Wis. Stats. Chapter 45

STATE OF WISCONSIN, DEPARTMENT OF VETERANS AFFAIRS
201 West Washington Avenue, P.O. Box 7843, Madison, WI 53707-7843
(608) 266-1311 1-800-WIS-VETS (1-800-947-8387)

VERIFICATION OF ILLNESS OR DISABILITY

Assistance to Needy Veterans Grant — Subsistence Aid

County Number

A.

TO BE COMPLETED BY THE PATIENT

Please release the information requested to the Wisconsin Department of Veterans Affairs.

1. Veteran's Name:	2. Patient's Name: (if different)	3. WDVA # or Veteran's Birth Date:
4. Patient's Address:	5. Date I feel I became ill/disabled:	
6. Patient's Signature:	Date:	

B.

TO BE COMPLETED BY A LICENSED PHYSICIAN OR OPTOMETRIST

Refer to the date listed in number 5 above by the patient. Please answer all questions fully. Unanswered questions will delay emergency aid.

1. Diagnosis of illness/disability:

2. Date illness or injury caused a loss or reduction of employment:

3. I estimate the veteran was or will be incapacitated for the following number of days following the date noted in #2 directly above:

☐ not incapacitated ☐ 30, ☐ 60, ☐ 90 days or longer ☐ incapacitation is permanent

DOCTOR'S COMMENTS:

DOCTOR INFORMATION:

WARNING: ONLY A LICENSED PHYSICIAN OR OPTOMETRIST MAY SIGN THIS FORM. THE FORM WILL NOT BE ACCEPTED IF IT IS SIGNED BY ANYONE ELSE.

(print or type)

Name Title ( ) Telephone

Address Email

Doctor's Signature **(NO STAMPED SIGNATURES)** Date Signed

Please complete and send to the address at the top of this form.
Do not give it to the patient.

You can print the most recent version of this form from the WDVA website at *www.WisVets.com/Forms.*