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| Wis. Stats. Chapter 45 | 201 West Washington Avenue, P.O. Box 7843, Madison, WI 53707-7843  (608) 266-1311 | 1-800-WIS-VETS (1-800-947-8387) | | |
| **VERIFICATION OF ILLNESS OR DISABILITY**  **Assistance to Needy Veterans Grant — Subsistence Aid** | | County  Number |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A.** | **TO BE COMPLETED BY THE PATIENT**  Please release the information requested to the Wisconsin Department of Veterans Affairs. | | | | | | | | | |
|  | 1. Veteran’s Name: | | 2. Patient’s Name:  (if different) | | | | 3. WDVA # or Veteran’s Birth Date: | | | |
|  | 4. Patient’s Address: | | 5. Date I feel I became ill/disabled: | | | | | | | |
|  | 6. Patient's  Signature: Date: | | | | | | | | | |
|  |  | | | | | | | | | |
| **B.** | **TO BE COMPLETED BY A LICENSED PHYSICIAN OR OPTOMETRIST** | | | | | | | | | |
|  | Refer to the date listed in number 5 above by the patient. Please answer all questions fully. Unanswered questions will delay emergency aid. | | | | | | | | | |
|  | 1. Diagnosis of illness/disability: | | | | | | | | | |
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|  |  | | | | | | | | | |
|  | 2. Date illness or injury caused a loss or reduction of employment: | | | | | | | | | |
|  | 3. I estimate the veteran was or will be incapacitated for the following number of days following the date noted in #2 directly above: | | | | | | | | | |
|  | not incapacitated  30,  60,  90 days or longer | | | | incapacitation is permanent | | | | | |
|  |  | | | | | | | | | |
|  | DOCTOR'S COMMENTS: | | | | | | | | |  |
|  | DOCTOR INFORMATION:  **WARNING: ONLY A LICENSED PHYSICIAN OR OPTOMETRIST MAY SIGN THIS FORM. THE FORM WILL NOT BE ACCEPTED IF IT IS SIGNED BY ANYONE ELSE.** | | | | | | | | |  |
|  | | | | | | | | |
|  | (print or type) |  | |  | | | | (     ) |  |  |
|  |  | Name | | Title | | | | Telephone | |  |
|  |  | | | | | | | | |  |
|  |  |  | | | |  | | | |  |
|  |  | Address | | | | Email | | | |  |
|  |  | | | | | | | | |  |
|  |  |  | | | | | |  | |  |
|  |  | Doctor's Signature **(NO STAMPED SIGNATURES)** | | | | | | Date Signed | |  |
|  |  |  | | | | | |  | |  |
|  |  | **Please complete and send to the address at the top of this form.**  **Do not give it to the patient.** | | | | | | | |  |