VA Claim Questionnaire—Surviving Spouse

Duckett Law LLC
Elder Law & Estate Planning

USING THIS ORGANIZER WILL ASSIST US IN DESIGNING AN ESTATE PLAN THAT MEETS YOUR GOALS.
ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL.

IF POSSIBLE, PLEASE RETURN THE COMPLETED WORKSHEET TO OUR OFFICE PRIOR TO YOUR APPOINTMENT VIA MAIL OR FAX.

VA CLAIM QUESTIONNAIRE—SURVIVING SPOUSE

Please complete as much information as possible.

PERSONAL INFORMATION ABOUT YOU

Full name: _____

Current address: _____

Were you married to the Veteran at the time of the Veteran's death? □ yes □ no

Date of marriage: ___/___/_____ Place married: _____

Have you remarried? □ yes □ no

Any prior claims filed? □ yes □ no

Please describe any pending claims: _____

_____

Any prior marriages? □ yes □ no

Date of marriage: ___/___/_____ to ___/___/_____

Place married: _____ Place marriage ended: _____

Date of marriage: ___/___/_____ to ___/___/_____

Place married: _____ Place marriage ended: _____

VETERAN INFORMATION

Full name: _____

Date of birth: ___/___/_____ Date of death: ___/___/_____

Was the Veteran receiving compensation or pension benefits at the time of death? □ yes □ no

Any prior marriages? □ yes □ no

Date of marriage: ___/___/_____ to ___/___/_____

Place married: _____ Place marriage ended: _____

Date of marriage: ___/___/_____ to ___/___/_____

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Place married: _____ Place marriage ended: _____

SERVICE INFORMATION

Branch of service: _____ Type of discharge: _____

Did the Veteran serve under any other names? □ yes □ no If yes, please provide the names:

_____

DISABILITY INFORMATION

Check all that apply to you.

- □ Declared incompetent
- □ Macular degeneration—Extent: _____
- □ Diagnosed with dementia—Stage: ◯ Early ◯ Mid ◯ Late
- □ Housebound (unable to leave without assistance)
- □ Need daily assistance from another to perform basic activities
- □ Receiving Medicaid—Type: _____
- □ Applied for Medicaid—Type: _____
- □ In a nursing home—Name: _____
- □ In an assisted living facility—Name: _____

Please list the names and addresses of all physicians providing care to you:

Name: _____ Address: _____

_____

Name: _____ Address: _____

_____

INCOME AND NET WORTH INFORMATION

<u>Accounts and Other Assets</u>

Checking accounts $ _____

Savings accounts $ _____

CDs $ _____

IRAs or other retirement (not pension payments) $ _____

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Stocks and bonds $ _____

Mutual Funds $ _____

Life Insurance (cash value) $ _____

Real property (not home) $ _____

Other property $ _____

Type: _____

Other property $ _____

Type: _____

Do you own a home? □ yes □ no

Income

Please list regular sources of monthly income and specify *gross* amounts:

Social Security: $ _____

Pension: $ _____

Other: _____ $ _____

Other: _____ $ _____

Please list any regular sources of monthly income expected to begin within the next 12 months and specify *gross* amounts (not listed above):

Other: _____ $ _____

Other: _____ $ _____

Are there any one-time or non-monthly sources of income that you expect to receive in the next 12 months? This would include inheritance, personal injury settlement, or income from a business. □ yes □ no

If so, please explain:

_____

_____

_____

_____

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Please list monthly out-of-pocket medical expenses. Medical expenses include prescriptions, home health aides, assisted-living expenses, long term care premiums, doctor co-pays, etc.:

Expense	Amount paid monthly
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

Thank you!

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