



ASSISTANCE TO NEEDY VETERANS GRANT APPLICATION

Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m)].

The provision of your social security number is voluntary. Failure to provide your social security number may result in an information processing delay.

Base File #
County
County Contact

Veteran's Name Mr. Ms.
First Name Middle Name Last Name Suffix
Address City State Zip Code
Birth Date Social Security Number

Applicant's Name Mr. Ms.
Veteran Relationship to Veteran Unremarried Spouse/Dependent of veteran killed in action or line of duty
Spouse/Dependent of activated or deployed veteran
First Name Middle Name Last Name Suffix
Applicant's Birth Date Applicant's Social Security Number

Patient's Name Mr. Ms.
Veteran Relationship to Veteran Spouse/Widow(er) Dependent
First Name Middle Name Last Name Suffix
Patient's Birth Date Patient's Social Security Number

Applicant's Marital Status Unmarried (includes widowed and divorced) Married Separated

Select Desired Benefit (Lifetime maximum of \$7,500 for all ANV Grant types combined)
Subsistence Aid (\$3,000 maximum per 12 month period) *MUST APPLY WITHIN 91 DAYS OF INCOME LOSS
Health Care Aid Vision Care: Qualifying Care including vision exam and one set of eyeglasses up to \$400 per consecutive 12 month period
Dental Care: Qualifying Care up to \$500 per consecutive 12 month period
Upper Denture up to \$1,875 per consecutive 48 month period
Lower Denture up to \$1,875 per consecutive 48 month period
Hearing Care: Qualifying Care up to \$200 per consecutive 12 month period
Left Hearing Aid up to \$1,875 per consecutive 48 month period
Right Hearing Aid up to \$1,875 per consecutive 48 month period

A Description of Benefits (DOB) authorizing care for a 90-day period will be posted for approved applications. It is to be printed by the CVSO for delivery to the provider who will complete the "Request for Payment" section and submit to WDVA for payment. Care must be completed before the "Expiration" date on the DOB. If an outstanding DOB exists, binding quotes from a provider are necessary in order to have an additional DOB issued.

Living Arrangements Own Home Mobile Home Live With Roommates VA Facility
Rent Homeless Live With Relatives VAP Facility

VA Health Care System (Wisconsin law requires use of all available resources and agencies [VA2.01(2)(a)])
Date veteran applied to Federal VA health care system
Has veteran been enrolled into the system? No Yes Date enrolled
Does the veteran have a service-connected disability? No Yes Disability rating %
List Disabilities

Health Insurance
I do not have health insurance that covers dental, vision or hearing care
I have health insurance that covers all or a portion of Dental Vision Hearing

Spouse and Legal Dependents Living With Applicant
First Name Last Name Birth Date Relationship to Veteran
Spouse Dependent
Spouse Dependent
Spouse Dependent
Spouse Dependent

Income—Verification Required (Veteran, Spouse, or Any Dependent Name)

Recipient 1

Current Income \$ _____ Frequency Monthly Annually Semi-Annually Quarterly
 Semi-Monthly Bi-Weekly Weekly

- Income Type
- | | |
|---|--|
| <input type="checkbox"/> National Guard/Reserve | <input type="checkbox"/> Dividends |
| <input type="checkbox"/> Compensation – VA | <input type="checkbox"/> Interest |
| <input type="checkbox"/> Compensation – Unemployment (insurance) | <input type="checkbox"/> Wages |
| <input type="checkbox"/> Compensation – Workers | Employer _____ |
| <input type="checkbox"/> Sick/Disability Pay (from employer or insurance) | <input type="checkbox"/> Overtime |
| <input type="checkbox"/> Pension – Other than Federal VA | <input type="checkbox"/> Bonuses |
| <input type="checkbox"/> Pension – Federal VA | <input type="checkbox"/> Commissions |
| <input type="checkbox"/> Social Security – Regular | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Social Security – Disability (SSD) | <input type="checkbox"/> Retirement (pay) |
| <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Student Financial Aid (all types) |
| <input type="checkbox"/> Aid to Families with Dependent Children | <input type="checkbox"/> Federal GI Bill |
| <input type="checkbox"/> Food Share (formerly called Food Stamps) | <input type="checkbox"/> State or Federal Voc Rehab |
| <input type="checkbox"/> Rental(income) | <input type="checkbox"/> Other |

Recipient 2

Current Income \$ _____ Frequency Monthly Annually Semi-Annually Quarterly
 Semi-Monthly Bi-Weekly Weekly

- Income Type
- | | |
|---|--|
| <input type="checkbox"/> National Guard/Reserve | <input type="checkbox"/> Dividends |
| <input type="checkbox"/> Compensation – VA | <input type="checkbox"/> Interest |
| <input type="checkbox"/> Compensation – Unemployment (insurance) | <input type="checkbox"/> Wages |
| <input type="checkbox"/> Compensation – Workers | Employer _____ |
| <input type="checkbox"/> Sick/Disability Pay (from employer or insurance) | <input type="checkbox"/> Overtime |
| <input type="checkbox"/> Pension – Other than Federal VA | <input type="checkbox"/> Bonuses |
| <input type="checkbox"/> Pension – Federal VA | <input type="checkbox"/> Commissions |
| <input type="checkbox"/> Social Security – Regular | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Social Security – Disability (SSD) | <input type="checkbox"/> Retirement (pay) |
| <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Student Financial Aid (all types) |
| <input type="checkbox"/> Aid to Families with Dependent Children | <input type="checkbox"/> Federal GI Bill |
| <input type="checkbox"/> Food Share (formerly called Food Stamps) | <input type="checkbox"/> State or Federal Voc Rehab |
| <input type="checkbox"/> Rental(income) | <input type="checkbox"/> Other |

Required – For Subsistence Aid Only Income lost due to illness, injury, or natural disaster

Date of Stop/Decrease _____

Income Before Stop/Decrease \$ _____ Frequency Monthly Annually Semi-Annually Quarterly
 Semi-Monthly Bi-Weekly Weekly

The reason for loss of income was due to

- Illness Injury (send a copy of police/fire report if applicable) Natural Disaster

NOTE: If aid is available for this type of incident and the applicant hasn't applied for it, a written explanation will be required.

- | | | | |
|-------------------------------------|--|--------------------------------|--|
| Liability insurance available | <input type="checkbox"/> Yes <input type="checkbox"/> No | Disability insurance available | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lawsuit will be filed or is pending | <input type="checkbox"/> Yes <input type="checkbox"/> No | Workers Compensation available | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crime Victim Compensation available | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Explanation of Incident

NOTE: If this was work related, the applicant should apply for Workers Compensation. If it occurred on private property, the applicant should check into liability insurance coverage. The applicant may be asked to provide additional information.

(continued on next page)

Name _____
 Base File # _____

Nature of Incident _____
 Date of Incident _____ Time of Day/Night _____
 Location of Incident _____ Phone _____
 Address _____ City _____ State _____ Zip Code _____

Witnesses

Name 1 _____ Phone _____
 Address _____ City _____ State _____ Zip Code _____
Name 2 _____ Phone _____
 Address _____ City _____ State _____ Zip Code _____

Give your actions and whereabouts for at least four (4) hours prior to the incident. Include the quantity and type of alcoholic beverages and/or drugs ingested, if any. If none, so state. Give a detailed account of the incident itself.

Liquid Assets (In Veteran, Spouse, or Any Dependent Name)

Owner 1 _____ I have no assets

<u>Asset Type</u>	<u>Value</u>	<u>Asset Type</u>	<u>Value</u>
<input type="checkbox"/> Checking Account	\$ _____	<input type="checkbox"/> Government Pension/Retirement Plan	\$ _____
<input type="checkbox"/> Savings Account	\$ _____	<input type="checkbox"/> Cash Value of Life Insurance	\$ _____
<input type="checkbox"/> Money Market	\$ _____	<input type="checkbox"/> Stocks (or stock accounts)	\$ _____
<input type="checkbox"/> Certificate of Deposit	\$ _____	<input type="checkbox"/> Bonds (or bond accounts)	\$ _____
<input type="checkbox"/> 401K Plan	\$ _____	<input type="checkbox"/> Custodial Accounts (Children or Grandchildren)	\$ _____
<input type="checkbox"/> 403B Plan	\$ _____	<input type="checkbox"/> Gambling Winnings	\$ _____
<input type="checkbox"/> IRA (Roth and Regular)	\$ _____	<input type="checkbox"/> Tax Refunds	\$ _____
<input type="checkbox"/> Company Pension/Retirement Plan	\$ _____	<input type="checkbox"/> Other	\$ _____

Owner 2 _____ I have no assets

<u>Asset Type</u>	<u>Value</u>	<u>Asset Type</u>	<u>Value</u>
<input type="checkbox"/> Checking Account	\$ _____	<input type="checkbox"/> Government Pension/Retirement Plan	\$ _____
<input type="checkbox"/> Savings Account	\$ _____	<input type="checkbox"/> Cash Value of Life Insurance	\$ _____
<input type="checkbox"/> Money Market	\$ _____	<input type="checkbox"/> Stocks (or stock accounts)	\$ _____
<input type="checkbox"/> Certificate of Deposit	\$ _____	<input type="checkbox"/> Bonds (or bond accounts)	\$ _____
<input type="checkbox"/> 401K Plan	\$ _____	<input type="checkbox"/> Custodial Accounts (Children or Grandchildren)	\$ _____
<input type="checkbox"/> 403B Plan	\$ _____	<input type="checkbox"/> Gambling Winnings	\$ _____
<input type="checkbox"/> IRA (Roth and Regular)	\$ _____	<input type="checkbox"/> Tax Refunds	\$ _____
<input type="checkbox"/> Company Pension/Retirement Plan	\$ _____	<input type="checkbox"/> Other	\$ _____

I certify that I have read, or have had read to me, all questions from this application and this paragraph and that my answers are true and complete to the best of my knowledge, and that I will promptly notify WDVA of any changes. I have applied for and accepted all benefits available from other agencies or organizations. If I receive, or am eligible to receive, money from another source which duplicates aid I received from this program, I will repay WDVA as soon as possible. I understand that I must provide the Wisconsin Department of Veterans Affairs, either personally or through my County Veterans Service Officer, with any information requested by the department within 30 days of the date of the request or I may be denied any benefit. I authorize the department and any of its employees to request and review any county, state or federal records relating to this application. I consent to the release by the Federal Department of Veterans Affairs (VA), Social Security Administration, Wisconsin Department of Revenue (DOR), and the County Veterans Service Office (CVSO) of all information necessary to process this grant application.

Phone () _____ Signature _____ Date _____

WARNING: If you knowingly make any false statement or submit fraudulent evidence in connection with this application, you are subject to severe penalties provided by law including fine, imprisonment or both and suspension of all veterans benefits from WDVA.