Clear Form

POA:		MCVSO Intake Form	Date:	

Please complete the form as best you can, type or print legibly

SECTION I. CLAIMANT: ☐ Yes ☐ No **Veterans Information**

1. VETERANS NAME: *(Last, First and Middle Name)*

2. SOCIAL SECURITY #:

3. GENDER: ☐ Male ☐ Female ☐ Other ☐ Decline

4. WHAT IS THE VETERAN'S RACE: *(You may check more than one. Information is required for statistical purposes only)* ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Native American or Pacific Islander ☐ Other: _____

5. DATE OF BIRTH: *(mm/dd/yyyy)*

6. PLACE OF BIRTH: *(City and State)*

7. DATE OF DEATH: (if applicable) *mm/dd/yyyy*

8. PLACE OF DEATH: (If applicable) *City and State*

9. PLACE OF BURIAL:(if applicable)

10. PERMANENT MAILING ADDRESS: *(Street, Apt #, City, State,Zip Code and County)*

11. PHYSICAL ADDRESS WHERE VETERAN RESIDES: *(Name of Assisted Living, Nursing Home, etc., Street, Apt #, City, State and Zip Code)*

12. HOME PHONE NUMBER: *(Include area code)*

13. MOBILE PHONE NUMBER: *(Include area code)*

14. E-MAIL ADDRESS:

15. CURRENT MARITAL STATUS: ☐ Married ☐ Never Married ☐ Separated ☐ Widow/Widower ☐ Divorced ☐ Other

THE VETERAN'S MARRIAGES: (*If additional space is needed, please use the remarks section, pg. 4)*

16. HOW MANY TIMES HAS THE VETERAN BEEN MARRIED: *(Including current marriage)*

17. IS THE VETERAN'S CURRENT SPOUSE ALSO A VETERAN: ☐ YES ☐ NO ☐ N/A

18. VETERAN'S CURRENT & PREVIOUS MARRIAGES:

18a. DATE & PLACE OF MARRIAGE *(City & state or country)*	18b. TO WHOM MARRIED *(First, Middle, Maiden / Last name)*	18c. TYPE OF MARRIAGE *(Ceremonial, Common-law, or other)*	18d. IF MARRIAGE TERMINATED *(Death, divorce)*	18e. DATE & PLACE MARRIAGE TERMINATED *(City & State or country)*

Veterans Military and VA Information

19. BRANCH OF SERVICE *(Check all that apply)*

USA ☐ USMC ☐ USN ☐ USAF ☐ USSF ☐ USCG ☐ NG ☐ Reserve ☐ Other:_____

20. DATE ENTERED MILITARY SERVICE:	*mm/dd/yyyy*
21. DISCHARGED FROM MILITARY SERVICE:	*mm/dd/yyyy*
21a. FUTURE SEPARATION DATE: *(If currently serving)*	*mm/dd/yyyy*

22. TYPE OF DISCHARGE:

☐ HON ☐ General (UHC) ☐ OTH ☐ Dishonorable ☐ Other: _____

23. HAVE YOU EVER SERVED IN THE RESERVE OR NATIONAL GUARD? ☐ YES ☐ NO

23a. DATES AND LOCATIONS OF ACTIVATIONS OR DEPLOYMENTS

i.

ii.

iii.

24. MILITARY & VA HISTORY: *(Check yes or no)*	**YES**	**NO**
24a. IS / WAS THE VETERAN A PURPLE HEART RECIPENT?	☐	☐
24b. IS / WAS THE VETERAN A FORMER PRISONER OF WAR?	☐	☐
24c. DID THE VETERAN SERVE IN COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐
24d. DID THE VETERAN SERVE IN SOUTHWEST ASIA BETWEEN 08/02/1990 & 11/11/1998?	☐	☐
24e. DID THE VETERAN SERVE IN VIETNAM OR ON BOARD A SHIP WITHIN 12 NAUTICAL MILES OF THE VIETNAM SHORELINE BETWEEN 01/09/1962 & 05/07/1975?	☐	☐
24f. DID THE VETERAN SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM 08/01/1953 THROUGH 12/31/1987?	☐	☐
24g. IS THE VETERAN RETIRED FROM THE MILITARY? Monthly Retirement amount$_____	☐	☐
25. IS THE VETERAN ENROLLED IN VA HEALTHCARE?	☐	☐

26. WHICH VA MEDICAL CENTER HAS THE VETERAN BEEN SEEN AT? *(List all that apply)*

i.

ii.

iii.

27. Has the Veteran ever filed a claim with the VA?	***28.* VA File Number:** *(if applicable)*
☐ YES ☐ NO *(If "Yes," provide the file number in block 27)*	

REMARKS:

29. IF YOU ARE FILING FOR DISABILITY COMPENSATION AND HAVE PRIVATE MEDICAL EVIDENCE, PLEASE COMPLETE THE FOLLOWING:		
DIAGNOSIS	**NAME OF DR. OR HOSPITAL**	**DATES OF TREATMENT**

SECTION II.	CLAIMANT: ☐ Yes ☐ No	**SPOUSE - DEPENDENT INFORMATION**

1. SPOUSE'S NAME *(Last, First & Middle Name)*

2. SPOUSE'S SOCIAL SECURITY#:	**3. GENDER:** ☐ Male ☐ Female ☐ Other ☐ Decline
4. SPOUSES DATE OF BIRTH: *(mm/dd/yyyy)*	**5. SPOUSE'S PLACE OF BIRTH:**

6. SPOUSES PERMANENT MAILING ADDRESS: *(If different from Veteran's)*

7. PHYSICAL ADDRESS WHERE SPOUSE RESIDES: *(Name of Assisted Living, Nursing Home, etc., Street, Apt #, City, State and Zip Code)*

8. SPOUSE HOME PHONE NUMBER: *(Include area code)*	**9. SPOUSE MOBILE PHONE NUMBER:** *(Include area code)*

10. SPOUSE'S E-MAIL ADDRESS:

11. SPOUSE'S CURRENT MARITAL STATUS:
☐ Married ☐ Never Married ☐ Separated ☐ Widow/Widower ☐ Divorced ☐ Other

THE SPOUSE'S MARRIAGES: *(If additional space is needed, please use the remarks section, pg. 4)*

12. HOW MANY TIMES HAS THE SPOUSE BEEN MARRIED? *(Including current marriage)*

12a. DATE & PLACE OF MARRIAGE *(City & State or Country)*	**12b. TO WHOM MARRIED** *(First, Middle & Maiden name)*	**12c. TYPE OF MARRIAGE** *(Ceremonial, common-law or other)*	**12d. IF MARRIAGE TERMINATED** *(Death, divorce)*	**12e. DATE & PLACE MARRIAGE TERMINATED** *(City & State or Country)*

13. HAS THE SPOUSE REMARRIED SINCE THE DEATH OF THE VETERAN? ☐ YES ☐ NO ☐ N/A

14. DO YOU HAVE AN ADULT CHILD THAT WAS TOTALLY DISABLED PRIOR TO THE AGE OF 18? ☐ YES ☐ NO ☐ N/A

SECTION II.a. **VETERAN'S UNMARRIED DEPENDENT CHILDREN**
(If additional space is needed, please use the remarks section below)

1a. NAME OF CHILD *First, Middle Initial, Last*	**1b. Date** *(mm/dd/yyyy)* **Place of Birth** *(City & State)*	**1c. SOCIAL SECURITY NUMBER**	**Biological**	**Adopted**	**Step-Child**	**18-23 yrs old & in School**	**Seriously Disabled prior to 18**
	DATE: PLACE:		☐	☐	☐	☐	☐
	DATE: PLACE:		☐	☐	☐	☐	☐
	DATE: PLACE:		☐	☐	☐	☐	☐
	DATE: PLACE:		☐	☐	☐	☐	☐
	DATE: PLACE:		☐	☐	☐	☐	☐
	DATE: PLACE:		☐	☐	☐	☐	☐

REMARKS:

SECTION III. CLAIMANT: ☐ Yes ☐ No **POINT OF CONTACT (POC) INFORMATION** *(If applicable)*

1. POINT OF CONTACT: *(Last, First & Middle Name)*

2. RELATION TO THE VETERAN OR CLAIMANT:

3. VA FIDUCIARY	**YES**	**NO**	**3b. POWER OF ATTORNEY**	**YES**	**NO**	**NONE**
	☐	☐		☐	☐	☐

***4.* MAILING ADDRESS:** *(Street, City, State and Zip Code)*

5. HOME PHONE NUMBER: *(Include area code)*

6. MOBILE PHONE NUMBER: *(Include area code)*

7. E-MAIL ADDRESS:

8. <u>USE THIS CONTACT INFORMATION FOR ALL VA CORRESPONDENCE?</u> ☐ YES ☐ NO

SECTION IV.	CLAIMANT'S DIRECT DEPOSIT INFORMATION

1. NAME OF FINANCIAL INSTITUTION:

2. TYPE OF ACCOUNT: *(Check the appropriate box)*

☐ CHECKING ☐ SAVINGS ☐ CLAIMANT DOES NOT HAVE AN ACCOUNT

3. ACCOUNT NUMBER:	4. ROUTING NUMBER:

BRIEF REASON FOR YOUR APPOINTMENT:

5. IF FILING FOR SURVIVORS PENSION OR NON SERVICE CONNECTED PENSION:

6. DO YOU OWN YOUR OWN HOME?	☐ YES ☐ NO
7. DOES YOUR HOME SIT ON MORE THAN 2 ACRES?	☐ YES ☐ NO
8. DO YOU OWN AN ADDITIONAL HOME OR LOT?	☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US?:

☐ Newspaper or Magazine ☐ Website ☐ Social Media ☐ Referred by friend ☐ Other

THANK YOU FOR COMPLETING THIS FORM. PLEASE RETURN IT TO THE INTAKE SPECIALIST

SECTION IV.	FOR OFFICE USE ONLY

RECORDS REQUEST:

Date: _____ ☐ NPRC ☐ DIPRIS ☐ ODVS ☐ VA FOIA ☐ OTHER: _____

Notes:

NOTES