Wisconsin Department of Veterans Affairs

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(608) 266-1311 | 1-800-WIS-VETS (947-8387) | WisVets.com

Wis. Stats. Chapter 45

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 120 DAYS OF INCOME LOSS**

Health Care Aid Components

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

You can print the most recent version of this form from the WDVA website at
http://dva.state.wi.us/Pages/newsedia/WDVAToolkit.aspx

Name ________________________
Base File # ________________________

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

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

Recipient 2 ________________________________

Current Income $ __________ Frequency ☐ Monthly ☐ Annually ☐ Semi–Annually ☐ Quarterly ☐ Semi–Monthly ☐ Bi–Weekly ☐ Weekly

Income Type

- ☐ National Guard/Reserve
- ☐ Compensation – VA
- ☐ Compensation – Unemployment (insurance)
- ☐ Compensation – Workers
- ☐ Sick/Disability Pay (from employer or insurance)
- ☐ Pension – Other than Federal VA
- ☐ Pension – Federal VA
- ☐ Social Security – Regular
- ☐ Social Security – Disability (SSD)
- ☐ Supplemental Security Income (SSI)
- ☐ Aid to Families with Dependent Children
- ☐ Food Share (formerly called Food Stamps)
- ☐ Rental(income)
- ☐ Dividends
- ☐ Interest
- ☐ Wages
  - Employer __________________
- ☐ Overtime
- ☐ Bonuses
- ☐ Commissions
- ☐ Child Support
- ☐ Retirement (pay)
- ☐ Student Financial Aid (all types)
- ☐ Federal GI Bill
- ☐ State or Federal Voc Rehab
- ☐ 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	☐ Yes	☐ No
Lawsuit will be filed or is pending	☐ Yes	☐ No
Crime Victim Compensation available	☐ Yes	☐ No
Disability insurance available	☐ Yes	☐ No
Workers Compensation available	☐ Yes	☐ 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

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

Owner 2 ____________________ ☐ I have no assets

Asset Type	Value	Asset Type	Value
☐ Checking Account	$	☐ Government Pension/Retirement Plan	$
☐ Savings Account	$	☐ Cash Value of Life Insurance	$
☐ Money Market	$	☐ Stocks (or stock accounts)	$
☐ Certificate of Deposit	$	☐ Bonds (or bond accounts)	$
☐ 401K Plan	$	☐ Custodial Accounts (Children or Grandchildren)	$
☐ 403B Plan	$	☐ Gambling Winnings	$
☐ IRA (Roth and Regular)	$	☐ Tax Refunds	$
☐ Company Pension/Retirement Plan	$	☐ 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.

You can print the most recent version of this form from the WDVA website at
http://dva.state.wi.us/Pages/newsedia/WDVAToolkit.aspx