Office
Street Address
City, St, Zip
Phone
Fax

Missouri Department of SOCIAL SERVICES

SAVE PRINT RESET

VETERANS ADMINISTRATION VERIFICATION (VENDOR)			Date:
Beneficiary	DOB	DCN	SSN

The above named person has applied for or is receiving Medicaid Title XIX coverage for Nursing Home Care. In determining eligibility, we must take into account all income available to the claimant. From your record, please verify any benefits being received or available to the above named veteran or his/her dependents. Your prompt attention in this matter will be appreciated.

Authorization for Release of Information	SIGNATURE	DATE

If claimant can only make their mark, please have two witness' sign below.

Witness Signature	DATE
Witness Signature	DATE

WORKER	PHONE NUMBER

VETERAN/BENEFICIARY	DOB	SSN	
BENEFICIARY STREET ADDRESS	CITY	STATE	ZIP CODE

CLAIM/SERIAL NUMBER	DATES OF SERVICE (IF KNOWN)

FAMILY SUPPORT DIVISION REPORT

Date claimant entered Nursing Home (Medicaid Title XIX)	

VETERANS ADMINISTRATION REPORT

Monthly Break down of Benefits to include Aid and Attendance

TYPE OF BENEFIT	AMOUNT	INCOME SOURCE NOT LISTED
Needs Based Pension		
DIC Payment		
Additional amount for Dependants		
Aid and Attendance		
TOTAL BENEFIT		

Effective Date of Benefit Reduction	DATE

COMMENTS:

SIGNATURE	TITLE	DATE