



Request for Information from Bureau of Veterans Affairs and Client's Authorization

Name of Veteran	C or XC No.	Date
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Bureau of Veterans Affairs Regional Office

RETURN TO:

I hereby grant permission for the Bureau of Veterans Affairs to disclose the information requested below to the Health and Human Services Commission. I understand that this information may have a bearing on my eligibility for assistance.

 Signature-Veteran

 Date

Please furnish the following information on benefits received by:

Name	Payee (if different)	Claimant Institutionalized? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address		

Comments: (up to 4 lines)

Signature-HHSC Staff

Telephone No. (include A/C)

TO BE COMPLETED BY BUREAU OF VETERANS AFFAIRS (please return to address indicated above)

EFFECTIVE DATE	GROSS AMOUNT	PENSION		DIC		COMPENSATION	INSURANCE
		Old Law	Improved Plan	Parents	Widows & Children		

Will improved pension payments for this claimant be capped at \$90? Yes No

If yes, in what month and year will claimant receive the first \$90 check?

Month	Year (4 digits)
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Has the check been augmented to include the needs of a dependent? Yes No

If yes, give the amount by which the claimant's check has been augmented for dependent(s): \$ _____

Is full payment being received? Yes No

If no, why? **Recoupment of Overpayment** **Suspension of Benefits** **Other:** _____

Does the check include an adjustment for out-of-pocket medical expenses? Yes No

If yes, amount of adjustment: \$ _____

Does the check include aid and attendance or housebound benefits? Yes No

If yes, amount of aid and attendance:\$ _____ ; amount of housebound benefits: \$ _____

 Signature-BVA Official

 Date

Telephone No. (include A/C)