



We Heart Veterans & VetAttend Professional Services, LLC

Working together to create a better quality of life
for our Veterans.

Assistance Application

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Phone: _____ Email: _____

Social Security NO.: _____ - _____ - _____ Monthly Income: \$ _____

Are you a Veteran of the U.S. Military?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you the surviving spouse of a Veteran?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you receiving Veteran's Benefits?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, what?	_____	
Can you provide a DD214?	YES <input type="checkbox"/>	NO <input type="checkbox"/>			

If no, explain: _____

Assistance Requested

Do you need assistance bathing and grooming?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you need meal preparation assistance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you need assistance with errands?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you need medication management?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you need transportation assistance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you need dressing/laundry assistance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Equipment Request

Do you need a wheelchair? YES NO

Do you need a walker or cane? YES NO

Do you need a bedside commode? YES NO

References

Please list anyone who referred you to We Heart Veterans.

Full Name: _____ Relationship: _____
Company: _____ Phone: _____

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Company: _____ Phone: _____

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Company: _____ Phone: _____

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Tell Us Your Story

Tell We Heart Veterans your story.
