

STATE OF CONNECTICUT/DEPARTMENT OF VETERANS' AFFAIRS

INCOME/ASSETS QUESTIONNAIRE (IA)/DVA CASE#:



Form: DVA-BO-IAQ (Rev: 01/07) Page 1 of 2

Instructions: **Please complete form in its entirety.** If no Income or Assets are indicated, please fill in each area with a zero. In addition, **please initial each section; sign and date at the end of this form.** According to Connecticut General Statute 27-108 such veterans who are able to pay in whole or in part for services are required to pay their cost of care based on their ability to pay. If unable to pay, those entering the hospital are required to have a completed and filed "pending" *Medicaid* (Title XIX) application. The veteran and/or responsible party are required to provide full disclosure of all financial information in accordance with CGS 27-117. If there is a pending Medicaid application, the veteran and/or responsible party are required to continue paying the charges assessed by the DVA pursuant to CGS 27-108 until such time as The Department of Social Services (DSS) determines that the veteran is eligible for assistance. Once Medicaid eligibility is determined, Medicaid assumes the primary responsibility for paying the veteran's care at the hospital; however, the veteran remains responsible for contributing his/her "applied income" towards the cost of care as computed by DSS pursuant to its administration of the Medicaid program.

Veteran's Name:		Spouse's Name:	
Street Address:		Street Address:	
City, State, Zip:		City, State, Zip:	
Home Phone:		Home Phone:	

TYPE OF INCOME/ ACCT# (If Applicable)	Source of Income/ Address (If Applicable)	Veteran Amount	Spouse Amount	Frequency
Social Security	Social Security Administration			Monthly
VA Pension/Comp.	U.S Department of Veterans' Affairs			Monthly
Retirement/Pension				
Retirement/Pension				
Dividends/Interest Account Number:				
Rental Property Income				
Other (describe):				

TYPE OF ASSET/ ID# (If Applicable)	Location of Asset Name, Address, Phone (If Applicable)	Veteran Amount	Spouse Amount
Savings Account Account Number:			
Savings Account Account Number:			
Checking Account Account Number:			
Checking Account Account Number:			
Certificate of Deposit Account Number:			
Stocks Certificate Number(s):			
Bonds Certificate Number(s):			
Prepaid Funeral Contract Number:			
Life Insurance Policy Policy Number:			
Motor Vehicle VIN Number:			
Real Estate/ Address:			
Other Asset Acct/ID Number:			

IA/DVA QUESTIONNAIRE

NAME: _____ CASE#: _____

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COURT-ORDERED OBLIGATION INFORMATION *(Note: Court Documentation is required).*

TYPE OF OBLIGATION	PAID TO (Name, Address)	VETERAN AMOUNT	SPOUSE AMOUNT	FREQUENCY
Alimony				
Child Support				
Other (identify):				

HOUSEHOLD COST INFORMATION

TYPE OF HOUSEHOLD COST	PAID TO (Name, Address)	VETERAN AMOUNT	SPOUSE AMOUNT	FREQUENCY
Rent				
Mortgage				
Real Estate Tax				
Rental/Mortgage Insurance				
Other (identify):				

FINANCIAL RELATIONSHIP TO VETERAN: *(Please check one)*

Self Power of Attorney Conservator of Estate *Probate Court:* _____ *Appointment Date:* _____
(Jurisdiction)

I certify that the information provided on this form is complete and accurate to the best of my knowledge. I understand that I am required to provide this information completely and accurately according to the Connecticut General Statutes (CGS) 27-117. I also understand that I am responsible for paying for the cost of my care at the Department of Veterans' Affairs (DVA), and that I will be assessed monthly charges based on my ability to pay as per CGS 27-108 and DVA regulations. I understand that paying the assessed charges may result in the depletion of my resources. If I reside in the hospital, I understand that I am *required* to apply for the Title XIX Medicaid benefits upon request, and to take all steps reasonably necessary to obtain Medicaid eligibility. If I apply for Title XIX benefits, I understand that I am responsible to continue paying for my portion of the cost of care as assessed by the Department of Veterans' Affairs pursuant to CGS 27-108 until such time as Title XIX is granted. If Medicaid eligibility is determined by the Department of Social Services, I understand that I am then responsible for contributing my "applied income" towards the cost of care, as computed by the Department of Social Services.

SIGNATURE: _____ DATE: _____