

<b>*** Office Use Only ***</b> Appointment with:	
Date:	Time:

**Cass County Veterans Service Office**  
**211 9th Street South, Fargo, ND 58108**  
**Phone: 701.241.5756 Fax: 701.239.6751**

<b>Veteran</b>	Last Name:		First Name:		Middle Name:		
	Address:			City:		State:	Zip:
	Gender:	Race :					
	Home Phone:			Cell Phone:			
	Date of Birth:		Place of Birth (City, State):		Email Address:		
	Date of Death:		Place of Death (City, State):		Branch of Service: Army Marines Navy Air Force Coast Guard Other		
	Social Security Number:			Maiden Name:			
				Serve Under Any other Name:			
	Marital Status:			*Date of Marriage:	*Place of Marriage (City, State):		
	Living with Spouse? Yes No			*Date of Divorce:	*Place of Divorce (City, State):		

*\*Include previous marriage(s) and additional divorce information on a separate piece of paper or in the comments block on page 5.*

<b>Veteran Income</b>	Employer:		
	Employer Address:		
	City:	State:	Zip:
	Phone:	Fax:	
	Job Title:	Dates of Employment: to	
	Receiving disability, Supplemental Social Security, or other government assistance? Please specify.		
	Yes	No	

<b>Spouse</b>	Last Name:		First Name:		Middle Initial:
	Gender:		Social Security Number:		Maiden Name:
	Cell Phone:		Work Phone:		Previously Married? Yes No Also a Veteran? Yes No
	Date of Birth:		Place of Birth (City, State):		Email Address:
	Date of Death:		Place of Death (City, State):		

*Include your spouse's previous marriages and divorce information on a separate piece of paper or in the comments block on page 5.*

<b>Spouse Income</b>	Employer:		
	Employer Address:		
	City:	State:	Zip:
	Phone:	Fax:	
	Job Title:	Dates of Employment: _____ to _____	
	Receiving disability, Supplemental Social Security, or other government assistance? Please specify.		Yes

<b>Dependent (1)</b>	Last Name:		First Name:		Middle Initial:				
	Social Security Number:	Date of Birth:	Place of Birth (City, State):		Gender:				
	Relationship to Veteran:								
	Student?	Yes	No	Adult?	Yes	No	Disabled?	Yes	No
	Name of School:			Disability:					

<b>Dependent (2)</b>	Last Name:		First Name:		Middle Initial:				
	Social Security Number:	Date of Birth:	Place of Birth (City, State):		Gender:				
	Relationship to Veteran:								
	Student?	Yes	No	Adult?	Yes	No	Disabled?	Yes	No
	Name of School:			Disability:					

*Include additional dependents on a separate piece of paper and attach to the form or in the comments block on page 5.*

<b>Next of Kin</b>	Last Name:		First Name:		Middle Initial:
	Street Address:		City:	State:	Zip Code:
	Daytime Phone:		Evening Phone:		
	Relationship to Veteran:				

<b>Medicare</b>	Name as it appears on Medicare Card:				
	Medicare A?	Yes	No	Effective Date:	
	Medicare B?	Yes	No	Effective Date:	
	Medicare D?	Yes	No	Effective Date:	

<b>Health Insurance</b>	Type of Insurance (Medicaid/Private):		Name of Company:	
	Insurance Address:			
	City:	State:	Zip Code:	Phone:
	Policy/Identification Number:		Group Number:	
	Policy Listed Under:		Coverage Ending Date:	

<b>Service Information</b>	In what era did you serve? <i>WWII Korea Vietnam Persian Gulf OEF/OIF Peacetime</i> <i>Other:</i>						Were you in combat? Yes No	
	Please list your dates and types of service. <i>Include additional periods on a separate piece of paper.</i>		Entry	Exit	Discharge			
			Entry	Exit	Discharge			
			Entry	Exit	Discharge			
	The reason for discharge: If other, please specify:							
	Are you receiving retirement pay from the military? If yes, please specify monthly amount:							
Are you receiving disability pay from the military? If yes, please specify monthly amount:								
Did you receive severance pay at discharge? If yes, please specify monthly amount:								
Were you ever a prisoner of war? Yes No If yes, where and for how long?				Were you wounded? Yes No If so, where on the body?				

<b>Medical Information</b>	Are you still having medical problems caused by the wound(s)? Yes No If so, what are the problems?					
	Do you have recurring dreams or intrusive memories about combat or your POW experience? Yes No		Do you have recurring dreams or intrusive memories about any traumatic experience during military service? Yes No		Do you avoid, or react unusually to, things that symbolize or remind you of a traumatic event in service? Yes No	
	Were you treated for any injury, disability, or disease in service? Yes No Briefly describe the injury, disability or disease.					
	Are you currently having problems with these same injuries, disabilities, or diseases? Yes No					
	Did you suffer from a disease or injury in service that was not treated by a doctor? Yes No If yes, please describe it.					
	Do you currently have a disease or injury that existed before your entry into service? Yes No Please describe it.					
	Did the disease or injury increase in severity (get worse) during service? Yes No					
	While in the service, were you exposed to (check all that apply): <i>Radiation Agent Orange Asbestos Toxic chemicals Nerve gas Depleted uranium Smoke from burning oil wells Other</i>					

VA-Related Information

<p>Have you ever applied for VA benefits? Yes No          Check all that apply.  <i>Compensation Pension Medical care Education</i>  <i>Vocational Rehab Nursing home care</i>  <i>Domiciliary care Home loan guaranty</i>  <i>Other</i></p>	<p>Are you now receiving VA benefits? Yes No          Check all that apply.  <i>Compensation Pension Medical care Education</i>  <i>Vocational Rehab Nursing home care</i>  <i>Domiciliary care Home loan guaranty</i>  <i>Other</i></p>
<p>Were you ever treated at a VA medical center? Yes No          Please specify when, where, and what the treatment was for:</p>	<p>Have you ever sought counseling or help from a Vet Center?          Yes No Please specify when and where.</p>
<p>Are you now being treated, or have you been treated in the past, by a private physician for an illness or disability incurred in or aggravated by service? Yes No Please specify when, where, and what the treatment was for:</p>	
<p>Are you currently being treated or have you ever been treated at a hospital for an illness or disability incurred in or aggravated by service? Yes No Please specify when, where, and what the treatment was for:</p>	
<p>In your opinion, are you permanently and totally disabled? Yes No Identify the medical condition(s) that cause you to be so disabled:</p>	
<p>If you have multiple disabilities, in your opinion is there one that by itself causes you to be totally disabled?          Yes No</p>	<p>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</p>
<p>Are you in a nursing home for long-term care due to disability? Yes No</p>	<p>Have you been determined disabled for purposes of Social Security Administration benefits?          Yes No</p>
<p>Describe all current disabilities:</p>	

Because pension (and healthcare in certain circumstances) 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.

Pension and Health Care Related Information

Source of Income (Gross Annual)	Veteran	Spouse	Children
Wages			
Social Security			
Private pension			
Civil service pension			
Interest			
Dividends			
Stocks & Bonds			
IRAs			
CDs			
Checking balance			
Savings balance			
Other (Source: )			
Other (Source: )			
Total Income:			

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? If yes, please list expense and total amount/year and attach to this form.

List any other information or comments that may be helpful.