APPLICATION

American Military Education Need Program

TOWN OF MALTA

SECTION A: APPLICANT INFORMATION

Name

____

Address

____

Email Phone

____

SECTION B: VETERAN INFORMATION

Name of Veteran: ____

Veteran Address: ____

(Attach Proof of Residency)

Branch of Military: __________ (Attach Proof of Military Service)

Relationship of Applicant to Veteran: ____

Individual Address: ____

(Attach Proof of Residency)

Reimbursement Amount ($250 maximum) (attach copy of tuition bill): _______________________________________

SECTION C: APPLICANT AFFIRMATION

I authorize release of my contact information, dwelling information, and other information to representatives of the Town of Malta, and/or its designated representatives. I understand that the information provided by me will be used only for the purposes of determining eligibility for the program and financial incentives. I understand that all information will be kept confidential, to the extent permitted by law.

I understand that this application does not guarantee that assistance will be granted to me. Whether or not services are provided will depend on the number of applications received and the availability of funds and priorities established for the program.

I understand that by submitting this application I am affirming that my annual family income is < $100,000.

I agree to provide the Town representatives at times that are mutually acceptable, to perform program activities including inspections and Quality Assurance activities. I agree to hold the Town harmless from any liability relating to this program.

I subscribe and affirm, under the penalties of law, that the statements made on all parts of this application, including statements made on any accompanying documents, have been examined by me and are to the best of my knowledge true and complete.
I understand that my signature on this form gives permission for Town representatives of the Town of Malta, and their designees, to assure my eligibility for the programs. I consent to any inquiry to verify or confirm the information that I have given. I understand that if I give false information or withhold information in order to receive benefits that I am not entitled to, I can be prosecuted to the fullest extent of the law.

X ____

Applicant Signature   Date

AGENCY USE ONLY

☐ Veteran Address in Malta

☐ Eligible for Program ☐ NOT Eligible for Program

Reimbursement Amount $____________________

Additional Comments: ____

____

Agency Representative Signature:__________________________________**Title:** ____________________________

Date: ____