



*Veterans Administration Nationwide Benefits Information 1-800-827-1000*

*Veterans' of Foreign Wars, Department of Connecticut*

# ***INITIAL INTERVIEW FORM VETERANS' BENEFITS CLAIM***

*Information is necessary to file a well documented claim for service-connected compensation, service-connected pension and non-service connected pension.*



## **Basic Document Requirements**

<b>Military Discharge Document (DD214)</b>	<b>Service Treatment Records</b>	<b>VA Benefit Documents</b>
<b>Marriage Certificate</b>	<b>Military Awards &amp; Decorations</b>	<b>Medical/Drug Expenses</b>
<b>Birth Certificates (claimed dependents)</b>	<b>Civilian Medical &amp; Lab Reports</b>	<b>Financial Assets Documents</b>
<b>Divorce Papers</b>	<b>Death Certificate (Widow(er))</b>	<b>All Medical Diagnosis</b>
<b>Relevant Medical Treatises</b>	<b>VA Examination Reports</b>	<b>Lay Evidence</b>
<b>Social Security # each family member</b>	<b>Income Data each family member</b>	

*Gary E. Waterhouse, State Service Officer, VFW, Department of Connecticut*



## INITIAL VETERAN INTERVIEW FORM Instructions

- A. Please take your time completing this form.
- B. It is long but its completion is necessary in order for me to properly evaluate your claim.
- C. Many of the questions in this form ask for very personal information. Please be assured that all information that you provide will be held in the strictest confidence.
- D. If you need to provide any additional information to supplement your answers, please attach additional documents to this form.
- E. After completing this form, **email** as a word or PDF file to **[gary.waterhouse@va.gov](mailto:gary.waterhouse@va.gov)**

You may also **send it by regular mail** to my office:

**Gary E. Waterhouse, State Service Officer**  
**Veterans of Foreign Wars, Department of Connecticut**  
**P.O. Box 3100909**  
**Room 3133, 555 Willard Avenue**  
**Newington, CT, 06131**  
**860-594-6610 (office)**  
**860-667-1214 (fax)**

***DO NOT SEND THIS FORM TO THE VA OR PROVIDE IT TO ANY GOVERNMENT REPRESENTATIVE WITHOUT FIRST SPEAKING TO ME PERSONALLY OR ANOTHER VETERANS SERVICE OFFICER REGARDING YOUR RIGHTS.***

### **What does it take to win a disability claim?**

There are three (3) elements to a successful claim:

**One:** A recent medical diagnosis of a **current** impairment, disability, or disease.

**Two:** Medical or, on occasion, lay evidence of an **in-service** occurrence or aggravation of the disease or injury.

**Three:** Medical proof of a **connection** between the in-service occurrence or aggravation of an injury or illness and the current disability.



## INITIAL VETERAN INTERVIEW FORM

Today's Date: \_\_\_\_\_ DD/MM/YYYY

1. Name of Veteran: \_\_\_\_\_

First Middle Last

2. If you served under another name: \_\_\_\_\_

First Middle Last

3. ***Claimant Other than the veteran:*** \_\_\_\_\_ SS#: \_\_\_\_\_

Person filing claim if other than veteran

First Middle Last

4. If other relationship to veteran: \_\_\_\_\_ 4A. Does Veteran Have a Conservator? Yes /No

5. Veterans Mailing Address: \_\_\_\_\_

(Number and street or rural route, city or P.O., State and ZIP Code)

6. Telephone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

7. Email Address: #1 \_\_\_\_\_ #2 \_\_\_\_\_

8. Date of Birth: DD/MM/YYYY: \_\_\_\_\_ 8a. Place of Birth \_\_\_\_\_

9. Social Security Number: \_\_\_\_\_ 9a. VA File Claim # \_\_\_\_\_

10. Military Service Number: \_\_\_\_\_

11. Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )

12a. Spouse: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

12b. Marriage Date: \_\_\_\_\_ Marriage Place: \_\_\_\_\_

12c. How were you married? Clergyman, Authorized Public Official, Common Law, Tribal, Other

12c. Previous Marriages: \_\_\_\_\_

List all previous marriages using spouse's maiden/unmarried name, date of end of marriage

### ***What type of Veterans Benefits are you looking for?***

1. **Service Connected Disability Compensation:** \_\_\_\_\_

a. Disability Compensation for Individual Unemployability: \_\_\_\_\_

b. "Presumptive" Disability Benefits (ie...Agent Orange): \_\_\_\_\_

c. Vocational Rehabilitation Benefits: \_\_\_\_\_

d. Automobile and Special Adaptive Equipment: \_\_\_\_\_

e. Home Modification: \_\_\_\_\_

2. **Non-Service Connected Pension:** \_\_\_\_\_

a. Assistance for Homeless Veterans: \_\_\_\_\_

3. **Dependents and Survivors Benefits:** \_\_\_\_\_

a. Dependency and Indemnity Compensation (DIC): \_\_\_\_\_

b. Death Pension Benefits: \_\_\_\_\_

4. **VA Home Loans:** \_\_\_\_\_

5. **VA Burial and Memorial Benefits:** \_\_\_\_\_

6. **VA Education (GI Bill) and Training:** \_\_\_\_\_

7. **VA Healthcare:** \_\_\_\_\_



### INITIAL VETERAN INTERVIEW FORM

13. Education: High School Graduate: ( ) YES ( ) NO College: ( ) YES ( ) NO

Name of College: \_\_\_\_\_

*If you are not a veteran, and your eligibility is based on the eligibility of a veteran who is a member of your family (your spouse or parent, for example) – please answer the questions below as if you were the veteran.*

14. Are you currently employed: ( ) YES ( ) NO 14a. Full time or Part Time Employment

If yes, what is your current occupation: \_\_\_\_\_

15. If not employed are you able to work: ( ) YES ( ) NO

16. If you are not employed, is it because of a medical problem related to your military Service? ( ) YES ( ) NO Explain: \_\_\_\_\_

17. Are you now receiving Social Security Disability Insurance, Supplemental Security Income, or other forms of government assistance? ( ) YES ( ) NO

Date of Award: \_\_\_\_\_ How much each month \_\_\_\_\_

17a. Net income (**pre-tax total**) all household sources: \$ \_\_\_\_\_

18. Do you have dependents? ( ) YES ( ) NO

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Spouse, Children and Dependent Parents

19. Are you a veteran of the U.S Armed Services? ( ) YES ( ) NO

If yes, do you have a copy of your **DD214** or other release from military service documents ( ) YES ( ) NO

20. Branch of Service: Circle any that may apply:

ARMY- NAVY- MARINES- AIR FORCE- COAST GUARD- MERCHANT MARINE- NOAA- OTHER

20a. U.S. Military Occupational Code: \_\_\_\_\_

21. Did you serve during a time of war or a recognized conflict? ( ) YES ( ) NO

Check any that may apply:

World War II:\_\_\_\_, Korea:\_\_\_\_, Vietnam:\_\_\_\_, Persian Gulf:\_\_\_\_, Iraq:\_\_\_\_, Afghanistan:\_\_\_\_,

Somalia:\_\_\_\_, Bosnia:\_\_\_\_, or Other Conflict: \_\_\_\_\_

UNIT: \_\_\_\_\_

Please be as specific as possible identifying the unit you served in during a time of war

21a. Did you serve outside the continental United States? ( ) YES ( ) NO

22. Please list your exact dates of military service:

From \_\_\_\_\_ to \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_

22a. Did you serve in the National Guard or Active Reserve of a Military Service? ( ) YES ( ) NO

From \_\_\_\_\_ to \_\_\_\_\_

23. Type of Military Service Discharge (Please circle all that apply)

**(Honorable) (General) (Other than Honorable) (Bad Conduct) (Dishonorable)**

Comments: \_\_\_\_\_



INITIAL VETERAN INTERVIEW FORM

24. Under what conditions were you discharged? (Please circle all that apply)

(Retired) (Completed Service Obligation) (Military Downsizing) (By reason of Physical Disability) (Discharged for Cause) Other: \_\_\_\_\_

25. Are you receiving retirement pay from the military? ( ) YES ( ) NO

If yes, please specify the monthly amount: \_\_\_\_\_

26. Are you receiving disability pay from the military? ( ) YES ( ) NO

If yes, please specify the monthly amount: \_\_\_\_\_

27. Did you receive severance pay at discharge? ( ) YES ( ) NO

If yes, please specify the amount: \_\_\_\_\_

28. Were you a **COMBAT Veteran**? ( ) YES ( ) NO 28a. Award or Decoration \_\_\_\_\_

29. Were you **INJURED/WOUNDED IN COMBAT**? ( ) YES ( ) NO 29a. **Purple Heart** ( ) YES ( ) NO

If yes, where on the body: \_\_\_\_\_

30. Are you still having medical problems caused by the injury or wound(s)? ( ) YES ( ) NO

If yes, what are the problems: \_\_\_\_\_

31. Were you ever a **PRISONER OF WAR**? ( ) YES ( ) NO

If yes, where, when and how long: \_\_\_\_\_

32. Do you have recurring dreams of intrusive memories about your combat or your POW experience? (*PTST Post Traumatic Stress Syndrome*) ( ) YES ( ) NO ( ) Unknown

33. Do you have recurring dreams or intrusive memories about any traumatic experience during military service (*a feeling of intense fear, helplessness, or horror*) ( ) YES ( ) NO ( ) Unknown

Comment: \_\_\_\_\_

34. Do you avoid or react unusually to things that symbolize or remind you of a traumatic event in service? ( ) YES ( ) NO ( ) Unknown

Comment: \_\_\_\_\_

35. Were you treated for any *injury, disability, or disease in service*? ( ) YES ( ) NO

If yes, describe the disability or the disease: \_\_\_\_\_

36. Are you currently having problems with these same disabilities or diseases? ( ) YES ( ) NO If yes, describe the problems. Please describe how your disability interferes with your work. Also be sure to describe any disability that has resulted from or has been aggravated by the service disability?

37. Did you suffer from a *disease or injury* in service that *was not treated* by a doctor? ( ) YES ( ) NO If yes, describe: \_\_\_\_\_

38. Do you currently have a *disease or injury* that existed *before* your entry into the service? ( ) YES ( ) NO If yes, describe: \_\_\_\_\_

39. Did the disease or injury increase in severity (*get worse*) during service? ( ) YES ( ) NO If yes, describe: \_\_\_\_\_



## INITIAL VETERAN INTERVIEW FORM

40. Are you currently suffering from a disability or disease that appeared within one year after discharge from service? ( ) YES ( ) NO If yes, describe: \_\_\_\_\_
41. While in military service, were you exposed to any of the following:
- a. Ionizing Radiation/ *Atomic blast, radioactive decay, nuclear fission and nuclear fusion*: ( ) YES ( ) NO
  - b. Herbicide Agents/*Vietnam, Korea, Thailand, Paris Island Agent Orange, Blue & White*: ( ) YES ( ) NO
  - c. Asbestos/ *Navy ships often contained multiple asbestos containing materials*: ( ) YES ( ) NO
  - d. Toxic Chemicals/ *Shipboard Hazard and Department of Defense (SHAD) and Project 112*: YES ( ) NO
  - e. Nerve Gas/*nerve, vesicant and incapacitating agents.(GA, GB (sarin), GD, GF, and VX)*: ( ) YES ( ) NO  
Khamisiya, Iraq Ammunition Storage Facility
  - f. Depleted Uranium/ *DU is used to make tank protective armor and ammunitions*: ( ) YES ( ) NO
  - g. Smoke from burning oil wells/ *Iraq*: ( ) YES ( ) NO
  - h. Biological, chemical, toxic agent, environmental or wartime hazards: ( ) YES ( ) NO
  - i. Preventive medicine or vaccine known or presumed to be associated with service in the Southwest Asia theater of operations during the Persian Gulf War: ( ) YES ( ) NO
- If other, describe: \_\_\_\_\_
42. Have you ever applied for **VA benefits**? ( ) YES ( ) NO  
If yes, check all that apply:
- ( ) Compensation ( ) Pension service- connected ( ) Medical Care ( ) Education
  - ( ) Pension Non-Service Connected ( ) Vocational Rehabilitation ( ) Nursing Home Care
  - ( ) Domiciliary Care at State Veterans Home ( ) Home Loan guaranty
  - ( ) Other: \_\_\_\_\_
43. If you have filed a claim, provide the claim number the VA assigned: \_\_\_\_\_
- 43a. Do you have any unsettled **VA Claims**? ( ) YES ( ) NO  
**Comment:** \_\_\_\_\_
- 43b. Does a Veterans Service Organization currently hold your power of attorney?  
( ) YES ( ) NO **Comment:** \_\_\_\_\_
44. Are you now receiving **VA benefits**? ( ) YES ( ) NO *If yes, check all that apply:*
- ( ) Compensation ( ) Pension ( ) Pension plus aid and attendance benefit
  - ( ) Medical Care ( ) Pension, Housebound or A&A ( ) Education Benefits
  - ( ) Vocational Rehabilitation ( ) Nursing home care ( ) Domiciliary Care ( ) Home Loan
45. At which VA regional office is your claim file located? \_\_\_\_\_
46. Were you ever treated at a **VA hospital or Outpatient Clinic**? ( ) YES ( ) NO *If yes, please specify:*
- When: \_\_\_\_\_ Where: \_\_\_\_\_
- By Whom: \_\_\_\_\_
- Type of Treatment: \_\_\_\_\_



### INITIAL VETERAN INTERVIEW FORM

47. Have you ever sought counseling or help from a **Vets Center**? ( ) YES ( ) NO If yes, please specify:

When: \_\_\_\_\_

Where: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

48. Are you **currently being treated**, or have you **been treated in the past**, by a Private Physician, Medical Doctor, Licensed Medical Professional or Other Treatment Specialist for an illness or disability? ( ) YES ( ) NO *List all healthcare providers*

Whom: \_\_\_\_\_ When: \_\_\_\_\_

Where: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

49. Are you **currently being treated** or have you **ever been treated at a hospital** for an illness or a disability? ( ) YES ( ) NO Do you have medical reports of treatment? ( ) YES ( ) NO

When: \_\_\_\_\_

Where: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

50. Are you **currently** taking **PRESCRIPTION DRUGS** for Health/Mental issues? ( ) YES ( ) NO

List Medications: \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Prescription Drug Provider: \_\_\_\_\_

***I disclose this personal and private information for the purpose of determining eligibility for benefits from the US Department of Veterans Affairs, the State of Connecticut and/or the CT Soldier, Sailors and Marines Fund. I provide this information of my own free will and accord knowing this information may be shared with others for the sole purpose of advancing a claim for benefits. I affirm the information on this form is true and correct to the best of my knowledge and belief.***

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*First-Middle-Last*

Person signing for veteran or as witness to signature: \_\_\_\_\_

