

VA CLAIM QUESTIONNAIRE

Please complete and bring with you to the meeting

CLAIMANT INFORMATION

Full name of the veteran: _____

Full name of the spouse: _____

Address where mail should be sent:

Address where claimant currently resides:

Date of birth: Veteran: ___/___/___ Spouse: ___/___/___

SSN: Veteran: ___/___/___ Spouse: ___/___/___

Date of death: Veteran: ___/___/___ Spouse: ___/___/___

Date of marriage: ___/___/___ Place married: _____

Is spouse a veteran? yes no

Previous claim filed? yes no File # _____

Was the veteran or spouse previously married? yes no (If yes, circle which one)

Date of marriage: ___/___/___ to ___/___/___

Place married: _____ Place marriage ended: _____

Date of marriage: ___/___/___ to ___/___/___

Place married: _____ Place marriage ended: _____

SERVICE INFORMATION

Has the veteran received any of the following? (check all that apply)

- Lump Sum Readjustment Pay \$ _____
- Separation Pay \$ _____
- Special Separation Benefit \$ _____
- Voluntary Separation Incentive \$ _____
- Disability Severance Pay \$ _____

The veteran is (check all that apply):

- on Medal of Honor Roll
- receiving VA compensation for service-connected disability
- receiving military retirement pay \$ _____ branch: _____
- formerly a POW (please give a short description below)

DISABILITY INFORMATION

Check all that apply

<u>Veteran</u>	<u>Spouse</u>
----------------	---------------

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Over 65 |
| <input type="checkbox"/> | <input type="checkbox"/> | Blind |
| <input type="checkbox"/> | <input type="checkbox"/> | Declared incompetent |
| <input type="checkbox"/> | <input type="checkbox"/> | Has macular degeneration – Extent: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Under 65, determined disabled by Social Security Admin. |
| <input type="checkbox"/> | <input type="checkbox"/> | Diagnosed with dementia – Stage: Early Mid Late |
| <input type="checkbox"/> | <input type="checkbox"/> | Is housebound (unable to leave without assistance) |
| <input type="checkbox"/> | <input type="checkbox"/> | Needs daily assistance from another to perform basic activities |
| <input type="checkbox"/> | <input type="checkbox"/> | Receives Medicaid – Type: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Has applied for Medicaid – Type: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is in a nursing home – Name: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is in an assisted living facility – Name: _____ |

Has the claimant been hospitalized in the last 12 months? yes no

Began ___/___/___ Ended ___/___/___

Name and address of facility: _____

Began ___/___/___ Ended ___/___/___

Name and address of facility: _____

Please list the names and addresses of all physicians providing care to the veteran or spouse:

Name: _____ Address: _____

Name: _____ Address: _____

INCOME AND NET WORTH INFORMATION

<u>Amount in</u>	<u>Veteran</u>	<u>Spouse</u>	(If a joint account, list in one)
Checking accounts	\$ _____	\$ _____	
Savings accounts	\$ _____	\$ _____	
CDs	\$ _____	\$ _____	
IRAs or other retirement	\$ _____	\$ _____	(Not pension payments)
Stocks and bonds	\$ _____	\$ _____	
Mutual Funds	\$ _____	\$ _____	
Life Insurance (cash value)	\$ _____	\$ _____	
Real property (not home)	\$ _____	\$ _____	
Other property	\$ _____	\$ _____	describe: _____
Other property	\$ _____	\$ _____	describe: _____

Will the veteran or spouse receive income in the next 12 months from:

- Business operation or rental property yes no
- Farm operation yes no
- Personal injury settlement yes no
- Anticipated inheritance yes no

If yes, please attach amounts to be received and any documentation showing amount received.

Please list regular sources of monthly income and amounts:

	<u>Veteran</u>	<u>Spouse</u>
Social Security:	\$ _____	\$ _____
Pension:	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____

Are there any one-time or non-monthly sources of income the claimant expects to receive in the next 12 months? yes no If so, please explain:

Please list your monthly medical out-of-pocket expenses (if married, please include spouse's medical expenses as well). Medicaid expenses include prescriptions, home health aides, assisted living expenses, long term care premiums, doctor co-pays, etc.:

<u>Expense</u>	<u>Amount paid monthly</u>
<hr/>	\$ <hr/>
<hr/>	\$ <hr/>
<hr/>	\$ <hr/>
<hr/>	\$ <hr/>
<hr/>	\$ <hr/>
<hr/>	\$ <hr/>

Other Monthly Expenses

	<u>Amount paid monthly</u>
Utilities	\$ <hr/>
Food	\$ <hr/>
Cable	\$ <hr/>
Transportation	\$ <hr/>
Cell Phone	\$ <hr/>
Clothing	\$ <hr/>
Mortgage/Rent	\$ <hr/>
Credit Card Payment	\$ <hr/>
Life Insurance Premium	\$ <hr/>
Property Taxes	\$ <hr/>
Loan Payments	\$ <hr/>
Other	\$ <hr/>

VA/ PERIODS OF WAR

War	Starting Date	Ending Date
WWII	December 7, 1941	December 31, 1946
Korea	June 27, 1950	December 31, 1955
Vietnam	August 5, 1964 (February 28, 1941 if in Country earlier)	May 7, 1975
Persian Gulf	August 2, 1990	Unknown