



CASTRO & CO.  
VETERAN BENEFITS ATTORNEYS

# Veteran Intake Packet

PRIVATE CLIENT SERVICES

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Suite 1550  
Miami FL 33131  
+1 305 747 7006

The North Plaza Tower  
121 South Orange Avenue  
Suite 1500  
Orlando FL 32801  
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## CASTRO & CO.

Continental Bank Building  
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14th Floor  
New York City, NY 10004  
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Wells Fargo South Tower  
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Suite 2450  
Los Angeles, CA 90071  
+1 213 277 5580

North Galleria Tower  
13155 Noel Road  
9th Floor  
Dallas, TX 75240  
+1 214 444 7010

### Section 1. Your Personal Information

1. Veteran's First Name	M. I.	Last Name	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	SSN, ITIN, or Foreign Tax ID #
2. Your Spouse's First Name	M. I.	Last Name	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	SSN, ITIN, or Foreign Tax ID #
3. Current Mailing Address	Apt#	City	State	Zip Code
4. Contact Information	Phone:	Cell Phone:	E-mail:	
5. Your Date of Birth	6. Your Job Title	Are you:	7. Legally Blind	Yes No
		8. Totally and Permanently Disabled		Yes No
9. Your Spouse's Date of Birth	10. Your Spouse's Job Title	Is Your Spouse:	11. Legally Blind	Yes No
		12. Totally and Permanently Disabled		Yes No

### Section 2. Marital Status and Household Information

1. As of December 31, 2018, were you?

Single

Married: Did you live with your spouse during any part of the last six months of the year? Yes No

Divorced or legally separated: Only check this box if last year was the year of the divorce or separation.

Widowed: Year of spouse's passing: \_\_\_\_\_

### Section 3. Veteran Information Overview

1. For which type(s) of veteran benefits is the applicant seeking assistance?
2. Is the applicant a veteran, surviving spouse, or a war-time veteran?
3. Has the applicant already filed a claim?
4. With which activities does the applicant require assistance? Check all that apply.

**Personal Hygiene**

**Dressing**

**Eating**

**Maintaining Continence**

**Transferring / Mobility**

**Supervision Due to Dementia or**

**Neurological Decline**

5. In what location is the care recipient/applicant seeking assistance?
6. What is the applicant's monthly income? Include spouse's income but do not include income received from the VA.
7. What is the total value of the resources held by the applicant? Include assets jointly held with a spouse. Do not include the value of your main home.
8. What is the veteran's state of residence?
9. For the person completing this form, please identify your relationship to the veteran as well as the name, number, and email address of the person who we should contact:

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## Section 4. Asset Inventory & Income Calculation

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### ASSETS

Column A Type of Asset	Column B Fair Market Value of Asset	Column C Original Purchase Price	Column D Liability on this Asset	Column E Description of Asset
<i>Checking Accounts</i>				
<i>Savings Accounts</i>				
<i>CDs</i>				
<i>Retirement Accounts</i>				
<i>Stocks &amp; Bonds</i>				
<i>Other Investments</i>				
<i>Life Insurance</i>				
<i>Main Home</i>				
<i>Other Real Estate</i>				
<i>Personal Effects</i>				
<i>Vehicles</i>				
<i>All Other Combined</i>				

### INCOME

<u>Types of Incomes</u>	<u>Amount x Frequency</u>	<u>Annual Total</u>
<i>Employment - Salary &amp; Wages</i>		
<i>Interest Income</i>		
<i>Dividends</i>		
<i>Business Income</i>		
<i>Capital Gain</i>		
<i>Pensions and Annuities</i>		
<i>Social Security</i>		
<i>Alimony</i>		
<i>Public Assistance</i>		
<i>Unemployment Income</i>		
<i>Rental Income</i>		
<i>Farm Income</i>		
<i>Child Support</i>		
<i>All Other Income</i>		