From: ______________________County Department of Social Services, North Carolina

To: Department of Veterans Affairs **Date: ___________________**
Claims Intake Center
PO Box 4444
Janesville, WI 53547-4444
Fax Toll Free: 1-844-531-7818

We are determining eligibility for public assistance. Please verify the amount of the VA benefits the claimant is receiving or entitled to and return this form by fax to worker listed below.

VA Claimant Name: ____________________ Veteran's Name (if different): ____________________

VA Claim Number: ________________________ Claimant Social Security #: _________________

I hereby grant permission and authorize the U.S. Dept. of Veterans Affairs to disclose to the above county department of social Services information that will be solely used for determining eligibility for Medicaid.

Signature of Claimant____________________________________Date:______________________
If you (USDVA) have questions about completing this verification form, please contact worker
_________________________________ at: Phone: ________________ **Fax:** ________________

<u>Information to be completed by Department of Veterans Affairs:</u>

VA Claim Number (if not supplied above) ____

Benefit Type:
[ ] Old Pension Law (Protected Pension Program)
[ ] Improved Pension
[ ] Reduced Improved Pension (up to $90 payment)[P.L. 102-568]
[ ] Compensation
[ ] Apportionment
[ ] Other ____________________

TOTAL VA Gross Monthly Benefit Amount: $ ___________________________ effective ___________________.

Does it include?
[ ] Aid & Attendance (A&A) Amount: $__________________
[ ] Homebound/Housebound (HB) Amount: $____________________
[ ] Educational Benefits Amount: $__________________
[ ] **None of the above**

Unusual Medical Expenses (UME)

Is VA benefit for this individual based on continued unreimbursed Unusual Medical Expenses [ ]Yes [ ]No
Amount of benefit received due to UME $__________________

Has claimant received any lump sum payments? [ ] Yes [ ] No
If yes, is lump sum for [ ] Retroactive Benefits [ ] Unusual Medical Expenses
Date received ________________ and amount __________

Verified by: ____________________________________ **Phone Number:** ________________________

Title: ______________________________ **Date**: ________________

DHB-5027 (Revised 10/22)

For County DSS Use Only

ABD		**F&C**	
Gross Benefit Amount	____________	Gross Benefit Amount	___________
Minus A&A/Homebound/Housebound amount	____________	Minus educational benefit	___________
Minus amount received due to UME	____________	**Equals countable benefit**	___________
Minus educational benefit	____________		
Equals countable benefit amount	____________		