Occurrence: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Paid Through December 31, \_\_\_\_\_

Type of Disaster/Emergency:

Fire  Flood  Hurricane  Severe Weather  Earthquake  Other \_\_\_\_\_

Is the affected dwelling the member's primary residence?  Yes  No

Is the member still residing in the dwelling?  Yes  No

If the member is not able to reside in the dwelling, please explain where the member is currently living and how long they anticipate being displaced: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe the damage incurred: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Additional sheets of paper may be attached if additional space is needed. When possible, please attach **copies** of any repair estimates, statements from FEMA, or local Law Enforcement, photographs, etc) to support this request.)*

Is the property covered by insurance?  Yes  No

Number of people residing in the impacted dwelling: \_\_\_\_\_

Relationship of those living in the dwelling with the impacted member: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Present Household 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 .....	\$		\$
American Legion Family (Local/District)	\$		\$
Miscellaneous .....	\$		\$

What effort has been made to secure aid from county, state, local agencies, church, other organizations, and family? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Comments or Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Unit Point of Contact** *(Community Service Chairman, President, or Secretary only)*

Officer's Name: \_\_\_\_\_

Officer's Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

***The Unit shall submit this supplemental data form with the application to the CA Department Community Service Chairman.***

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