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: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

IS THIS VETERAN PERMANENTLY UNABLE TO WORK BECAUSE OF DISABILITY? ☐ YES ☐ NO

DID THIS VETERAN SUFFER AN IN-SERVICE INJURY OR ILLNESS THAT CAUSES A CURRENT DISABILITY: ☐ YES ☐ NO

VETERAN'S GROSS MONTHLY INCOME: $

SPOUSE'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

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/DEPENDANT:	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 initiated
☐ Claim being reviewed
☐ Claim denied

Name and Address of County Human Services Office

REMARKS: *(For official use only)*

CVSO REPRESENTATIVE: (PRINT)	PHONE #:	DATE:

INSTRUCTIONS FOR COUNTY USE AND COMPLETION OF VETERAN'S BENEFITS VERIFICATION AND REFERRAL FORM CW 5

USE THE CW 5:

1. To verify the status amount of the veteran's benefits being received.
2. To refer applicants or recipients to the County Veterans Service Office (CVSO).
3. To obtain new veteran benefits when the information on the Statement of Facts forms for the following programs indicates possible eligibility for benefits or county general assistance or relief:
   - California Work Opportunity and Responsibility to Kids (CalWORKs)
   - Medi-Cal
   - State-Run County Medical Services Program
   - Food Stamps
   - AFDC-Foster Care
   - Kin GAP
   - Healthy Families
   - Other Program Statement of Facts forms

DO NOT COMPLETE THIS FORM IF THE SERVICE PERSON IS STILL ON ACTIVE DUTY, OR NONE OF THE FOLLOWING INFORMATION IS KNOWN:

1. Veteran's Social Security Number (SSN) and Date of Birth;
2. Veteran's Military Serial Number;
3. Veterans Administration (VA) Claim Number.

If either of the above applies, **do not** initiate a CW 5. Do make an entry in the "County Use Only" section of the SAWS 2 or the MC 210 or the "ELIGIBILITY WORKER ONLY": section of the FC 2 form stating why a referral was not made and place the form in the case file.

INSTRUCTIONS FOR COMPLETION OF CW 5:

1. Enter name and address of County Veterans Service Office (CVSO) in upper left-hand corner of the address box.
2. Enter name and address of County Welfare Department (CWD) in lower left-hand address box.
3. Check the appropriate request box to verify or determine benefits.
4. Enter worker and applicant/recipient case information in upper right-hand box.

Section I - Have applicant enter all known veteran and, if applicable, claimant information. At least one is required: (a) Veteran's SSN and date of birth, (b) Veteran's military serial number, or (c) VA claim number.

Section II - Have applicant enter all claimant information.

Section III - Have the veteran, dependent/claimant of foster care representative read, sign and date the authorization statement (attach a copy of placement order in foster care cases).

Section IV - This section will be filled in by the CVSO.

DISTRIBUTION AND FILING OF THE CW 5:

Complete original and photocopy 5 copies of the form. Distribute as follows:

- Original and 3 copies to CVSO. Have the veteran, dependent/claimant, or foster care representative hand carry 4 copies of the form along with medical documents, military papers, etc, to the CVSO. Referral by mail may be used if hand carry method is not possible.
- One copy for case file to be retained until original is completed and returned to CWD by CVSO. CWD will keep the completed original CW 5 as a permanent record and discard the copy.
- A copy of the completed original will be kept by CVSO.

If Veterans Affairs Aid and Attendance Benefits have been granted to the veteran, widow or parent of the veteran, CVSO will also send a copy of the completed original to: Department of Health Services, Recovery Branch, Health Insurance Unit 105, P.O. Box 1287, Sacramento, CA 95806.