VeteranCare Home Care Program

Surviving Spouse Demographic Information Work Sheet Required For Your Application.

Date: _____ Applicant Name:_____

Maiden Name: _____ SSN: _____

Age: _____ Date of Birth:_____ Place of Birth: _____

Complete Address: _____

_____

Phone: _____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Never Married ☐ Remarried after Veteran

City & State of Marriage: _____ Date of Marriage: _____

Next of Kin: _____

Relationship: _____Phone: _____

Address: _____

Email: _____

Veteran's Full Name:_____

Vet Date of Birth: _____ City/State of Birth: _____

SS#: _____ **Date of Death:** _____

Veteran Service Information:

Branch: _____ Service Number: _____ Date Entered: _____

Date Discharged: _____ City & State of Discharge: _____

(Note 1: Attach—Record of Service or DD214 and Honorable Discharge Document)

VeteranCare will be contacting your Doctor for Medical Information

Dementia (Yes or No) ____ Alzheimer's (Yes or No) ____ Memory Loss (Yes or No) _____

Physician Name: _____

Phone: _____ Fax: _____

Address: _____

I give my permission for *VeteranCare* to contact my doctor for medical information.

Applicant Signature: _____ Date: _____

VeteranCare Home Care Program

Surviving Spouse Financial Information Work Sheet Required For Your Application

Spouse's Monthly Income

Social Security: $_____

Source: _____ $ _____

Source: _____ $ _____

Combined Total Monthly Income $ _____ Plus 5% $ _____

Financial Information: Please attach bank statements for checking and savings, CDs, stock statements, etc.—all liquid assets statements.

-If you receive a pension or retirement from a ☐ company, ☐ state or ☐ government agency, or ☐ civil service pensions, please identify: _____

-Pensions from the VA, please identify if it is a ☐ military ☐ retirement, ☐ disability pension, or ☐ other: _____

Liquid Assets include; Checking: _____ Savings: _____

CD's: _____ IRA: _____ Annuity: _____

Mutual Funds: _____ Stocks, Bond: _____

Dollar Amount of Interest Earned per Month $_____ Per year $ _____

Other: _____ **Liquid Asset Total $** _____

Unreimbursed Monthly Medical Expenses

$ _____ Services Fee for Home Health Care

$ _____ Private Medical Insurance; Name: _____

$ _____ Amount deducted from Social Security for Medicare (Part B)

$ _____ Attendant Affidavit

Combined Total Monthly Medical Expenses $ _____

Own your own home? Yes ☐ No ☐ Medicaid: Yes ☐ No ☐ LTC: Yes ☐ No ☐

Marriage or Marriages

How many marriages each? Spouse: _____ Veteran : _____

(Note 2: Marriage or Marriages certificate, if available, along with name change court docs)

Applicant Signature: _____ Date: _____