Iowa Veterans Trust Fund
Assistance Request

In order to qualify for assistance from the trust fund, the applicant must have a household income at or below ***300 percent of the Federal Poverty Guidelines.*** Further asset guidelines may apply and are identified within the applicable option. ***All services must be started within six months of approval, if not, additional review is required by the Commission.***

PLEASE COMPLETE ALL QUESTIONS AND SUBMIT TO YOUR *LOCAL COUNTY VETERANS AFFAIRS OFFICE* FOR APPROVAL. ONCE APPROVED BY THE COUNTY, THE APPLICATION WILL BE FORWARDED TO THE IOWA DEPARTMENT OF VETERANS AFFAIRS FOR CONSIDERATION BY THE COMMISSION.
All services rendered must be invoiced within ninety days of completion.

FULL NAME OF VETERAN_____

SOCIAL SECURITY NUMBER_____

DATE OF BIRTH_____

STREET ADDRESS_____

CITY, STATE, ZIP_____

HOME PHONE_____WORK PHONE_____CELL_____

DO YOU ☐ RENT OR ☐ OWN U.S. CITIZEN? ☐ YES OR ☐ NO VETERAN? ☐ YES OR ☐ NO

WIDOW OF A VETERAN? ☐ YES OR ☐ NO

BRANCH: ☐ ARMY ☐ NAVY ☐ MARINES ☐ AIR FORCE ☐ COAST GUARD ☐ MERCHANT MARINE

DATES OF SERVICE_____TO_____ TYPE OF DISCHARGE_____

LENGTH OF IOWA RESIDENCY_____ PREVIOUS STATE/COUNTY_____

CURRENT EMPLOYER _____

EMPLOYER'S ADDRESS_____

HOUSEHOLD CONTRIBUTOR DATA

FULL NAME_____

RELATIONSHIP_____DATE OF BIRTH_____

HOME PHONE_____WORK_____CELL_____

U.S. CITIZEN? ☐ YES OR ☐ NO VETERAN? ☐ YES OR ☐ NO WIDOW OF A VETERAN? ☐ YES OR ☐ NO

CURRENT EMPLOYER _____

EMPLOYER'S ADDRESS_____

DEPENDENT DATA

DO CHILDREN RESIDE IN THE HOME? ☐ YES OR ☐ NO

FULL NAME_____

RELATIONSHIP_____DATE OF BIRTH_____

FULL NAME_____

RELATIONSHIP_____DATE OF BIRTH_____

FULL NAME_____

RELATIONSHIP_____DATE OF BIRTH_____

FULL NAME_____

RELATIONSHIP_____DATE OF BIRTH_____

FULL NAME_____

RELATIONSHIP_____DATE OF BIRTH_____

TOTAL HOUSEHOLD MONTHLY INCOME

PLEASE NOTE: IF YOU HAVE A DISABLED CHILD OVER THE AGE OF 18 THAT RECEIVES INCOME, PLEASE NOTE AMOUNTS/SOURCE BELOW.

INCOME SOURCE	APPLICANT	SPOUSE / OTHER	CHILD
TAKE HOME PAY	$	$	$
UNEMPLOYMENT	$	$	$
SOCIAL SECURITY	$	$	$
SUPPLEMENTAL SECURTY INCOME (SSI)	$	$	$
IPERS	$	$	$
CHILD SUPPORT	$	$	$
PENSION	$	$	$
INTEREST/DIVIDEND/RENT	$	$	$
FIP	$	$	$
TOTAL GROSS INCOME	$	$	$
VA COMPENSATION	$	$	$
VA PENSION	$	$	$
OTHER SOURCES OF INCOME	$	$	$

LIQUID ASSET DATA

CASH ON HAND $_____CHECKING ACCOUNT BALANCE $_____

LIST CHECKING ACCOUNT FINANCIAL INSTITUTIONS AND ACCOUNTS

_____

_____

SAVINGS ACCOUNT BALANCE $_____

LIST SAVINGS ACCOUNT FINANCIAL INSTITUTIONS AND ACCOUNTS

_____

_____

MONEY MARKET ACCOUNT BALANCE $_____

LIST MONEY MARKET ACCOUNT FINANCIAL INSTITUTIONS AND ACCOUNTS

_____

_____

STOCKS OR BONDS AMOUNT $_____

CERTIFICATES OF DEPOSIT AMOUNTS $_____

TREASURY BILLS $_____OTHER LIQUID ASSETS $_____

NON-TRUST FUND ASSISTANCE

TITLE XIX_____

HEALTH INSURANCE COMPANY_____POLICY#_____

FOOD SUPPORT_____FUEL ASSISTANCE_____

MEDICALLY NEEDY SPEND DOWN AMOUNT $_____

COUNTY RELIEF? ☐ YES OR ☐ NO IF YES, WHICH COUNTY_____

WHAT KIND OF ASSISTANCE? _____

ASSISTANCE FROM OTHER COUNTIES_____

ASSISTANCE FROM OTHER AGENCIES_____

MONTHLY EXPENSES

RENT OR MORTGAGE	$	TRAILER LOT RENT	$
ELECTRIC/GAS BILL	$	CABLE TELEVISION	$
WATER/SEWER/TRASH	$	DOCTOR BILLS	$
FOOD	$	HOSPITAL BILLS	$
VEHICLE GAS/MAINTENANCE	$	CREDIT CARD DEBT INSTALLMENT PAYMENTS	$ $
CAR PAYMENT	$	DENTAL BILLS	$
CAR INSURANCE	$	MEDICATION COSTS	$
CHILD CARE	$	WAGE GARNISHMENT	$
PHONE BILL	$	OTHER MONTHLY BILLS	$
CELL PHONE BILL	$	OTHER MONTHLY BILLS	$

TOTAL MONTHLY EXPENSES $_____

LIST BILLS OWED BUT NOT BEING PAID_____

_____

_____

PROVIDE SUMMARY OF FINANCIAL NEED_____

_____

_____

_____

_____

PLEASE SELECT ASSISTANCE YOU ARE APPLYING FOR:

☐ **14.4(1) Travel expenses for wounded veterans or visiting spouse, directly related to medical care.** Travel expenses under this sub rule include the unreimbursed cost of airfare, lodging and a per diem of $50 per day for required medical that exceeds 125 miles from the veteran's home. Not exceeding $1,000.00. Amount of Request $_____

☐ **14.4(2) Job training or college tuition assistance**
A veteran may not be paid more than $5,000.00 for retraining or postsecondary education to enable the veteran to obtain gainful employment. To include internet access for further education.
Amount of Request $_____

☐ **14.4(3) Unemployment assistance during a period of unemployment due to prolonged physical or mental condition or disability resulting from military service.** Maximum monthly benefit: $500. Maximum in a 12-month period: $3,000. Lifetime maximum benefit: $6,000.
Amount of Request $_____ Date Unemployment Began_____
Reason for Unemployment_____
Documents Needed to Support Request:
• Copy of a DD Form 214 or other relevant release form;
• Denials from other agencies;
• Verification of assistance from other agencies and/or counties

☐ **14.4(4) Dental, vision, hearing, and prescription drug assistance for veterans & dependents.** Payment will be made directly to the medical provider for medical needs not covered by Medicaid, Medicare, insurance, or VA. Maximum benefit for dental care - $10,000, vision care - $500, hearing care - $1,500 per ear, and prescription drugs - $1,500. Prescriptions drugs cover prescribed over the counter drugs. Lifetime maximum benefit $10,000 per eligible family member.
Type of Request: ☐ Dental ☐ Vision ☐ Hearing ☐ Prescription Drugs
Amount of Request $_____
Documents Needed to Support Request
• Copy of a DD Form 214 or other relevant release form;
• Denials from other entities;
• Verification of assistance from other agencies or counties;
• Medical documentation of the health care need;
• Estimated cost of the care on a statement from the health care provider / or the unpaid portion of an unpaid medical invoice; and
• Federal ID number and contact information for the institution where payment will be made.

☐ **14.4(5) Durable equipment to allow a veteran to remain in their home or to fully utilize their home.** Lifetime maximum - $5,000 in a twelve-month period. Lifetime maximum benefit $10,000.
Amount of Request $_____
Documents Needed to Support Request:
• Copy of a DD Form 214 or other relevant release form;
• Denials from other agencies;
• Verification of assistance from other agencies or counties;
• Medical documentation of the needed equipment and how it will aid the veteran in remaining in their home or fully utilizing their home;
• Invoice from a supplier or installer of durable medical equipment or estimate cost of equipment and installation.
• Federal ID number and contact information for the entity where payment will be made

☐ **14.4(6) Individual or family counseling and substance abuse programs.** Veterans who are eligible for VA health care must initially access VA psychiatric care and may use the trust fund to supplement that care if it will occur with a greater frequency or is closer than VA care. For non-VA services, up to $150 per hour and $75 per half-hour is available for outpatient counseling visits and $40 per hour for group

counseling. Total benefits cannot exceed $5,000 per family in a 12 – month period, with reduced limits based on the following: Individual veteran counseling services - $2,500 maximum. Individual veteran substance abuse treatment and counseling combined -
$3,500 maximum. Family counseling services that may also include individual counseling and substance abuse services - $5,000.
Amount of Request $_____
Documents Needed to Support Request:
• Copy of a DD Form 214 or other relevant release form;
• Denials from other agencies;
• Verification of assistance from other agencies or counties;
• If VA eligible, evidence of treatment at a VA medical center;
• Evidence of attendance of a counseling program and documentation of the cost of the program; and
• Federal ID number and contact information for the entity where payment will be made.

☐ **14.4(7) Ambulance and emergency room services for veterans who are emergency patients and lodging for immediate family members.**
Assistance to veterans for expenses related to ambulance trips, including air ambulance transportation, and emergency room visits for emergency care patients. All efforts should be made to utilize all other methods of payment prior to accessing assistance under this sub rule. The maximum amount that may be paid may not exceed $10,000. Amount of Request $_____

☐ **14.4(8) Emergency housing repair, emergency transitional housing assistance, and emergency vehicle repair.**
Housing Repair: Housing repair is limited to repairs that are required to improve the conditions and integrity of the home and are necessary for the safety and security of the residents. In situations where a home is damaged beyond repair, assistance under this sub rule is available to assist the applicant in purchasing a new home. You must provide pictures of needed repairs, and at least two (2) estimates that state the rationale for the repairs (i.e., that they are needed for personal safety and/or security purposes). Contractors must be registered with the State of Iowa. Lifetime maximum benefit: $10,000.
Transitional Housing: Assistance for transitional housing may be provided to applicants who are displaced from their homes during a period of repairs related to a disaster, vandalism, home accident, or other reason that make staying the homes hazardous to the health of the residents. Any refunded security deposits paid for under this sub rule shall be returned to the Iowa Veterans Trust Fund.
Vehicle Repair or Replacement: Assistance for vehicle repair is limited to expenses that are required for continued use of the vehicle. This assistance will only be granted in cases where the vehicle is needed for travel to and from work- related activities, the applicant is over the age of 65, or substantial hardship will occur if the vehicle is not repaired. You must provide pictures of needed repairs, and at least two (2) estimates that state the rationale for the repairs (i.e., that they are needed for personal safety and/or security purposes). An ASE certified mechanic must do all repairs. Approved amount will not exceed the value of the vehicle. If the vehicle is not worth repairing, the veteran has the option to replace the existing vehicle not exceeding $5k. Vehicle replacement is a ONE-TIME only $5,000.

The maximum amount that may be paid for any consecutive 12–month period may not exceed $1,000 for transitional housing. Lifetime maximum benefit for housing repair & vehicle repairs is $10,000.
Amount of Request $_____
Documents Needed to Support Request:
• Copy of a DD Form 214 or other relevant release form;
• Denials from other agencies;
• Verification of assistance from other agencies or counties;
• Rental agreement for transitional housing;
• Repair estimates from the entity that will be performing the vehicle or home repair or an unpaid repair invoice; and for replacement vehicles an invoice including a pre-condition inspection.
• Federal ID number and contact information for the entity where payment will be made.

☐ **14.4(9) Expenses related to establishing a minor child is a dependent of a deceased veteran.**
The maximum amount that may be paid may not exceed $2,500.
Amount of Request $_____

☐ **35A.13 (6.n) Homelessness:** Rental housing assistance for veterans who meet the definition of homeless, as set out in 42 U.S.C 11302, for payment of rental application fees to obtain rental housing. One-time basis per recipient not to exceed $1,000 per recipient.
Amount or Request $_____

I understand that I am required to ensure that the information I have entered on this form is as complete and accurate as feasible on the date it was completed. I further understand that the data I have supplied on this form will be investigated and used by any and all members of the Iowa Veterans Commission or Iowa Department of Veterans Affairs to determine my eligibility for the assistance requested. I also understand that intentionally providing false information could lead to a six-month bar from receiving any benefits from the Iowa Veterans Trust Fund. Therefore, I hereby authorize release of this information to and only to these individuals.

APPLICANT'S SIGNATURE_____DATE_____

FOR COUNTY USE ONLY

1. Please include a signed letter from the County Veterans Affairs office indicating the pertinent facts surrounding this application.
2. Did the county apply for all other state and federal benefits entitled to the veteran? (Y/N)
   If yes, explain _____

Types of assistance:	**Unemployment Assistance**	**Dental Medical Vision**	**Emergency Home Repair**	**Counseling**	**Transitional Housing**	**Vehicle Repair / Replacement**
Required forms:						
Last 30 days of bank statements or current debit card balance	X	X	X	X	X	X
IDVA Trust Application	X	X	X	X	X	X
DD-214	X	X	X	X	X	X
Required county signature page	X	X	X	X	X	X
Service Connected letter	X					
Verification of unemployment dates	X					
Estimate, Federal ID/W-9 form		X	X			X
Proof of home ownership & home owners insurance			X			
Photo's with two estimates		X	X	X		X
Denial letters if applicable		X		X	X	X
Verification of assistance from other agencies if applicable		X		X	X	X
Evidence from VA (denial or eligibility)		X		X		
Rental agreement, Federal ID/W-9 form					X	
Proof of copies **current** driver's license, vehicle insurance, registration & mileage						X

3. Did you find additional pertinent facts not shown on the application? (Y/N)
   If yes, explain _____
   What is your recommendation concerning thisapplication? Approve___Disapprove_____

4. Explain reason for recommendation_____
   *County Officer Signature*_____
   Effective 04/06/23