_____County Department of Social Services

North Carolina Division of Veterans Affairs Date: _____
District Office Fax No. _____

We are determining eligibility for public assistance. Please verify the amount of the VA benefits the claimant is receiving or entitled to.

VA Claimant Name: _____ **Veteran's Name (if different):** _____

VA Claim Number: _____ **Claimant Social Security #:** _____

I hereby grant permission and authorize the U.S. Dept. of Veterans Affairs to disclose to NC Division of Veteran Affairs information that will be solely used for determining eligibility for Medicaid.

_____ _____
Signature of claimant **date**

If you (NCDVA) have questions about completing this verification form, please contact:

Worker: _____ **Phone**: _____ **Fax:** _____

Information to be completed by N.C. Division of Veterans Affairs:

VA Claim Number (if not supplied above) _____

Benefit Type:

[ ] Old Pension Law (Protected Pension Program)
[ ] Improved Pension
[ ] Reduced Improved Pension (up to $90 payment)[P.L. 102-568]
[ ] Compensation
[ ] Apportionment
[ ] Other _____

TOTAL VA Gross Monthly Benefit Amount: $ _____ effective _____.
Does it include?

[ ] Aid & Attendance (A&A) Amount: $_____
[ ] Homebound/Housebound (HB) Amount: $_____
[ ] Educational Benefits Amount: $_____
[ ] **None of the above**

Unusual Medical Expenses (UME)

Is VA benefit for this individual based on continued unreimbursed Unusual Medical Expenses [ ]Yes [ ]No
Amount of benefit received due to UME $_____

Has claimant received any lump sum payments? [ ] Yes [ ] No

If yes, is lump sum for [ ] Retroactive Benefits [ ] Unusual Medical Expenses
Date received _____ and amount _____

Verified by: _____ **Phone Number:** _____

Title: _____ **Date**: _____

For County DSS Use

Gross Benefit Amount	_____
Minus A&A/Homebound/Housebound amount	_____
Minus amount received due to UME	_____
Minus educational benefit	_____
Equals countable benefit amount	_____

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