

ELDER LAW OF LOUISVILLE

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VA CLIENT QUESTIONNAIRE

CLAIMANT INFORMATION:

Full name of Vet: _____

Full name of spouse: _____

Address: _____

Telephone: (_____) _____

Email: _____

Vet DOB: _____ Spouse DOB: _____

Vet's City, State, Country of birth: _____

Vet's SSN: _____ Spouse SSN: _____

Date of Current Marriage: _____

Where: _____

Is spouse a vet? ____ Yes ____ No Spouse VA file #: _____

Dates of death: Veteran: _____ Spouse: _____

Was the ___ Vet or ___ Spouse previously married? ____ Yes ____ No

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:

Active Duty #1:

Branch of Service: _____ Service Number: _____

Date entered Active Duty: _____ Place: _____

Date left Active Duty: _____ Place: _____

Rank: _____

Active Duty #2:

Branch of Service: _____ Service Number: _____

Date entered Active Duty: _____ Place: _____

Date left Active Duty: _____ Place: _____

Rank: _____

Has the veteran received any of the following:

_____ Lump Sum Readjustment Pay in the amount of \$ _____

_____ Separation pay in the amount of \$ _____

_____ Special Separation Benefit in the amount of \$ _____

_____ Voluntary Separation Incentive in the amount of \$ _____

_____ Disability Severance Pay in the amount of \$ _____

_____ Other: _____

in the amount of \$ _____

Check all that 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)

SPOUSE'S SERVICE INFORMATION (if applicable):

Active Duty #1:

Branch of Service: _____ Service Number: _____

Date entered Active Duty: _____ Place: _____

Date left Active Duty: _____ Place: _____

Rank: _____

Active Duty #2:

Branch of Service: _____ Service Number: _____

Date entered Active Duty: _____ Place: _____

Date left Active Duty: _____ Place: _____

Rank: _____

Has the spouse received any of the following:

- _____ Lump Sum Readjustment Pay in the amount of \$ _____
- _____ Separation pay in the amount of \$ _____
- _____ Special Separation Benefit in the amount of \$ _____
- _____ Voluntary Separation Incentive in the amount of \$ _____
- _____ Disability Severance Pay in the amount of \$ _____
- _____ Other: _____
in the amount of \$ _____

Check all that apply:

The Spouse 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)

DISABILITY INFORMATION:

Check all that apply:

Veteran Spouse is:

- Over 65
- Blind
- Declared incompetent
- Has macular degeneration Extent: _____
- Disabled per Social Security Administration
- Diagnosed with dementia Stage: Early Mid Late
- Housebound (can't leave residence w/out assistance)
- Needs the regular aid and attendance of another person for activities of daily living (example: dressing, feeding, bathing, toileting, protective environment, mobility)
- Receives Medicaid or 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 and/or doctor:

Began: _____ Ended: _____

Name and address of facility and/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 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:	\$ _____	\$ _____

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: _____ Dates: _____ to _____

Annual earnings: \$ _____

Number of days lost due to disability: _____

2nd Name of Employer: _____

Address: _____

Job title: _____ Dates: _____ to _____

Annual earnings: \$ _____

Number of days lost due to disability: _____

Attach a separate sheet if needed.

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
*dependent for tax purposes

Dependent #1:

Name: _____ DOB: _____

Address: _____ SSN: _____

Check any of the following that apply:

_____ Full time student _____ Adopted
_____ Stepchild _____ Married now or previously
_____ Disabled At what age: _____
Disability: _____

Dependent #2:

Name: _____ DOB: _____
Address: _____ SSN: _____

Check any of the following that apply:

_____ Full time student _____ Adopted
_____ Stepchild _____ Married now or previously
_____ Disabled At what age: _____
Disability: _____

Attach a separate sheet if needed.

CHILDREN INFORMATION:

Child #1:
Name: _____ DOB: _____ SSN: _____
Address: _____

Child #2:
Name: _____ DOB: _____ SSN: _____
Address: _____

Attach a separate sheet if needed.