

VERIFICATION OF ILLNESS OR DISABILITY

Veterans Assistance Grant — Subsistence Aid

County Number

1. Veteran's	Name:	2.	Patient's Name: (if different)	3. WDVA # or Veteran's Birth I
4. Patient's A	Address:	5.	Date I feel I became	e ill/disabled:
6. Patient's				
Signature				Date:
	PLETED BY A LICENSED A	DVANCED PRAC	FICE NURSE PRE	SCRIBER, PHYSICIAN OR
OPTOMETR				
Refer to the emergence		by the patient. Pleas	se answer all questior	ns fully. Unanswered questions will de
*	of illness/disability:			
0				
2. Date illne	ss or injury caused a loss or redu	ction of employmen	t:	
3 Lestimate	the veteran was or will be incapa	ecitated for the follo	wing number of days	following the date noted in #2 directly
above:	the veteral was of will be meape		wing number of days	Tonowing the date noted in #2 direct.
not inc	capacitated $\Box 30 \Box 60$	90 days or long	rer	incapacitation is permanent
			501	
	RE PROVIDER'S COMMENTS	· ·	501	
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HEALTH CA	RE PROVIDER'S COMMENTS	:		
HEALTH CA	•	:		
HEALTH CA HEALTH CA WARNING:	RE PROVIDER'S COMMENTS RE PROVIDER INFORMATION ONLY A LICENSED ADVAN	: N: CED PRACTICE	NURSE PRESCRIE	BER, PHYSICIAN OR OPTOMETI
HEALTH CA HEALTH CA WARNING:	RE PROVIDER'S COMMENTS	: N: CED PRACTICE	NURSE PRESCRIE	BER, PHYSICIAN OR OPTOMETI
HEALTH CAT HEALTH CAT WARNING: MAY SIGN T	RE PROVIDER'S COMMENTS RE PROVIDER INFORMATION ONLY A LICENSED ADVAN	: N: CED PRACTICE	NURSE PRESCRIE	BER, PHYSICIAN OR OPTOMETI
HEALTH CA HEALTH CA WARNING:	RE PROVIDER'S COMMENTS RE PROVIDER INFORMATION ONLY A LICENSED ADVAN	: N: CED PRACTICE	NURSE PRESCRIE	BER, PHYSICIAN OR OPTOMET
HEALTH CAT HEALTH CAT WARNING: MAY SIGN T	RE PROVIDER'S COMMENTS RE PROVIDER INFORMATION ONLY A LICENSED ADVAN THIS FORM. THE FORM WI	: N: CED PRACTICE	NURSE PRESCRIE PTED IF IT IS SIG	BER, PHYSICIAN OR OPTOMETH SNED BY ANYONE ELSE. ()
HEALTH CAT HEALTH CAT WARNING: MAY SIGN T	RE PROVIDER'S COMMENTS RE PROVIDER INFORMATION ONLY A LICENSED ADVAN THIS FORM. THE FORM WII	: N: CED PRACTICE	NURSE PRESCRIE PTED IF IT IS SIG	BER, PHYSICIAN OR OPTOMETI SNED BY ANYONE ELSE. (
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