THE LAW OFFICE OF JEFFREY M. JANEIRO, P.L.
3400 Tamiami Trail North, SUITE 203
NAPLES, FL 34103
TEL. (239)-513-2324
FAX. (239)-513-9580
www.janeirolaw.com

VA CLAIM QUESTIONNAIRE

Please complete and bring with you to the meeting

CLAIMANT INFORMATION

Full name of veteran: _____

Full name of spouse: _____

Address where mail should be sent:

_____

Address where claimant currently resides:

_____

Date of birth: Veteran: ___/___/_____ Spouse: ___/___/_____

Date of death: Veteran ___/___/_____ Spouse: ___/___/_____

Date of marriage: ___/___/_____ Place married: _____

Is spouse a veteran? □ yes □ no

Previous claim filed? □ yes □ no File # _____

Was the veteran or spouse previously married? □ yes □ no (If yes, circle which one)

Date of marriage: ___/___/_____ to ___/___/_____

Place married: _____ Place marriage ended: _____

Date of marriage: ___/___/_____ to ___/___/_____

Place married: _____ Place marriage ended: _____

SERVICE INFORMATION

Has the veteran received any of the following? (check all that apply)

- □ Lump Sum Readjustment Pay $ _____
- □ Separation Pay $ _____
- □ Special Separation Benefit $ _____
- □ Voluntary Separation Incentive $ _____
- □ Disability Severance Pay $ _____

The veteran is (check all that apply):

- □ on Medal of Honor Roll
- □ receiving VA compensation for service-connected disability
- □ receiving military retirement pay $ _____ branch: _____
- □ formerly a POW (please give a short description below)

_____

_____

_____

DISABILITY INFORMATION

Check all that apply

Veteran	Spouse	
□	□	Over 65
□	□	Blind
□	□	Declared incompetent
□	□	Has macular degeneration – Extent: _____
□	□	Under 65, determined disabled by Social Security Admin.
□	□	Diagnosed with dementia – Stage: Early Mid Late
□	□	Is housebound (unable to leave without assistance)
□	□	Needs daily assistance from another to perform basic activities
□	□	Receives Medicaid – Type: _____
□	□	Has applied for Medicaid – Type: _____
□	□	Is in a nursing home – Name: _____
□	□	Is in an assisted living facility – Name: _____

Has the claimant been hospitalized in the last 12 months? □ yes □ no

Began ___/___/_____ Ended ___/___/_____

Name and address of facility: _____

_____

Began ___/___/_____ Ended ___/___/_____

Name and address of facility: _____

_____

Please list the names and addresses of all physicians providing care to the veteran or spouse:

Name: _____ Address: _____

_____

Name: _____ Address: _____

_____

INCOME AND NET WORTH INFORMATION

Amount in	Veteran	Spouse	(If a joint account, list in one)
Checking accounts	$ _____	$ _____	
Savings accounts	$ _____	$ _____	
CDs	$ _____	$ _____	
IRAs or other retirement	$ _____	$ _____	(Not pension payments)
Stocks and bonds	$ _____	$ _____	
Mutual Funds	$ _____	$ _____	
Life Insurance (cash value)	$ _____	$ _____	
Real property (not home)	$ _____	$ _____	
Other property	$ _____	$ _____	describe: _____
Other property	$ _____	$ _____	describe: _____

Will the veteran or spouse receive income in the next 12 months from:

Business operation or rental property	□ yes □ no
Farm operation	□ yes □ no
Personal injury settlement	□ yes □ no
Anticipated inheritance	□ yes □ no

If yes, please attach amounts to be received and any documentation showing amount received.

Please list regular sources of monthly income and amounts:

	Veteran	Spouse
Social Security:	$ _____	$ _____
Pension:	$ _____	$ _____
Other: _____	$ _____	$ _____
Other: _____	$ _____	$ _____

Are there any one-time or non-monthly sources of income the claimant expects to receive in the next 12 months? □ yes □ no If so, please explain:

_____

_____

_____

_____

Please list your monthly medical out-of-pocket expenses (if married, please include spouse's medical expenses as well). Medicaid expenses include prescriptions, home health aides, assisted living expenses, long term care premiums, doctor co-pays, etc.:

Expense	Amount paid monthly
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____