WISCONSIN DVA VETERANS FORWARD
Wisconsin Department of Veterans Affairs

201 West Washington Avenue, P.O. Box 7843, Madison, WI 53707-7843
(608) 266-1311 | 1-800-WIS-VETS (1-800-947-8387)

Wis. Stats. Chapter 45

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.