90-400 APPENDIX C. FORM CW 5

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

VETERANS BENEFITS VERIFICATION AND REFERRAL

NOTE: Do not complete this form unless one of the following is known:

- Veterans Social Security Number and Date of Birth
- Military Serial Number
- Veterans Administration (VA) Claim Number

You and any member of your household for whom you are applying for aid must give us the Social Security Number(s) (SSN). The SSN(s) are used to determine your eligibility and failure to cooperate may result in denial or discontinuance of aid. Authority: 45 Code of Federal Regulations Section 205.52, and Welfare and Institutions Code Section 11268(a).

Name and Address of County Veterans Service Office

CASE NAME:

CASE NUMBER (INCLUDING MEDS AID CODE):

APPLICANT/RECIPIENT PHONE #:

CASE WORKER:

WORKER PHONE #:

SECTION I

VETERAN'S NAME (LAST, FIRST, MIDDLE)	BIRTH DATE:	BIRTHPLACE:	LIVING? ☐ YES ☐ NO	IF DECEASED: DATE OF DEATH: PLACE OF DEATH:
VETERAN'S ADDRESS: (NUMBER, STREET, CITY, STATE, ZIP CODE)		DOES THIS VETERAN LIVE IN YOUR HOME? ☐ YES ☐ NO	VA CLAIM NUMBER: SOCIAL SECURITY NUMBER: MILITARY SERIAL NUMBER:	
BRANCH OF SERVICE:	DATE OF ENTRY:	DATE OF DISCHARGE:	TYPE OF DISCHARGE: ☐ HONORABLE ☐ GENERAL ☐ MEDICAL ☐ OTHER THAN HONORABLE ☐ UNKNOWN	

VETERAN'S MARITAL STATUS:	IS THIS VETERAN PERMANENTLY UNABLE TO WORK BECAUSE OF DISABILITY?	DID THIS VETERAN SUFFER AN IN-SERVICE INJURY OR ILLNESS THAT CAUSES A CURRENT DISABILITY:
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED	☐ YES ☐ NO	☐ YES ☐ NO

VETERAN'S GROSS MONTHLY INCOME: $	IS ANYONE IN LONG-TERM CARE: ☐ YES ☐ NO IF YES, (✓) BELOW: ☐ VETERAN ☐ SPOUSE ☐ OTHER	IS ANYONE BLIND, OR IS HOME CARE NEEDED TO FEED, BATHE, OR DRESS A HOUSEHOLD MEMBER: ☐ YES ☐ NO IF YES, (✓) BELOW: ☐ VETERAN ☐ SPOUSE ☐ OTHER
SPOUSE'S GROSS MONTHLY INCOME: $		

SECTION II

NAME OF CLAIMANT:	RELATIONSHIP TO VETERAN:	BIRTH DATE:	SOCIAL SECURITY NUMBER:	ADDRESS:

SECTION III

I hereby authorize the welfare department to release the above information to the County Veterans Service Office and the Veterans Administration for purposes of identifying or obtaining benefits available to the persons identified above. I also authorize the County Veterans Service Office and Veterans Administration to release their findings (to be noted below).

SIGNATURE (OR MARK) OF VETERAN/DEPENDENT:	DATE:	SIGNATURE OF WITNESS TO MARK:	DATE:

SECTION IV *(To be completed by the County Welfare Department and the County Veterans Service Office)*

The County Welfare Department requests the County Veterans Service Office to:

☐ Verify any VA benefits received by the veteran and/or dependent(s): ☐ Determine veteran/dependent's eligibility for veteran's benefits:

	1-Veteran	2-Claimant	3-Claimant	4-Claimant
Monthly Benefit	$	$	$	$
Beginning Date *(Month/Day/Year)*				
Ending Date *(Month/Day/Year)*				
Lump Sum Payment *(Past 6 Months)*	$	$	$	$

(✓) If monthly benefit is paid.
☐ Compensation
☐ Pension
☐ Other *(see remarks)*
☐ Includes A & A benefits of $_____

(✓) Eligibility Status:
☐ No basic eligibility
☐ Claim initiative
☐ Claim being reviewed
☐ Claim denied

REMARKS: *(For official use only)*

Name and Address of County Human Services Office

CWDO REPRESENTATIVE: (PRINT)	PHONE #:	DATE: