



Name of Inquirer: \_\_\_\_\_

Is the inquirer POA for the claimant? \_\_\_Yes \_\_\_No

Relationship of Inquirer to Claimant: \_\_\_\_\_

Inquirer primary phone number: \_\_\_\_\_

Secondary phone number: \_\_\_\_\_

Who is applying for benefits? \_\_\_Veteran & Spouse \_\_\_Veteran \_\_\_Surviving Spouse

Name: \_\_\_\_\_ Age: \_\_\_\_\_

What is their marital status? \_\_\_Single \_\_\_Married \_\_\_Widowed \_\_\_Divorced

Is the claimant still driving? \_\_\_Yes \_\_\_No

If applying for benefits as a surviving spouse, provide the name of the Veteran under the claim will be filed under: \_\_\_\_\_

**Service Experience**

The Veteran MUST have been active at least one day during a Wartime period. If so, which one:

\_\_\_\_\_ Date of entry: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Did the Veteran serve at least 90 days of active military service? \_\_\_\_\_

Was the Veteran discharged from the service honorably? \_\_\_Yes \_\_\_No

**Monthly income**

<u>Source</u>	<u>Veteran</u>	<u>Spouse</u>
<b>Social Security</b>	\$ _____	\$ _____
<b>Pension</b>	\$ _____	\$ _____
<b>Retirement Payments</b>	\$ _____	\$ _____
<b>Disability Payments</b>	\$ _____	\$ _____
<b>Interest/Dividends</b>	\$ _____	\$ _____
<b>Other income</b>	\$ _____	\$ _____

**TOTAL MONTHLY INCOME:** \_\_\_\_\_

**Monthly Out of Pocket Medical Expenses**

<u>Source</u>	<u>Veteran</u>	<u>Spouse</u>
Medicare Part B	\$	\$
Medicare Supplement Premiums	\$	\$
Medicare Drug Plan Premium	\$	\$
Home Care Monthly Cost	\$	\$
Adult Day Care Monthly Cost	\$	\$
Assisted Living Monthly Cost	\$	\$
Nursing Home Monthly Cost	\$	\$
Any other recurring monthly medical costs (i.e., incontinence products; PERS, etc	\$	\$

**TOTAL OUT OF POCKET MONTHLY EXPENSES:** \_\_\_\_\_

**Assets/Net Worth**

<u>Source</u>	<u>Veteran</u>	<u>Spouse</u>
Checking account	\$	\$
Saving account	\$	\$
CD's	\$	\$
Mutual funds/bonds/stocks	\$	\$
Property other than residence	\$	\$

**TOTAL ASSETS & SAVINGS:** \_\_\_\_\_

**Medical Condition** (what is applicant's current medical diagnosis)

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What activities of daily living does the claimant require assistance with?

- Bathing
- Dressing
- Medication Management/Reminders
- Toileting
- Meals
- Transferring
- Transportation
- Continence

**CONTACT INFORMATION FOR NOTICE OF ELIGIBILITY AND PROBABLE AMOUNT OF THE BENEFIT**

Your name \_\_\_\_\_

Your address \_\_\_\_\_

Phone number or numbers where we can call you \_\_\_\_\_

Best time to call: \_\_\_\_\_ Best day to call: \_\_\_\_\_

Or email where we can send you information: \_\_\_\_\_

Questions? Call 877-369-5598

Return completed form to [vainfo@agingwithgrace.net](mailto:vainfo@agingwithgrace.net) or fax to 1-732-876-0235 or mail completed form to:

Aging with Grace™  
187 Delaware Avenue  
Oakhurst, NJ 07755  
ATTN: VA Consultant

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