**PENSION/SURVIVOR’S INTAKE FORM**

 *Please answer* **all** *questions – if not applicable enter “N/A”*

* *Did the Veteran serve at least 90 consecutive days of active duty at least one day of which was during a designated period of war*
* *Did the Veteran serve 1 day of wartime service that resulted in a discharge for Service-connected Disability*
* *Did the Veteran serve at least 90 days or more in more than one period of war*
* *Did Veteran receive a discharge other than* ***dis****honorable*

**You must:**

* *Demonstrate financial need and meet an income and net worth test (real property (land) and personal property (material possessions) less than $50K, not including the value of your home.*
* *Are you totally and permanently disabled not due to willful misconduct* ***or***
* *Are you age 65 or over*

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you the veteran? Y/N**

**Are you applying for Non-service connected Pension** or **Survivor’s Pension** or **Special Monthly Pension (SMP)**

**Survivor’s Pension only – Do you have a copy of marriage certificate and Veteran’s death certificate? Y/N** *If applicant is child of veteran will need a copy of birth certificate*

**Is the Veteran over 65 years of age? Y/N**

**Does the Veteran suffer from a permanent disability which would render it impossible for the average person to follow a substantially gainful occupation? Y/N**

**Specify medical condition(s) that cause you to be so disabled: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **First middle last**

**Name used in service if different: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **First middle last**

**Veteran’s branch of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Veteran’s dates of service: \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant (if other than veteran):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **First middle last**

**Relationship to veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**( ) Mailing address is same as above**

**Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell/work/home)**

**Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(cell/work/home)**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number: \_\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

**( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated**

**Are you currently employed? Y/N If yes, what is your occupation:\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you able to work? Y/N**

**If you (veteran) are not employed, is it because of medical problems related to your military service? Y/N**

**Are you receiving Social Security Disability, Supplemental Social Security, or other forms of government assistance? Y/N Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have dependents? Y/N If yes, how many? \_\_\_\_\_\_\_ Please list below:**

**Name Date of Birth Social Security # relationship to vet**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What VA Regional office is the veteran’s file located: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has the veteran ever been treated at a VA medical center or outpatient facility? Y/N**

**If yes, please specify when, where, and what the treatment was for:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you receiving VA benefits? Y/N If yes, check all that apply:**

**( ) Compensation ( ) Pension ( ) Home loan guaranty**

**( ) Medical care ( ) Education ( ) Vocational Rehabilitation**

**( ) Domiciliary care ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Because pension is need based, you must report all household income to the VA. Completing the information below will help in assessing eligibility. Write in all the monthly income for the veteran/spouse and all dependents who reside in the household.*

**Source of income:**

**Veteran** **Spouse** **Child**

$\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Wages:**

$\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security:**

$\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Private pension:**

$\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Civil service pension:**

$\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Interest:**

$\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dividends:**

$\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:**

$\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Totals:**

**$\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Unreimbursed medical expenses** (hospital expenses, doctor’s office fees, dental fees, prescription/non-prescription drug costs, vision care costs, medical insurance premiums, nursing home costs, hearing aid costs, home health service expenses, expenses related to transportation to hospital, doctor, or other medical facility, monthly Medicare deduction**) may be used to reduce countable income.**

**$\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Note:*** *If a veteran without a spouse or other dependent is a patient in a Medicaid paid nursing home, VA will only pay the qualifying veteran $90 per month. This is solely for the veteran’s personal use and cannot be applied to the cost of nursing home care or attached by Medicaid.*