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
VETERANS ASSISTANCE GRANT APPLICATION (HEALTH CARE AID)

Please submit this application if you are applying for assistance with Dental, Hearing and Vision care.

- 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 combined lifetime maximum of $7,500 for Health Care Aid and Subsistence Aid.

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

- Be a veteran as defined in Wis. Stat. § 45.01(12).
- Household income at or below 200 percent of the federal poverty guidelines in effect at the time the application is received by the department, unless the applicant is the spouse or dependent of an activated or deployed member of the U.S. Armed Forces or Wisconsin National Guard. Current federal poverty guidelines can be found here: https://aspe.hhs.gov/poverty-guidelines.
- Does not have household liquid assets in excess of $1,000. The amount of liquid assets does not include the first $50,000 of cash surrender value of any life insurance policy.

Required Documentation:

- Complete Application for Veterans Assistance Grant – Health Care Aid (**Form WDVA 2450**).
- Declaration of Aid (**Form WDVA 2451**) signed by County Agent, CVSO, or economic assistance consortium.
- Notice of Decision letter (NOD) from local consortium that indicates the applicant has applied for Food Share and Medicaid or Badger Care.
- Any additional documentation or verification requested by the department.

***NOTICE:** Application will be terminated if requested documentation and/or verification is not received at the department's central office within 60 days of notification for additional documentation and/or verification.

A provider may request a one-time 90-day extension by faxing or mailing a written statement to WDVA which must be received within fourteen (14) calendar days before the expiration date listed on the first description of benefits (DOB). The healthcare provider must certify that 1) care has begun and additional time is needed to complete care; 2) the patient will not incur costs; and 3) the healthcare services to be provided are included in the first DOB. Veterans must reapply for benefits if additional time is needed after the extension has expired.

The Department shall not make a payment unless the provider gives the Department an itemized written invoice within 60 days of the expiration date listed on the DOB or the Department approves an extension.

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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 | 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 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/Veteran's Social Security Number

You can print the most recent version of this form from the WDVA website at http://dva.state.wi.us/Pages/newsedia/WDVAToolkit.aspx

Veteran's Name: _____

Base File #: _____

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

Select Desired Benefit (Lifetime maximum of $7,500)

Dental Care: →

☐ Dental Care assistance may not exceed $800 per consecutive 12-month period

☐ Extended Dental Care assistance may not exceed $4,000 per consecutive 24-month period. Extended Dental Care means a dental device, including dentures, that replaces one or more teeth and includes all dental preparation and the manufacture and fitting of the device.

Hearing Care: →

☐ Hearing Care assistance may not exceed $200 per consecutive 12-month period

☐ Aid for each hearing aid assistance may not exceed $1,875 per consecutive 24-month period

Vision Care: →

☐ Vision care aid and a prescription for lens and frame generally assistance may not exceed $400 per consecutive 12-month period

A Description of Benefits (DOB) – 2 pages – authorizing care for a 90-day period will be posted for approved applications. It is to be printed by the CVSO for delivery to the provider who will complete page 2, "Request for Payment" section, of the DOB and submit to WDVA for payment. Care must be completed before the "Expiration" date on the DOB. If an outstanding DOB exists, binding quotes from a provider are necessary in order to have an additional DOB issued.

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

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Veteran's Name: _____

Base File #: _____

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)4.]

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)

Recipient 1 _____

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

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	$		
☐ Cash Value of Life Insurance	$		

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Veteran's Name: _____

Base File #: _____

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. I have applied for and accepted all benefits available from other agencies or organizations. 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 within 60 days of the date of the request or I may be denied any benefit. 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.

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