HASKINS SHORT & BRINDLEY LLC

5113 Monona Dr., Monona, WI 53716
P: 608-237-6673 F: 608-237-6965
HSBElderLaw.com

Brenda R. Haskins, JD
Julie A. Short, JD
Anne M. H. Brindley, JD
Anna M. Dontje, JD
Diane Easley, Paralegal
Peggy J Young, Paralegal
Therese Ladell, Paralegal
Eric J. Deml, Program Specialist
Pamela J. Russell, Paralegal

Please Note: If you live in an independent living facility, a physician's statement must accompany this evaluation form. An eligibility letter will not be generated without this statement.

Confidential VA Benefits Evaluation Form

How did you hear about us?_____

For whom are you requesting this evaluation? (Self, relative, friend, parent)_____

Primary Contact:_____

Telephone Number:_____

Email Address:_____

Relationship to VA Claimant:_____

Tell us about the Recipient (Potential VA Claimant)

Full Name:_____Age _____

Phone Number:_____ Alternate Phone: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____Zip Code: _____

How many children do you have? _____ List their names, ages, and addresses:

_____

_____

_____

_____

_____

Are you currently: Married ____ Divorced ____ Widowed ____

If you are currently married, do you live with your spouse? Yes _____ No _____

If not, please explain why: _____

_____

_____

Spouse's Name: _____

Was your spouse a veteran? Yes _____ No _____

Date of marriage: _____ City/state of marriage:_____

Spouse's Social Security Number: _____ Spouse's Date of Birth:_____

Spouse's address (if different from client): _____

City: _____ State: _____ Zip Code: _____

If you are the widow/widower of a veteran, did you live continuously with the veteran from the date of marriage until the date of death? Yes _____ No _____

If no, why not? _____

If you are the widow/widower of a veteran, did you remarry after the veteran passed away? Yes __ No__

Previous Marital Information

How many times have you been previously married? _____

How many times was your spouse previously married? _____

Do you have any dependent or disabled children living with you? Yes _____ No _____

If yes, how many? _____ How are they dependent on you? _____

Please provide all marital history below, including the city and state of all marriages, date married, how the marriage or marriages ended (death or divorce) and the date and location of the death or divorce.

Who	Date and Place of Marriage	To Whom Married (include maiden name)	Type of Marriage (ceremonial, common-law, other)	How Marriage Terminated (death, divorce, not terminated)	Date and Place of Marriage Termination
Veteran					
Veteran					
Spouse					
Spouse					

Health Information

In your opinion, would a doctor certify that you need assistance with daily living, such as bathing, dressing, food preparation, medication management, etc.? Yes ____ No _____

What types of activities do you need assistance with?

_____

_____

_____

Facility Provider Information

Is anyone currently receiving medical/facility care? Veteran ___ Spouse ____ Both ____

Are you currently in a facility? Yes _____ No _____

If yes, which type of facility are you in? Assisted Living __ Nursing Home __ Independent Living __

What is the date that you moved into your first facility? _____

What is the name of your facility? _____

Name of administrator: _____

Monthly cost of facility: $_____

Do you currently live at home? Yes _____ No _____

Are you receiving at-home care? Yes _____ No _____

If yes, what date did you begin receiving care? _____

Who provides your at-home care? _____

Is your at-home care provider compensated for that care? Yes ____ No ____

If yes, what is the monthly amount you pay for this care? $_____

If you are not receiving care, will you soon be receiving care from any of the previous sources?

Yes _____ No _____ If yes, which one? _____

Medical Expense Information

Do you have long-term care (LTC) insurance? Yes _____ No _____

If yes, does it help pay for your current care? Yes _____ No _____

Monthly cost of your LTC? $_____ What amount does it cover? _____

Do you have health insurance? Yes _____ No _____

If yes, what is the name of that health insurance provider? _____

Monthly cost of that insurance $_____

Does your spouse have long-term care (LTC) insurance? Yes _____ No _____

If yes, does it help pay for his/her current care? Yes _____ No _____

Monthly cost of spouse LTC? $_____ What amount does it cover? _____

Does your spouse have health insurance? Yes _____ No _____

If yes, what is the name of that health insurance provider? _____

Monthly cost of that insurance $_____

Are you or your spouse currently receiving Medicaid? Self: Yes ___ No ___ Spouse: Yes ___ No ___

What is the estimated monthly amount you jointly spend on medications? $_____

Military Service Information

Are you (claimant) a veteran? Yes _____ No _____

Are you (claimant) a widow of a veteran? Yes _____ No _____

If yes, what was your maiden name? _____

What is the veteran's place of birth (city and state)? _____
In what branch of the military did the veteran serve? _____
Did the veteran serve in active duty during a declared state of war? Yes _____ No _____
In which war did the veteran serve and during what time period? _____
Did the veteran receive an honorable discharge? Yes _____ No _____
Have you ever filed a claim with the VA? Yes _____ No _____
If yes, for what? _____
Are you currently receiving pension benefits or compensation from the VA? Yes _____ No _____
If yes, what is the monthly amount you receive? $ _____ What is your VA file number? _____
What is the highest level of education that the veteran has completed? _____

Financial Information

Income:

Please list the **GROSS** monthly income for both the veteran and spouse (if applicable) and from which source it is received:

Source	Social Security/ Social Security Disability	Pension (please specify source)	Interest/ Dividend Income	Military Retirement Pay	SSI or other Public Assistance	Other (please specify source)
Veteran						
Spouse						

Assets:

Do you have a trust? Yes _____ No _____
If yes, is it revocable, irrevocable or type unknown? _____
Do you have a will? Yes _____ No _____

Please list all assets that make up you net worth in the appropriate spaces below:

Account Type	Cash/ Non-Interest Accounts	Interest Bearing Accounts	Stocks, Bonds, Mutual Funds	IRAs, 401(k)s	Business or Rental Property
Veteran					
Spouse					

Do you have a life insurance policy? Yes _____ No _____
If yes, what is the cash value of the policy? $_____

Do you and/or your spouse currently own your primary residence? Yes _____ No _____
If yes, what is the value of this property? $_____ Current Mortgage Amount: $_____
Do you currently have a reverse mortgage on this property? Yes _____ No _____

Do you plan on selling any property in the future? Yes _____ No _____
If yes, which property listed above will you be selling? _____

I certify that the information provided is true and correct to the best of my knowledge.

VA Claimant Signature (or POA): _____ Date: _____

Spouse's Signature (or POA): _____ Date: _____

NOTE: If the Financial POA signs, the Financial POA documents must be provided.

Revised July 2017