Wis, Stats, Chapter 45

## INSTRUCTIONS VETERANS ASSISTANCE GRANT APPLICATION (SUBSISTENCE AID)

Please submit this application if you are applying for Subsistence Aid due to an illness, injury or natural disaster which has resulted in a loss of income.

## \*THIS APPLICATION MUST BE SUBMITTED WITHIN TWELVE (12) MONTHS FOLLOWING THE DATE OF THE LOSS OF INCOME\*

Subsistence Aid will be limited to the difference between the amount of earned and unearned income available before the loss of income and the earned and unearned income being received after the loss of income, subject to limitations under § 45.40(1m)(b) and (3), Stats.

- If you are the veteran completing this application, please complete the "Veteran's Name" section.
- If you are the spouse or dependent of the veteran completing this application:
  - o For yourself; please complete the "Veteran's Name" and "Applicant's Name" sections.
  - On behalf of the veteran, please complete the "Applicant's Name" and "Patient's Name" sections.

There is a \$3,000 maximum per 12-month period for this benefit and a combined lifetime maximum of \$7,500 for Health Care Aid and Subsistence Aid.

To be eligible, an applicant must meet the following requirements:

- Be a veteran as defined in Wis. Stat. § 45.01(12).
- Household income at or below 200 percent of the federal poverty guidelines in effect at the time the application is received by the department. Current federal poverty guidelines can be found here: <a href="https://aspe.hhs.gov/poverty-guidelines">https://aspe.hhs.gov/poverty-guidelines</a>.
- Spouse or dependent of an activated or deployed member of the U.S. Armed Forces or Wisconsin National Guard must submit evidence that the service member has been deployed or activated, that due to the activation or deployment, a loss of income has occurred, that an economic emergency has occurred during the activation or deployment, and that the spouse and dependents are residents of this state.
- Does not have more than six (6) months in available liquid assets and available income to meet basic subsistence needs and is not eligible to or did not receive aid from other sources to meet those needs. The amount of liquid assets does not include the first \$50,000 of cash surrender value of any life insurance policy.

## **Required Documentation:**

- Complete Application for Veterans Assistance Grant Subsistence Aid (Form WDVA 2453).
- Declaration of Aid (**Form WDVA 2451**) signed by County Agent, CVSO, or the economic assistance consortium. **Must** be submitted with the application.
- Verification of Illness or Disability (**Form WDVA 2045**) **must** be received from the treating licensed health care provider, if loss of income is due to illness or injury.
- Notice of Decision (NOD) letter from local consortium that indicates the applicant has applied for Food Share and Medicaid or Badger Care.
- Copy of bank statements for the six (6) months immediately preceding date of application (highlight/circle living expenses).
  - \* If bank statements cannot be obtained please submit the following: copy of current lease or mortgage statement for applicant's primary residence, proof of current medical insurance premiums, and copies of electric, heat, and water bills for applicant's primary residence, and applicant's phone bill for the past six (6) months.
- Any other documentation or verification requested by the Department.

\*NOTICE: Application will be terminated if requested documentation and/or verification is not received at the department's central office within 60 days of notification for additional documentation and/or verification.



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## **VETERANS ASSISTANCE GRANT APPLICATION (SUBSISTENCE AID)**

Personal Information you provide	le may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].	Base File #		
· -	urity number is voluntary. Failure to provide your social security	County	County	
number may result in an information processing delay.		County Conta	ct	
Veteran's Name (To be com	pleted by veteran or if the veteran's spouse/dependent is applying for b	penefits) Mr.	Ms.	
First Name	Middle Name Last Na	ame	Suffix	
Address	City	State	Zip Code	
-				
Date of Birth	Email Address	Social Secu	urity Number	
Applicant's Name (To be co	ompleted only if veteran is <u>not</u> completing the application) Mr.	☐ Ms.		
Relationship to Veteran	Unremarried Spouse/Dependent of veteran killed in	action or line of a	1,,6,,	
Relationship to Veteran	Spouse/Dependent of activated or deployed veteran	action of fine of c	iuty	
First Name	Middle Name Last Na	2000	0.00	
Trist Name	Whate Name Last 14	anne	Suffix	
First Ivaine	Middle Pallie Last No	ame	Suffix	
Address	Middle Name Last Na		Suffix	
Address	Middle Name Last Na	ame	Suffix	
		ame		
Address	Middle Name Last Na	ame	Suffix	
Address  Applicant's Date of Birth	Middle Name Last Na	ame	Suffix	
Address  Applicant's Date of Birth	Middle Name Last Na Applicant's Email Address	nme Applicant	Suffix	
Address  Applicant's Date of Birth  Patient's Name (Veteran's in	Middle Name Last Na  Applicant's Email Address  Iformation if veteran is not completing the application) Mr.	nme Applicant	Suffix	
Address  Applicant's Date of Birth  Patient's Name (Veteran's in	Middle Name Last Na  Applicant's Email Address  Iformation if veteran is not completing the application) Mr.	Applicant  Ms.	Suffix	
Address  Applicant's Date of Birth  Patient's Name (Veteran's in Relationship to Veteran	Middle Name  Last Na  Applicant's Email Address  Information if veteran is <u>not</u> completing the application)  Mr.  Spouse/Widow(er)  Dependent	Applicant  Ms.	Suffix Suffix Social Security Number	
Address  Applicant's Date of Birth  Patient's Name (Veteran's in Relationship to Veteran  First Name	Middle Name  Last Na  Applicant's Email Address  Information if veteran is not completing the application)  Mr.  Spouse/Widow(er)  Dependent  Middle Name  Last Na	Applicant  Ms.	Suffix Suffix Suffix Suffix	
Address  Applicant's Date of Birth  Patient's Name (Veteran's in Relationship to Veteran	Middle Name  Last Na  Applicant's Email Address  Information if veteran is <u>not</u> completing the application)  Mr.  Spouse/Widow(er)  Dependent	Applicant  Ms.	Suffix Suffix Social Security Number	
Address  Applicant's Date of Birth  Patient's Name (Veteran's in Relationship to Veteran  First Name  Address	Middle Name  Last Na  Applicant's Email Address  Information if veteran is not completing the application)  Mr.  Spouse/Widow(er)  Dependent  Middle Name  Last Na  Middle Name  Last Na	Applicant  Ms.	Suffix Suffix Suffix Suffix	
Address  Applicant's Date of Birth  Patient's Name (Veteran's in Relationship to Veteran  First Name	Middle Name  Last Na  Applicant's Email Address  Information if veteran is not completing the application)  Mr.  Spouse/Widow(er)  Dependent  Middle Name  Last Na	Applicant  Ms.	Suffix Suffix Suffix Suffix	

		Veteran's Name:	
		Base File #:	
Applicant's Marital Status	Unremarried (includes widowed and di	vorced)	parated
Income lost due to illness, ini	ury or natural disaster (\$3,000 maximum per	· 12-month period )	
	APPLY WITHIN TWELVE (12) MONTHS	- ,	JCOME
	. ,	OF VERIFIED LOSS OF IT	COME
Date of Stop/Decrease (In	, <u> </u>		
Income before Stop/Decre	ease Frequency Month	aly Annually Semi-A	Annually  Quarterly
	☐ Semi-	Monthly Bi-Weekly D	Weekly
Reason for Loss of Incom	ne 🗌 Illness 🔲 Injury 🔲 Natural Disast	er (send a copy of police/fire	report, if applicable)
*NOTE: If aid is available be required.	for this type of incident and the applicant has	not applied for it, a written ex	planation as to why will
Liability insurance availal Lawsuit will be filed or is Crime Victim Compensat	s pending Yes No Workers	· _	☐ Yes ☐ No ☐ Yes ☐ No
Explanation of Incident			
	of a work-related incident, the applicant needs the applicant needs to check into liability insur- nation.		
Nature of illness, injury or nat	tural disaster		
Date of Incident	Time of day/night		
Location of Incident		Phone Number	
Address	City	State	_ Zip Code
Witnesses			
Name 1		Phone Number	
	City		
	City		

Veteran's Name:	Veteran's Name:	
Base File #:		
Explanation of Incident, cont.		
Please provide an explanation of your actions and whereabouts for at least four (4) hours prior to the incident. Include the quarant type of alcoholic beverages and/or drugs ingested, if any. If none, so state. Give a detailed account of the incident itself. At additional sheets if necessary.		
	—	
	—	
Under penalty of applicable law, I certify that the explanation of the incident, above, is true and complete to the best of my knowled and belief.	edge	
Applicant's Signature Date		

		Base File #:		
Living Arrangemen	nts Own Home	Mobile Home	Live with Roomm	ates
	Rent	Homeless	Live with Relative	s VAP Facility
Spouse and Legal I	Dependents Living with App	olicant		
First Name	Last Name	Bir	th Date	Relationship to Veteran  Spouse Dependent
				Spouse Dependent
				Spouse Dependent
				Spouse Dependent
	have health insurance that co			] Vision
_		• —		Vis. Admin. Code § VA 2.01(2)(a)]
_	-			vis. Admin. Code & vA 2.01(2)(a)]
Date veter	an applied to Federal VA hea	alth care system		
Has vetera	in been enrolled into the syste	m? No Yes	If yes, Date enrolled _	
Does the veteran h	nave a service-connected dis	ability? 🗌 No 🔲 Yes	s If yes, Disability rating	g %
Income – Verificati	ion Required (Veteran, Spo	use or any Dependent)	For Past 30 Days	
Recipient 1				
	e _\$ Free			Annually Quarterly
	☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly			
Income Type	☐ Wages – Employer \$		· <u> </u>	rith Dependent Children
	Overtime		Food Share (form	erly called Food Stamps)
	Bonuses		Rental (Income)	
	Commissions		☐ National Guard/R	eserve
	Sick/Disability Pay (from	n employer or insurance)	Compensation - V	VA.
	Child Support		Compensation – U	Unemployment Insurance
	Dividends		Compensation - V	Vorkers
	Interest		Pension – Other to	han Federal VA
	Retirement (pay)		Pension – Federal	l VA
	Social Security - Regula	ır	Student Financial	Aid (all types)
	Social Security - Disabil	lity	Federal GI Bill	
	☐ Supplemental Security I	ncome (SSI)	State or Federal V	oc Rehab
	Other			

Veteran's Name:

	Veteran's Name:  Base File #:			
Income – Verificat	ion Required (continued)	)		
Recipient 2				
Current Incom	e _\$	Frequency Monthly	Annually Semi-Annually	Quarterly
Income Type	□ Wages − Employer S     □ Overtime     □ Bonuses     □ Commissions     □ Sick/Disability Pay O     □ Child Support     □ Dividends     □ Interest     □ Retirement (pay)     □ Social Security - Resocial Security - Discussions     □ Supplemental Security     □ Other	\$(from employer or insurance gular sability	nthly Bi-Weekly Weekly Aid to Families with Dependent of Food Share (formerly called Food Rental (Income) National Guard/Reserve Compensation - VA Compensation - Unemployment Compensation - Workers Pension - Other than Federal VA Pension - Federal VA Student Financial Aid (all types) Federal GI Bill State or Federal Voc Rehab	d Stamps) Insurance
<b>Liquid Assets</b> (In V	Teteran, Spouse, or any De	ependent's Name)		
Owner 1			☐ I have no assets	
Asset Type  Checking A Savings A Money Ma Certificate Cash on H	ccount \$ rket \$ of Deposit \$		Accounts (Children or Grandchildren) Winnings	Value
Owner 2  Asset Type		Value Asset Ty	☐ I have no assets	Value
Checking A Savings Ao Money Ma Certificate Cash on Ha	ccount \$ rket \$ of Deposit \$		Accounts (Children or Grandchildren) Winnings ands	\$ \$ \$ \$

	Veteran's Name:			
Base File #:				
Living Expenses (Applicant's Primary	y Residence)			
Living Expense	Six Month Avg	Living Expense	Six Month Avg	
☐ Rent/Mortgage ☐ Food ☐ Current Medical Insurance Premium ☐ Current Prescribed Medicatio ☐ Essential Travel	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	☐ Child Care Required ☐ Electricity/Heat ☐ Water ☐ Telephone	\$ \$ \$ \$	
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 60 days of the date of the request or I may be denied this 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 subject to severe pena	•	or submit fraudulent evidence in conn w including fine, imprisonment or b	11	

benefits from WDVA.