

CHILDREN OF FALLEN SOLDIERS RELIEF FUND

The Children of Fallen Soldiers Relief Fund Was Founded To Honor Our Service Men and Women Who Have Lost Their Lives For Our Continued Freedom by Providing Surviving or Severely Injured Veteran's with children financial assistance during their time of hardship.

Please include a copy of your most recent tax filing even if you have not filed for several years, all military dependent ID cards and/or copies of DD 1172 enrollment form, DD 93, DD 214, form, a one-page statement concerning your reason for requesting funds, the amount requested, and the specific purpose to which the funds will be applied, a breakdown of monthly income and expenses and copies of VA approved disability documents . Incomplete applications will not be considered. Note: additional documents may be requested in order to complete the application process.

DISABLED APPLICATION FOR FINANCIAL ASSISTANCE

APPLICANT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVE PHONE: _____

SSN: _____ DOB: _____ EMAIL: _____

APPLICANT'S HIGHEST LEVEL OF EDUCATION: _____

MILITARY BRANCH: _____ DATE OF INJURY/DISABILITY _____

RANK: _____ VA DISABILITY % RATING: _____ DATE OF RATING _____

PHYSICIANS NAME/PHONE NO. _____

(PLEASE INCLUDE DOCUMENTS INDICATING DISABILITY & VA APPROVAL)

IF SPOUSE, OTHER PARENT OR HOUSEHOLD MEMBERS ARE EMPLOYED COMPLETE THE FOLLOWING:

NAME/RELATIONSHIP: _____

EMPLOYERS NAME: _____

ADDRESS: _____

SUPERVISORS NAME : _____ PHONE: _____

OTHER CHILDREN WHO QUALIFY AS A DEPENDENT OF THE ABOVE DISABLED VETERAN WHO ARE CURRENTLY UNDER YOUR LEGAL CUSTODY:

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

PLEASE PROVIDE CONTACT INFORMATION FOR OTHER PHYSICIANS, NURSES, HEALTH CARE PROVIDERS (INCLUDE TITLE) ON A SEPARATE SHEET IF NECESSARY

DR. NAME: _____ PHONE: _____

TOTAL MONTHLY INCOME: _____ TOTAL MONTHLY EXPENSES: _____

DATE: _____ SIGNATURE: _____

HOW DID YOU HEAR ABOUT US? _____

DATE OF APPLICATION: _____ SIGNATURE: _____

Grant recipients will be selected in accordance with criteria established by Children of Fallen Soldiers Relief Fund and are based on need and the amount of proceeds available for disbursement at the time of application. Proceeds will be disbursed only upon clarification of information received. Recipients hereby authorize CFSRF, its Directors, Board Members, trustees, employees, agents, licensees, successors and assigns to take pictures and interview family members and grantees for the sole purpose of furthering the charitable purpose of CFSRF. All applicants upon signing this application consent to the use of this information in Press Releases, website publications and other media in an effort to further our mission. Our support is available from funds received from the public and there may be times when you will be asked to consider receiving the award personally from a donor in your area, please initial here after reviewing the above. _____

Mail, fax or email the completed form and all attachments to:

CFSRF, P.O. Box 3968 , Gaithersburg, MD 20885-3968

(301) 685-3421 or (866) 96-CFSRF (301) 630-0592 Fax Email: grants@cfsrf.org