CRAWFORD COUNTY VETERANS SERVICE COMMISSION
112 East Mansfield Street, Suite 95, Bucyrus, OH 44820
Phone: 419-562-7761 Fax: 419-562-0662

EMERGENCY FINANCIAL ASSISTANCE APPLICATION APPOINTMENT NOTIFICATION

*The Crawford County Veterans Service Commission emergency financial aid is governed by OHIO REVISED CODE TITLE 59. We are **NOT** part of, nor under the auspices of the **DEPARTMENT OF VETERANS AFFAIRS**.*

Funding for this program is provided in accordance with the ORC Title 59 (Military Affairs) through the property taxes of all Crawford County citizens be they veteran or non-veteran. The employee assisting you with your application DOES NOT have authority to approve or deny your request for aid.

Veteran/Applicant: _____

Date Application Picked Up: _____

A COMPLETED APPLICATION IS DUE ON THE 2ND OR 4TH WEDNESDAY OF THE MONTH. THE APPOINTMENT WILL BE SCHEDULED PRIOR TO THAT DATE TO ENSURE DEADLINE IS MET.

Your Appointment is For Day of Week: _____ Date: _____ Time: _____
Location: 112 East Mansfield St, Suite 95, Bucyrus, OH 44820

*****CANCELLATION NOTICE IS REQUIRED AT LEAST TWENTY-FOUR (24) HOURS BEFORE SCHEDULED APPOINTMENT*****

Expected Board Meeting Date *(*if the completed application is received by due date)*: _____

Your application for emergency financial assistance will be considered based upon the information obtained from the following documents:

☐	**VALID OHIO DRIVERS LICENSE or OHIO STATE ID:** Required prior to each application.
☐	**DD214 STATING HONORABLE of UNDER HONORABLE SERVICE BEYOND TRAINING:** Service must be with Regular Armed Forces of the United States.
☐	**PROOF OF CRAWFORD COUNTY RESIDENCY FOR THE LAST 90 DAYS:** Proof considered can be Rent Receipts, Mortgage Payments, Voter Registration, Notarized Statement from Landlord/Employer, Utility Bill in Veteran or Spouse Name.
☐	**SOCIAL SECURITY CARDS OF ALL HOUSEHOLD MEMBERS.**
☐	**BIRTH CERTIFICATES OF CHILDREN AND IF APPLICABLE CUSTODY PAPERS.**
☐	**MARITAL STATUS:** Marriage Record, Divorce Decree, Legal Separation Papers.
☐	**DISABILITY:** If you or your spouse are unable to work due to a disability you must bring in medical documentation from your doctor stating the reason and when, or if, you will be able to return to work.
☐	**VERIFICATION OF ALL MONIES AVAILABLE TO THE HOUSEHOLD OVER THE PAST 4 WEEKS TO INCLUDE:** Stocks, Bonds, Recent Bank Statements (Must be less than 1 week old), Pay Stubs, Human Services, Earning Statements, ALL Social Security benefits, ALL VA benefits Self-Employed: Provide accounting statement or verifiable documents, previous year Income Tax Return and current year financial ledger.
☐	**BASIC MONTHLY LIVING EXPENSES:** Rent Receipts/Agreement, Mortgage (Payment Insurance & Taxes), Utility Billings, Car Payments, Internet Billings, Cash Advance Statements, Home Furnishing Rental Payment Statements, Home Phone Billings, Cellular Phone Billings, Recurring Medical Billings

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EMERGENCY FINANCIAL ASSISTANCE APPLICATION SUSPICION OF FRAUD NOTICE

If a Veterans Service Commission (VSC) employee suspects an applicant of fraud, or attempted fraud, in the process of applying for, or receiving emergency financial assistance from the VSC, the VSC employee will discuss the matter with the Executive Director, presenting all information related to the allegation.

Initial for acknowledgement of review and understanding of the above: ☐

If, after reviewing all relevant information, the Executive Director determines that the applicant may have engaged in conduct that constitutes fraud, he/she will notify the Sheriff's Office and request further investigation.

Initial for acknowledgement of review and understanding of the above: ☐

Purchasing of restricted items or misuse of food and toiletries vouchers may result in termination of future assistance and prosecution. The veteran's signature on the voucher signifies comprehension of the restricted items and use of the voucher.

Initial for acknowledgement of review and understanding of the above: ☐

Applicant Name: ☐

Applicant Signature: _____ **Date:** _____

OFFICE USE ONLY:

Fraud Suspected: Yes / No Date:_____

Executive Director Informed of Details of Suspicion: Yes / No Date:_____

Executive Director Authorized Investigation: Yes / No Date:_____

VSO Employee Assigned to Investigate and Report: Yes / No Date:_____

Fraud Found: Yes / No Date:_____

Fraud Reported to Crawford County Sheriff's Department: Yes / No Date:_____

Further action and Recommendations: _____

_____

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EMERGENCY FINANCIAL ASSISTANCE APPLICATION RELEASE OF INFORMATION

I, _____, hereby authorize any and all doctors, hospitals, psychologists, therapists, counselors, agencies (including Job and Family Services), landlords, schools, past or present employers, attorneys, courts, and law enforcement agencies having any information concerning me, any person for which I have a domestic partnership, or any member of my family to relate to the Crawford County Veterans Service Office any and all information they may request as fully as if I had personally requested the information.

Information that may be released includes, but is not limited to:

- Any and all medical records
- Social Security records
- Financial records
- Evaluation of rehabilitation records
- Child Support Enforcement Agency records
- Department of Human Services records
- Ohio Bureau of Employment Services records
- Complete personnel records
- Arrest records
- Any and all court records
- Job and Family Services records

This authorization shall apply not only to records made prior to the date show on this authorization, but also to records made within one year after that date. This authorization is subject to revocation at any time except to the extent that any person authorized to make any disclosure has already taken action in reliance on it.

This authorization will terminate one (1) year from the date of signature.

A photocopy of this authorization shall have the same force and effect as the original. This information will be used to determine eligibility for financial assistance.

Giving false information can jeopardize my eligibility for assistance from the Crawford County Veterans Service Office and is a prosecutable offense.

Date: _____ Signature: _____
SSN: _____

Reply: _____

_____

_____

_____

Signature: _____ Date: _____

Agency: _____ Phone #: _____

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EMERGENCY FINANCIAL ASSISTANCE APPLICATION
YOUR STORY

This is your story. Take your time and be detailed.

What is your emergency?

What circumstances caused this emergency situation?

What other actions are you taking to remedy your financial distress?

I certify that the information given in this story is correct to the best of my knowledge. I understand that false statements made in this story may lead to prosecution.

Date Signed

Applicant's Signature

☐ *Check this box is there is a continuation page attached*

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EMERGENCY FINANCIAL ASSISTANCE APPLICATION PAYMENT AUTHORIZATION AND DISCLOSURE OF ADULT RESIDENTS OF HOUSEHOLD

I authorize the Crawford County Veterans Service Commission/Office, via the Crawford County Auditor office, at any time to make payment(s) to any agency, creditors, company, individuals, or businesses or others on my behalf or as necessary for the grant(s) of Emergency Financial Assistance by the Crawford County Veterans Service Commission or a Veterans Service Commissioner.

ALL ADULTS IN THE HOUSEHOLD MUST SIGN THIS DOCUMENT
FAILURE TO DISCLOSE ALL ADULT RESIDENTS OF THE HOUSEHOLD CONSTITUTES FRAUD

VETERAN'S PRINTED NAME: _____

VETERAN'S SIGNATURE (APPLICANT): _____

ALL OTHER ADULT MEMBERS OF HOUSEHOLD:

PRINT NAME: _____ **SSN:** _____

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **SSN:** _____

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **SSN:** _____

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **SSN:** _____

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **SSN:** _____

SIGNATURE: _____ **DATE:** _____

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EMERGENCY FINANCIAL ASSISTANCE APPLICATION

This application must be completed by answering all questions before scheduled appointment

VETERAN'S INFORMATION

Veteran's Name: Last	First	MI	SSN	Date of Birth

Marital Status	Date of Marriage*	Date of Divorce	Date of Death

**Note: Common law marriages are recognized in Ohio only if they were established prior to October 10, 1991*

Spouse's Name: Last	First	MI	SSN	Date of Birth

VETERAN'S MILITARY SERVICE (MUST HAVE PROOF OF SERVICE)

Date From	Date To	Type of Discharge	Branch of Service	Verified (Office Use Only)
				Yes – No – DD214 - VA
Date From	**Date To**	**Type of Discharge**	**Branch of Service**	**Verified (Office Use Only)**
				Yes – No – DD214 - VA

APPLICANT'S INFORMATION

Applicant's Name: Last	First	MI	SSN	Date of Birth

Relationship to Veteran (Circle Applicable)	Date Established Residency in Crawford County: (PROOF REQUIRED)
Self / Spouse / Widow / Dependent Parent / Minor Child / Ward	

Current Address	City	State	Zip

Date Moved In	Name of Current Landlord or Mortgage Co.	Landlord / Mortgage Co. Telephone	Fax

Previous Address	City	State	Zip	Date Moved in	Date Moved Out

DEPENDENTS

Name	Relationship	SSN	Date of Birth	In Custody of Who	Child Support $

Does anyone else live in your household? (Explain)

APPLICANT'S CONTACT INFORMATION

Primary Phone No.	Secondary Phone No.	Email Address	Other:

Has anyone in your household applied for assistance from any other agency in the past 90 days? Explain

EMPLOYMENT	VETERAN	SPOUSE	OTHER
Occupation			
Employer Name			
Employer Address			
Employer Phone			
Dates of Employment			
Rate of Pay			

Are you seeking employment? Where?, If not seeking employment, EXPLAIN WHY:

ASSETS				
Type	**Value**	**Type**	**Value**	**Loan Balance Remaining**
Checking	$	Home	$	$
Savings	$	Vehicle	$	$
Cash on Hand	$	Vehicle	$	$
Other	$	Other	$	$

HOUSEHOLD INCOME AND BILLS					
Income Type NET	**Last 30 Days**	**Next 30 Days**	**Bill Type**	**Last 30 Days**	**Next 30 Days**
Wages – Veteran*	$	$	Food & Toiletries	$	$
Wages – Spouse*	$	$	Rent/Mortgage	$	$
Wages – Other Member*	$	$	Electric	$	$
All VA Benefits	$	$	Water/Sewer	$	$
Private Retirement	$	$	Natural Gas/Propane	$	$
Social Security – Veteran	$	$	Other	$	$
Social Security – Spouse	$	$	Vehicle Payment & Insurance	$	$
Social Security - Children	$	$	Other Insurance	$	$
Welfare	$	$	Prescriptions/Medical	$	$
Unemployment Benefits	$	$	Gasoline	$	$
Worker's Comp	$	$	Cash/Title Loans	$	$
Child Support Received	$	$	Telephone	$	$
Household - Other	$	$	Internet	$	$
			Cable	$	$
Total Net Income:	**$**	**$**	**Total Expenses:**	**$**	**$**

Did you receive an Income Tax Return in the last tax year: Yes / No					
State Income Tax Return Amount:	**$**		**Federal Income Tax Return Amount:**	**$**	

** Estimate next 30 days wages, if paid hourly*

BILLS YOU WILL BE PAYING

LIST BILLS/EXPENSES YOU WILL PAY WITH YOUR INCOME FOR THE NEXT 30 DAYS	
BILLS YOU WILL BE PAYING	**AMOUNT**
EXAMPLE: RENT TO ABC RENTALS	$ 450.00
	$
	$
	$
	$
	$
	$
	$
	$
	$
TOTAL	$

ASSISTANCE REQUESTED

Indicate bills you are requesting the board to assist paying. The total assistance requested cannot exceed $1,400.00

Housing Assistance:

☐ Rent for (month) _____, to be paid to _____, in the amount of $ _____

Is there an eviction notice? Yes / No

☐ Mortgage to be paid to _____, in the amount of $ _____

Is there a foreclosure notice? Yes / No

Auto Loan Assistance:

☐ Auto Loan to be paid to _____, in the amount of $ _____

Is there a repossession notice? Yes / No

Utilities Assistance:

	Type	*To be paid to*		*Amount*	*Shutoff Notice?*
☐	Electric		$		Y / N
☐	Water		$		Y / N
☐	Gas / Propone / Fuel		$		Y / N
☐	Phone		$		Y / N
☐	Internet		$		Y / N
☐	City Utilities		$		Y / N
☐	Other:		$		Y / N

TOTAL (may not exceed $1,400.00)	$
Do you require assistance with food / toiletries?	Yes / No

I HAVE COMPLETED AND/OR REVIEWED ALL INFORMATION PERTAINING TO MY APPLICATION FOR FINANCIAL ASSISTANCE. I CERTIFY THAT THE INFORMATION GIVEN ON THIS APPLICATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT BY SIGNING THIS APPLICATION I AM GIVING PERMISSION TO ANY GOVERNMENT ORGANIZATION TO REVIEW THE COMPLETE FINANCIAL FILE. I UNDERSTAND THAT FALSE STATEMENTS MADE ON THIS APPLICATION MAY LEAD TO PROSECUTION.

_____ Date Signed

_____ Applicant's Signature

This section will be completed by the Crawford County Veterans Service Officer during interview with the Applicant		
SUM OF INCOME FOR NEXT 30 DAYS (FROM PAGE 2)	$	
(-) SUBTRACT		
SUM OF BILLS APPLICANT WILL BE PAYING (FROM PAGE 3) + (ADD) NEXT 30 DAYS FOOD AND TOILETRIES AMOUNT (FROM PAGE 2)	$	
(=) EQUALS		
REMAINING INCOME NOT USED ON BILLS LISTED ABOVE	$	

Total count of assistance approved in lifetime (cannot exceed 18):	
Total count of assistance approved in calendar year (cannot exceed 4):	
What was the date of the last assistance (cannot be less than 30-days)	
Will the applicant be required to meet the board? (every 3rd application)	Yes / No
If applicant requested food / toiletries, what is their authorized amount:	
Including food / toiletries, what is the total assistance requested (may not exceed $1,800)	
Notes:	
Reviewed by:	Date:

Executive Director's Review and Comments	
Recommend: APPROVAL / DISAPPROVAL	
Reviewed by:	Date: