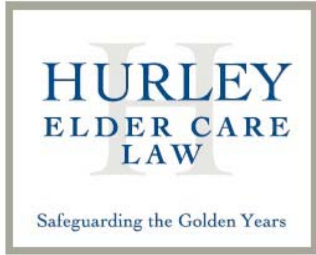

VA Claim Questionnaire

Revised September 13, 2007

CLAIMANT INFORMATION

Name of vet: ____

Name of spouse: ____

Address: ____

Telephone: (____) ____-_____ email: ___________________@_________

Vet DOB: ___/___/___ Spouse DOB ___/___/___

City, State, Country of birth – Vet: ___________________________________

Vet SSN ____-____-_____ Spouse SSN ____-____-____

Date of Marriage ____/____/____ Where: ________________________

Is spouse a vet? Yes No Spouse VA file # _________________

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

Was the vet or spouse previously married: No Yes (If so circle which one)

1. Dates of marriage from ___/___/___ to ___/___/___

City/State of marriage: ____

City/State where ended: ____

2. Dates of marriage from ___/___/___ to ___/___/___

City/State of marriage: ____

City/State where ended: ____

VETERAN'S SERVICE INFORMATION

Has the veteran received any of the following:

_____ Lump Sum Readjustment Pay $ _____________

_____ Separation pay $ _____________

_____ Special Separation Benefit $ _____________

_____ Voluntary Separation Incentive $ _____________

_____ Disability Severance Pay $ _____________

_____ Other $ _____________
Benefit: _________________________

Check all the apply:

The veteran is:

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

____

____

____

____

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DISABILITY INFORMATION

Check all that apply:

Veteran	Spouse	
□	□	**Over 65**
□	□	**Blind**
□	□	**Declared incompetent**
□	□	**Has macular degeneration Extent: ______________________**
□	□	**Disabled per Social Security Administration**
□	□	**Diagnosed with dementia Stage: Early Mid Late**
□	□	**Is housebound**
□	□	**Needs the regular aid and attendance of another person for activities of daily living**
□	□	**Receives Medicaid**
□	□	**Has applied for Medicaid**
□	□	**Is in a nursing home or assisted living**

Name of facility(ies):____

Has the claimant been recently hospitalized?

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

Name and address of facility or doctor: _________________________

____

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

Name and address of facility or doctor: _________________________

____

Please list below the names and addresses of all physicians currently providing care to the veteran or spouse. Also list any hospitals where the veteran or spouse have recently received care:

_________________________________ _______________________________

_________________________________ _______________________________

_________________________________ _______________________________

_________________________________ _______________________________

INCOME AND NET WORTH INFORMATION

Amount in:	Veteran	Spouse	Dependent(s)
Checking accounts	$__________	$__________	$____________
Savings accounts	$__________	$__________	$____________
CDs	$__________	$__________	$____________
IRAs, Keoghs	$__________	$__________	$____________
Stocks and bonds	$__________	$__________	$____________
Mutual Funds	$__________	$__________	$____________
Life Insurance (Cash Value)	$__________	$__________	$____________
Real Property (not home)	$__________	$__________	$____________
Other property	$__________	$__________	$____________

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

Business operation or rental property ____ No ____ Yes

Farm operation ____ No ____ Yes

Personal injury settlement ____ No ____ Yes

Anticipated inheritance ____ No ____ Yes

If so, attach amounts to be received and any documentation

Regular sources of Monthly Income and amounts

	Veteran	Spouse
Social Security:	$ _______________	$ _________________
Other pension	$ _______________	$ _________________
Other	$ _______________	$ _________________

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Any other one-time or non-regular (coming every month) sources of income upcoming in the next 12 months and amounts for

Veteran	**$___________**	**Source:_______________________**
	$___________	**Source:_______________________**
	$___________	**Source:_______________________**
Spouse:	**$___________**	**Source:_______________________**
	$___________	**Source:_______________________**
	$___________	**Source:_______________________**
Dependents:	**$___________**	**Source:_______________________**
	$___________	**Source:_______________________**
	$___________	**Source:_______________________**

CLAIMANT'S WORK HISTORY (IF UNDER 65)

Is claimant employed? ____ No ____ Yes Date last worked ___/___/___

Was claimant self-employed before becoming disabled? ___ No ___ Yes

What kind of work? ____

Is claimant still self-employed? ____ No ____ Yes

Is claimant receiving disability benefits from Social Security? ____ No ____ Yes

Claimant 's highest level of education completed: _______________

Work History from one year before claimant became disabled to the present:

1st Name of Employer: ____

Address: ____

Job title __________________________ Annual earnings $ ____________

Dates from ____/____/____ to ____/____/_____

Number of days lost due to disability: _______________

2nd Name of Employer: ____

Address: ____

Job title __________________________ Annual earnings $ ____________

Dates from ____/____/____ to ____/____/_____

Number of days lost due to disability: _______________

3rd Name of Employer: ____

Address: ____

Job title __________________________ Annual earnings $ ____________

Dates from ____/____/____ to ____/____/_____

Number of days lost due to disability: _______________

DEPENDENT INFORMATION

Please list the names and information of:

- **children under 23**
- **children over 23 who are disabled**
- **non-child dependents* of veteran, other than spouse**

#1

Name __________________________________ DOB ____/____/____

Address ____

City, State, Zip: _________________________________ SSN: ____-____-_____

Check any of the following that apply:

- □ **full time student**
- □ **adopted**
- □ **stepchild**
- □ **married now or previously**
- □ **disabled**

At what age? _____ Disability __________________________________

#2

Name __________________________________ DOB ____/____/____

Address ____

City, State, Zip: _________________________________ SSN: ____-____-_____

Check any of the following that apply:

- □ **full time student**
- □ **adopted**
- □ **stepchild**
- □ **married now or previously**
- □ **disabled**

At what age? _____ Disability __________________________________

#3

Name __________________________________ DOB ____/____/____

Address ____

City, State, Zip: _________________________________ SSN: ____-____-_____

Check any of the following that apply:

- □ **full time student**
- □ **adopted**
- □ **stepchild**
- □ **married now or previously**
- □ **disabled**

At what age? _____ Disability __________________________________

*** A dependent for tax purposes**

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