



ARMY FEE ASSISTANCE

Wounded Warrior Eligibility Certification

Completion of this form serves as certification that the Sponsor is eligible to receive Army Fee Assistance benefits under Wounded Warrior Status.

Wounded Warrior's Information:

Name: _____

Rank: _____ Social Security Number: XXX-XX-_____ *Last 4 of SSN*

Qualifying Child Information:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Spouse/Parent/Guardian Information:

Name: _____

Spouse/Parent/Guardian Phone Number: _____

Spouse/Parent/Guardian Email Address: _____

Physician Certification:

Medical Facility Name: _____

Date Sponsor entered medical facility: _____ Release date: _____

If Sponsor is still in the medical facility named above, provide the expected release date: _____

Date outpatient care began: _____ Expected end date: _____

Attending physician name: _____

Attending physician phone number: _____

By signing this form, I attest that the Sponsor named above is under my care and is receiving medical treatment under Wounded Warrior Status.

Signature of Attending Physician

Date of Certification

Please retain a copy of this document for the sponsor's file confirming your authorization to release the information above. The original form must be submitted to the GSA Subsidy Administration Section to complete the Army Sponsor's file and certify his/her Wounded Warrior Status.

