

TAMPA BAY ELDER LAW CENTER

A Private Law Firm

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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.

