



VETERANS AID & ATTENDANCE QUALIFICATION WORKSHEET

APPLICANT INFORMATION

Veteran Name: _____

Spouse Name: _____

Address: _____

Address: _____

Height: _____ Weight: _____

Height: _____ Weight: _____

Date of Birth: _____

Date of Birth: _____

SERVICE INFORMATION

Did the veteran serve during one of the following war-times: O Yes O No

WWII 12/07/1941 – 12/31/1946

Korean War 06/27/1950 – 01/31/1955

Vietnam Conflict 08/05/1964 – 05/07/1975

Gulf War 08/02/1990 - Present

If yes, what branch of service, for how long, and what type of discharge did the veteran receive:

Branch: _____ Length of Service: _____ Type of Discharge: _____

CURRENT HEALTH INFORMATION – VETERAN

Is the veteran alive?(If deceased, the following questions may be disregarded.) O Yes O No

Is the veteran suffering from any type of blindness? O Yes O No

Does the veteran need any assistance with the following (check all that apply):

- Eating Bathing Dressing Toileting Transferring

Does the veteran suffer from a mental disability (i.e. Alzheimer's)? O Yes O No

Does the veteran still operate a motor vehicle? O Yes O No

Has the veteran used tobacco within the past 2 years? O Yes O No

List medical conditions treated in the last 5 years and surgery performed or scheduled in last 5 years.

Veteran	Medication	Condition	Diagnosis and/or Treatment Dates	Comments

Is there a family history of Cognitive Impairment (i.e. Alzheimer's, dementia, etc.) or cancer?

Yes No

Have you suffered a stroke or been diagnosed with diabetes?

Yes No

Is there longevity in your family? _____

CURRENT HEALTH INFORMATION - SPOUSE

Is the spouse alive? (If deceased, the following questions may be disregarded.) Yes No

Is the spouse suffering from any type of blindness? Yes No

Does the spouse need any assistance with the following (check all that apply):

Eating Bathing Dressing Toileting Transferring

Does the spouse suffer from a mental disability (i.e. Alzheimer's)? Yes No

Does the spouse still operate a motor vehicle? Yes No

Has the spouse used tobacco within the past 2 years? Yes No

List medical conditions treated in the last 5 years and surgery performed or scheduled in last 5 years.

Spouse	Medication	Condition	Diagnosis and/or Treatment Dates	Comments

Is there a family history of Cognitive Impairment (i.e. Alzheimer's, dementia, etc.) or cancer?

Yes No

Have you suffered a stroke or been diagnosed with diabetes?

Yes No

Is there longevity in your family? _____

HOUSING INFORMATION - VETERAN

Does the veteran live alone, without any assistance? Yes No

Does the veteran currently reside in an assisted living facility? Yes No

Does the veteran currently reside in a nursing facility? Yes No

Is the veteran receiving care through a caregiver agreement? Yes No

HOUSING INFORMATION - SPOUSE

Does the spouse live alone, without any assistance? Yes No

Does the spouse currently reside in an assisted living facility? Yes No

Does the spouse currently reside in a nursing facility? Yes No

Is the spouse receiving care through a caregiver agreement? Yes No

MONTHLY INCOME

	Veteran's Monthly Income	Spouse's Monthly Income
Social Security Benefits	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Total Monthly Income	\$ _____	\$ _____

Do not include interest and dividend income on this form.

If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance, or any other reason.

MONTHLY UNREIMBURSED MEDICAL EXPENSES ("UME")

	Veteran's Monthly URME	Spouse's Monthly URME
Nursing Home	\$ _____	\$ _____
Assisted Living	\$ _____	\$ _____
Home Health Care	\$ _____	\$ _____
Medicare Premiums	\$ _____	\$ _____
Insurance Premiums	\$ _____	\$ _____
Monthly Prescription Cost	\$ _____	\$ _____
Monthly Other Cost	\$ _____	\$ _____
Total Monthly UME	\$ _____	\$ _____

MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12, and quarterly expenses by 3.)

\$ _____	Rent/Mortgage
\$ _____	Real Estate Taxes
\$ _____	Water
\$ _____	Sewer
\$ _____	Utilities (Heat, Electric) (1/12 of last 12 months)
\$ _____	Homeowner's insurance premium
\$ _____	Condominium fees
\$ _____	Total Monthly Housing Expenses

MONTHLY NON-SHELTER EXPENSES

(Please estimate.)

\$ _____	Food
\$ _____	Medical
\$ _____	Clothing
\$ _____	Telephone
\$ _____	Transportation (including auto insurance)
\$ _____	Home Maintenance
\$ _____	Life Insurance Premiums
\$ _____	Health Insurance Premiums
\$ _____	Medicare Supplemental Insurance Premiums
\$ _____	Cable TV
\$ _____	Federal and State Income Taxes
\$ _____	Other
\$ _____	Total Monthly Non-Shelter Living Expenses

ASSETS/LIABILITIES

(Please insert the value of each asset/liability in the appropriate space.)

Asset	Veteran	Spouse	Joint	Liabilities
Automobile				
Additional Automobile				
Checking Account				
Savings Account				
Money Market Account				
Certificate of Deposit				
Residence				
Mutual Funds				
Stocks				
Bonds				
Annuities				
IRA				
Other Real Estate				
Nursing Home Deposit				
Other				
Other				
Totals				

LIFE INSURANCE

COMPANY NAME (include address and policy No.)	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

GIFTS

Please list gifts made in excess of \$100.00 in any one month, to an individual or group of individuals, within the past 60 months:

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Have you ever filed a Federal Gift Tax Return? Yes No

If so, please state details _____

CHILDREN (if applicable)

CHILD'S NAME	ADDRESS (With Zip Code)	TELEPHONE NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Are all of your children in good health? Yes No

Are any of your children receiving SSI or other forms of government entitlement? Yes No

Do any of your children live with you in your home? Yes No

PLANNING GOALS

Do the veteran/spouse have any intent to benefit their children? Yes No

Are the veteran/spouse looking for control and independence? Yes No

THIRD PARTY COMPENSATION

If a licensed insurance agent, financial advisor, or other person is seeking compensation on this case, Krause Financial Services must know of their relationship prior to the development of a plan. **Once a plan is developed by way of a planning letter, no compensation – commissions or otherwise, will be made available to any third party.**

Will a third party be seeking compensation in this transaction? Yes No

CERTIFICATION

The undersigned hereby represents to Krause Financial Services that the information contained in this intake form is accurate and complete, and that the undersigned understands that Krause Financial Services will rely on this information for purposes of developing a plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on program eligibility.

Dated: _____

Signature of Client or Client Representative:

Additional Comments: _____

Once completed, please return this form to:

Krause Financial Services, Inc.

Dale M. Krause, J.D., LL.M.

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