WISCONSIN DVA VETERANS FORWARD | Wisconsin Department of Veterans Affairs

2135 Rimrock Road, P.O. Box 7843, Madison, WI 53707-7843
(608) 266-1311 | 1-800-WIS-VETS (947-8387) | WisVets.com

Wis. Stats. Chapter 45

INSTRUCTIONS
ASSISTANCE TO NEEDY VETERANS GRANT APPLICATION (SUBSISTENCE AID)

Please submit this application if you are applying for Subsistence Aid due to an illness, injury or natural disaster which has resulted in a loss of income.

Subsistence Aid will be limited to the difference between the amount of earned and unearned income available before the loss of income and the earned and unearned income being received after the loss of income, subject to limitations under § 45.40(1m)(b) and (3), Stats.

- If you are the veteran completing this application, please complete the "Veteran's Name" section.
- If you are the spouse or dependent of the veteran completing this application:
  - For yourself; please complete the "Veteran's Name" **and** "Applicant's Name" sections.
  - On behalf of the veteran, please complete the "Applicant's Name" **and** "Patient's Name" sections.

There is a $3,000 maximum per 12-month period for this benefit and a lifetime maximum of $7,500 for all Assistance to Needy Veterans Grant types combined (Health Care Aid and Subsistence Aid).

To be eligible, an applicant must meet the following requirements:

- A veteran as defined in Wis. Stat. § 45.01(12).
- Spouse and dependents of an activated or deployed member of the U.S. Armed Forces or Wisconsin National Guard, must submit evidence that the service member has been deployed or activated, that due to the activation or deployment, a loss of income has occurred, the spouse or dependent experienced an economic emergency during the member's deployment or activation, and that the spouse and dependents are residents of this state.
- Does not have more than six months in assets and income available to meet basic subsistence needs and is not eligible to receive aid from other sources to meet those needs.

Required Documentation:

- Complete Application for Assistance to Needy Veterans Grant (**Form WDVA 2453**).
- Verification of Illness or Disability (**Form WDVA 2045**) **must** be received from the treating licensed health care provider, if loss of income is due to an illness, injury or disability.
- Copy of bank statements for the three months preceding date of application (highlight/circle living expenses).

  * If bank statements cannot be obtained please submit the following: copy of current lease or mortgage statement for applicant's primary residence, proof of current medical insurance premiums, copy of current electric, heat, and water bills for applicant's primary residence, copy of applicant's current phone bill.

- Any other documentation or verification requested by the Department.

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Personal Information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

The provision of your social security number is voluntary. Failure to provide your social security number may result in an information processing delay.

Base File #
County
County Contact

Veteran's Name (To be completed by veteran or if the veteran's spouse/dependent is applying for benefits) ☐ Mr. ☐ Ms.

First Name | Middle Name | Last Name | Suffix

Address | City | State | Zip Code

Date of Birth | Email Address | Social Security Number

Applicant's Name (To be completed only if veteran is **not** completing the application) ☐ Mr. ☐ Ms.

Relationship to Veteran ☐ Unremarried Spouse/Dependent of veteran killed in action or line of duty
☐ Spouse/Dependent of activated or deployed veteran

First Name | Middle Name | Last Name | Suffix

Address | Middle Name | Last Name | Suffix

Applicant's Date of Birth | Applicant's Email Address | Applicant's Social Security Number

Patient's Name (Veteran's information if veteran is **not** completing the application) ☐ Mr. ☐ Ms.

Relationship to Veteran ☐ Spouse/Widow(er) ☐ Dependent

First Name | Middle Name | Last Name | Suffix

Address | Middle Name | Last Name | Suffix

Patient/Veteran's Date of Birth | Patient's Email Address | Patient/Veteran's Social Security Number

Veteran's Name: _____

Base File #: _____

Applicant's Marital Status ☐ Unremarried (includes widowed and divorced) ☐ Married ☐ Separated

Income lost due to illness, injury or natural disaster ($3,000 maximum per 12 month period.)

Date of Stop/Decrease (Income) _____

Income before Stop/Decrease _____ Frequency ☐ Monthly ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Reason for Loss of Income ☐ Illness ☐ Injury ☐ Natural Disaster (send a copy of police/fire report, if applicable)

***NOTE:** If aid is available for this type of incident and the applicant has not applied for it, a written explanation as to why will be required.

Liability insurance available ☐ Yes ☐ No

Disability insurance available ☐ Yes ☐ No

Lawsuit will be filed or is pending ☐ Yes ☐ No

Workers Compensation Available ☐ Yes ☐ No

Crime Victim Compensation available ☐ Yes ☐ No

Explanation of Incident

***NOTE:** If this is a result of a work related incident, the applicant needs to apply for Workers Compensation. If it occurred on private property, the applicant needs to check into liability insurance coverage. The applicant may be asked to provide additional information.

Nature of illness, injury or natural disaster

Date of Incident _____ Time of day/night _____

Location of Incident _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Witnesses

Name 1 _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Name 2 _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Veteran's Name: _____

Base File #: _____

Explanation of Incident, cont.

Please provide an explanation of your actions and whereabouts for at least four (4) hours prior to the incident. Include the quantity and type of alcoholic beverages and/or drugs ingested, if any. If none, so state. Give a detailed account of the incident itself. Attach additional sheets if necessary.

Under penalty of applicable law, I certify that the explanation of the incident, above, is true and complete to the best of my knowledge and belief.

Applicant's Signature _____ Date _____

Veteran's Name: _____
Base File #: _____

Living Arrangements ☐ Own Home ☐ Mobile Home ☐ Live with Roommates ☐ VA Facility
☐ Rent ☐ Homeless ☐ Live with Relatives ☐ VAP Facility

Spouse and Legal Dependents Living with Applicant

First Name	Last Name	Birth Date	Relationship to Veteran
			☐ Spouse ☐ Dependent
			☐ Spouse ☐ Dependent
			☐ Spouse ☐ Dependent
			☐ Spouse ☐ Dependent

Health Insurance
☐ I do not have health insurance that covers dental, vision, or hearing care
☐ I have health insurance that covers all or a portion of ☐ Dental ☐ Hearing ☐ Vision

VA Health Care System (Wisconsin law requires use of all available resources and agencies [Wis. Admin. Code § VA 2.01(2)(a)]

Date veteran applied to Federal VA health care system _____

Has veteran been enrolled into the system? ☐ No ☐ Yes If yes, Date enrolled _____

Does the veteran have a service-connected disability? ☐ No ☐ Yes If yes, Disability rating _____ %

Income – Verification Required (Veteran, Spouse or any Dependent) **For Past 30 Days**

Recipient 1 _____

Current Income $ _____ Frequency ☐ Monthly ☐ Annually ☐ Semi-Annually ☐ Quarterly
☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Income Type

☐ Wages – Employer $	☐ Aid to Families with Dependent Children
☐ Overtime	☐ Food Share (formerly called Food Stamps)
☐ Bonuses	☐ Rental (Income)
☐ Commissions	☐ National Guard/Reserve
☐ Sick/Disability Pay (from employer or insurance)	☐ Compensation - VA
☐ Child Support	☐ Compensation – Unemployment Insurance
☐ Dividends	☐ Compensation - Workers
☐ Interest	☐ Pension – Other than Federal VA
☐ Retirement (pay)	☐ Pension – Federal VA
☐ Social Security - Regular	☐ Student Financial Aid (all types)
☐ Social Security - Disability	☐ Federal GI Bill
☐ Supplemental Security Income (SSI)	☐ State or Federal Voc Rehab
☐ Other	

Veteran's Name: _____
Base File #: _____

Income – Verification Required (continued)

Recipient 2 _____

Current Income $ _____ Frequency ☐ Monthly ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Income Type

- ☐ Wages – Employer $
- ☐ Overtime
- ☐ Bonuses
- ☐ Commissions
- ☐ Sick/Disability Pay (from employer or insurance)
- ☐ Child Support
- ☐ Dividends
- ☐ Interest
- ☐ Retirement (pay)
- ☐ Social Security - Regular
- ☐ Social Security - Disability
- ☐ Supplemental Security Income (SSI)
- ☐ Other
- ☐ Aid to Families with Dependent Children
- ☐ Food Share (formerly called Food Stamps)
- ☐ Rental (Income)
- ☐ National Guard/Reserve
- ☐ Compensation - VA
- ☐ Compensation – Unemployment Insurance
- ☐ Compensation - Workers
- ☐ Pension – Other than Federal VA
- ☐ Pension – Federal VA
- ☐ Student Financial Aid (all types)
- ☐ Federal GI Bill
- ☐ State or Federal Voc Rehab

Liquid Assets (In Veteran, Spouse, or any Dependent's Name)

Owner 1 _____ ☐ I have no assets

Asset Type	Value	Asset Type	Value
☐ Checking Account	$	☐ Custodial Accounts (Children or Grandchildren)	$
☐ Savings Account	$	☐ Gambling Winnings	$
☐ Money Market	$	☐ Tax Refunds	$
☐ Certificate of Deposit	$	☐ Other	$
☐ Cash on Hand	$		

Owner 2 _____ ☐ I have no assets

Asset Type	Value	Asset Type	Value
☐ Checking Account	$	☐ Custodial Accounts (Children or Grandchildren)	$
☐ Savings Account	$	☐ Gambling Winnings	$
☐ Money Market	$	☐ Tax Refunds	$
☐ Certificate of Deposit	$	☐ Other	$
☐ Cash on Hand	$		

Veteran's Name: _____

Base File #: _____

Living Expenses (Applicant's Primary Residence)

Living Expense	Three Month Avg	Living Expense	Three Month Avg
☐ Rent/Mortgage	$	☐ Child Care Required	$
☐ Food	$	☐ Electricity/Heat	$
☐ Current Medical Insurance Premium	$	☐ Water	$
☐ Current Prescribed Medication	$	☐ Telephone	$
☐ Essential Travel	$		

I certify that I have read, or have had read to me, all questions from this application and this paragraph and that my answers are true and complete to the best of my knowledge, and that I will promptly notify WDVA of any changes. If I receive, or am eligible to receive, money from another source which duplicates aid I received from this program, I will repay WDVA as soon as possible. I understand that I must provide the Wisconsin Department of Veterans Affairs, either personally or through my County Veterans Service Officer, with any information requested by the department. I authorize the department and any of its employees to request and review any county, state or federal records relating to this application. I consent to the release by the Federal Department of Veterans Affairs (VA), Social Security Administration, Wisconsin Department of Revenue (DOR), and the County Veterans Service Office (CVSO) of all information necessary to process this grant application.

Phone ( ) _____ Signature _____ Date _____

WARNING: If you knowingly make any false statement or submit fraudulent evidence in connection with this application, you are subject to severe penalties provided by law including fine, imprisonment or both and suspension of all veterans benefits from WDVA.