

VA CLAIM QUESTIONNAIRE

Please complete and bring with you to the meeting

CLAIMANT INFORMATION

Full name of veteran: _____

Full name of spouse: _____

Address where mail should be sent:

Address where claimant currently resides:

Date of birth: 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>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

