AMERICAN LEGION AUXILIARY
Department of California

Temporary Financial Assistance - Hospital Representative/CBOC Deputy Monthly Review

Case Number		This form must be filled out monthly on all Department TFA Cases and returned to the Department VA&R Chairman within thirty (30) days of receipt.
Name of Veteran		
Address		
City/Zip		
Case Investigated Reported by		
Name		
Address		
City/Zip		

Expenditure of Department Funds

Check Number	Date of Check	Amount of Check
How were the funds spent?		
Are receipts enclosed?	If not, why?	
How many times has the veteran been visited since the last Department check was received?		
What progress has been made to secure local assistance since case was brought to your attention?		
Is any member of the family employed at this time?	Who?	In what capacity?
Monthly earnings?	Is the veteran cooperative?	
How much longer will aid be required?		
Additional remarks on changes in this case since last report:		
Are you closing this case?		
If yes, indicate reasons this is possible:		

Signature of Hospital Representative/CBOC Deputy_____Date _____

Department VAR Chairman