

**Pension Intake Form**

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*If you are a veteran or a veteran's family member, you may be entitled to veterans' benefits. In particular, if the veteran is disabled and in need of financial help, he or she may be eligible for VA pension (as may his or her survivors). The following questions will help you and your advocate organize the information you need to apply for benefits. If additional room is needed to complete an answer, please attach a separate piece of paper. Do not send this form to the VA; give it to your accredited service officer.*

Date \_\_\_\_\_

(1) Name of veteran: \_\_\_\_\_  
First MiddleLast

(2) Name used in service if different: \_\_\_\_\_

(3) Applicant if other than the veteran:  
\_\_\_\_\_  
First MiddleLast

(4) Relationship to veteran: \_\_\_\_\_

(5) Address: \_\_\_\_\_  
Number Street Apt. No.  
\_\_\_\_\_  
City State Zip Code

(6) Mailing address: \_\_\_\_\_  
Number Street Apt. No.  
\_\_\_\_\_  
City State Zip Code

(7) Telephone:  
Home ( ) \_\_\_\_\_  
Work ( ) \_\_\_\_\_

(8) Date of birth:  / /  
Month Day Year

(9) Social Security number:  - -

(10) Single( ) Married( ) Separated( ) Divorced( ) Widowed( )

(11) Are you currently employed? yes( ) no( )  
If yes, what is your occupation? \_\_\_\_\_

(12) If not employed, are you able to work?      yes( ) no( )

(13) If you are not employed, is it because of medical problems related to your military service?      yes( ) no( )

(14) Are you receiving Social Security Disability, Supplemental Social Security, or other forms of government assistance? If you are, please specify:

\_\_\_\_\_

(15) Do you have dependents?  
yes( ) no( )

If yes, how many? \_\_\_\_\_

Please list your dependents' names, how they are related to the veteran, dates of birth, and Social Security numbers:

\_\_\_\_\_

\_\_\_\_\_

**Information Related to Service**

(16) Are you a veteran of the U.S. armed forces?  
yes( ) no( )

*If you are a veteran, please attach a copy of your discharge form, the DD 214. If you do not have a copy of your DD 214, please obtain from your advocate and complete and attach Standard Form (SF) 180, Request Pertaining to Military Records, to obtain a copy of your DD 214.*

(17) To what branch of the service (army, navy, air force, marines, coast guard, merchant marine) did you belong?

\_\_\_\_\_

(18) In what era (Korea, Vietnam, Persian Gulf, OEF/OIF, or other) was your service?

\_\_\_\_\_

*If the veteran did not have at least one day of service during the above wartime periods, the veteran is not eligible for pension.*

(19) Please list your dates of service:

Entry \_\_\_\_\_ Discharge \_\_\_\_\_

Entry \_\_\_\_\_ Discharge \_\_\_\_\_

Entry \_\_\_\_\_ Discharge \_\_\_\_\_

(20) Please state your type of discharge:

\_\_\_\_\_

(21) Were you in combat?  
yes( ) no( )

(22) Were you wounded?  
yes( ) no( )

If so, where on the body?

\_\_\_\_\_

(23) Are you still having medical problems caused by the wound(s)?  
yes( ) no( )

If so, what are the problems?

\_\_\_\_\_

(24) Were you treated for any injury, disability, or disease in service?  
yes( ) no( )

If yes, briefly describe the disability or disease.

\_\_\_\_\_

Information Related to VA Benefits

(25) Have you ever applied for VA benefits?  
yes( ) no( )

If yes, check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Compensation              | <input type="checkbox"/> Pension            |
| <input type="checkbox"/> Medical care              | <input type="checkbox"/> Education          |
| <input type="checkbox"/> Vocational rehabilitation | <input type="checkbox"/> Nursing home care  |
| <input type="checkbox"/> Domiciliary care          | <input type="checkbox"/> Home loan guaranty |

Other (please specify): \_\_\_\_\_

*If this is a new claim, ask your advocate about filing an informal claim.*

(26) If you have filed a claim before, please give the claim number that the VA assigned: \_\_\_\_\_  
\_\_\_\_\_

(27) Are you now receiving VA benefits?  
yes( ) no( )

If yes, check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Compensation                    | <input type="checkbox"/> Pension            |
| <input type="checkbox"/> Pension plus aid and attendance |   |
| <input type="checkbox"/> Pension plus housebound         |   |
| <input type="checkbox"/> Medical care                    | <input type="checkbox"/> Education          |
| <input type="checkbox"/> Vocational rehabilitation       | <input type="checkbox"/> Nursing home care  |
| <input type="checkbox"/> Domiciliary care                | <input type="checkbox"/> Home loan guaranty |

Other (please specify): \_\_\_\_\_

(28) At which VA regional office is your claim file located?

\_\_\_\_\_

(29) Were you ever treated at a VA medical center or outpatient facility?

yes ( ) no ( )

If yes, please specify when, where, and what the treatment was for:

\_\_\_\_\_  
\_\_\_\_\_

(30) Have you ever sought counseling or help from a Vet Center?

yes ( ) no ( )

If yes, please specify when and where:

\_\_\_\_\_

(31) In your opinion, are you permanently and totally disabled?

yes ( ) no ( )

If yes, identify the medical condition(s) that cause you to be so disabled:

\_\_\_\_\_

(32) If you have multiple disabilities, in your opinion is there one of your disabilities that by itself causes you to be totally disabled?

(33) In your opinion, do you suffer from a permanent disability which would render it impossible for the average person to follow a substantially gainful occupation?

yes ( ) no ( )

(34) Are you in a nursing home for long-term care due to disability?

(35) Have you been determined disabled for purposes of Social Security Administration benefits?

yes ( ) no ( )

(36) Are you age 65 or over?

yes ( ) no ( )

(37) List the names and addresses of any physicians or hospitals that are currently treating you:

\_\_\_\_\_  
Name Address  
\_\_\_\_\_  
Name Address  
\_\_\_\_\_  
Name Address  
\_\_\_\_\_  
Name Address

*Because pension is need based, you must report all household income to the VA. Completing the table below will help in assessing eligibility. Write in the amount of all the monthly income for the veteran and all dependents who reside in the household.*

Source of Income      Veteran      Spouse      Children

Wages                                 \$                                 \$                                 \$  
Social Security  
Private pension  
Civil service pension  
Interest  
Dividends  
Other  
Other  
Other

(38) Unreimbursed medical expenses may be used to reduce countable income. Does the veteran, or his or her dependent family members, have any unreimbursed medical expenses?  
yes( ) no( )