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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: |
|  |        |
|  |        |
|  | 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.** |  |