

Date: _____

VETERAN

First, Middle, Last			
Maiden Name		Social Security Number	
Service Branch		Entry Date	
Military Service Number		Discharge Date	
Highest rank		Date of death	
Assisted Living Facility		Referral Source	
Home Phone		Work Phone	
Cell Phone		Fax Number	
Address			
City, State Zip		County:	
Date of Birth		Place of Birth	
Prior Marriages: Whom		Date;	
How ended		Date disability started	
Type of disability		Hospitalization dates	
U.S. Citizen: Yes/No		Country:	
Date of Marriage		Date of Citizenship:	
Email address			

SPOUSE

First, Middle, Last			
Maiden Name		Social Security Number	
Cell Phone		Work Phone	
Date of Birth		Place of Birth:	
Email address			
Date of Marriage to Veteran			
Other Marriages: Whom		Date:	
How ended		Date disability started	
Type of disability		Hospitalization dates	

CONTACT PERSON

First, Middle, Last			
Maiden Name		Social Security Number	
Cell Phone		Work Phone	
Date of Birth		Relationship	
Email address			
Address			
City, State Zip		County:	

INCOME	Vet	Spouse	MEDICAL EXP	Vet	Spouse
SS			ALF/NH		
SS			MED SUPP		
PENSION			LTC		
PENSION			DRUGS		
Other Monthly Income			SUPPLIES		
			ASSISTANCE		
			Mo/Asst. Living Fee		
			Add Assistance Fee		
TOTAL			TOTAL		

ASSETS				DEBTS	
	Amount	Income Tax Basis	Ownership		Amount
House				Mortgage	
IRA				CC	
Annuities					
CD					
Investments					
Money Market					
Savings					
Checking					
Stocks					
TOTAL				TOTAL	

NOTES:

As of 01/07/14

Married \$2,085 Month

Single Veteran \$1,758 Month

Widow of Veteran \$1,130 Month

Intake Information by:

NOTES:

QUALIFICATIONS

- Veteran must have served at least 1 day during qualified war period
- Veteran must have served at least 90 days of active duty
- Veteran received a better than dishonorable discharge
- Claimant is either over 65 years of age OR totally disabled
- Claimant is surviving spouse of a qualified and did not remarry
- Claimant or spouse needs assistance with at least two (2) activities of daily living (ADLs)
- Claimant's monthly medical expenses equals or exceeds their monthly income

DISABILITY INFORMATION

Check all that apply

Veteran Spouse

- | | | |
|--------------------------|--------------------------|---|
| <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"/> | Needs assistance with dressing and undressing |
| <input type="checkbox"/> | <input type="checkbox"/> | Needs assistance with keeping themselves presentable |
| <input type="checkbox"/> | <input type="checkbox"/> | Needs assistance with bathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Needs assistance with taking medications |
| <input type="checkbox"/> | <input type="checkbox"/> | Needs assistance with feeding |
| <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: _____ |