NOTICE OF FORM CHANGE NO. 06-138

DATE
11-02-2006

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ Private and Public Adoption Agencies
☐ District Attorney
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE: CW 5 (7/01) English and Spanish
Veterans Benefits Verification and Referral

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☐ Revised	DATE OF FORM 7/01	REPLACES	☐ Obsolete

REQUIRED FORM- ☒ No Change Permitted
REQUIRED FORM- ☐ Substitute Permitted With Prior DSS Approval
☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ Other:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☒ Use until exhausted
☐ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☐ Use new form effective

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Form is now master only.

Check on the internet to see if forms are available at www.dss.cahwnet.gov

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 651-8876 or by electronic mail at LTS@dss.ca.gov.

VETERANS BENEFITS VERIFICATION AND REFERRAL

NOTE: Do not complete this form unless one of the following is known:

- **Veterans Social Security Number and Date of Birth**
- **Military Serial Number**
- **Veterans Administration (VA) Claim Number**

You and any member of your household for whom you are applying for aid must give us the Social Security Number(s) (SSN). The SSN(s) are used to determine your eligibility and failure to cooperate may result in denial or discontinuance of aid. Authority: 45 Code of Federal Regulations Section 205.52, and Welfare and Institutions Code Section 11268(a).

Name and Address of County Veterans Service Office

CASE NAME:

CASE NUMBER (INCLUDING MEDS AID CODE):

APPLICANT/RECIPIENT PHONE #:

CASE WORKER:

WORKER PHONE #:

SECTION I

VETERAN'S NAME (LAST, FIRST, MIDDLE): | BIRTH DATE: | BIRTHPLACE: | LIVING? ☐ YES ☐ NO | IF DECEASED: DATE OF DEATH: PLACE OF DEATH:

VETERAN'S ADDRESS: (NUMBER, STREET, CITY, STATE, ZIP CODE) | DOES THIS VETERAN LIVE IN YOUR HOME? ☐ YES ☐ NO | VA CLAIM NUMBER:____ SOCIAL SECURITY NUMBER:____ MILITARY SERIAL NUMBER:____

BRANCH OF SERVICE: | DATE OF ENTRY: | **DATE OF DISCHARGE:** | TYPE OF DISCHARGE: ☐ HONORABLE ☐ GENERAL ☐ MEDICAL ☐ OTHER THAN HONORABLE ☐ UNKNOWN

VETERAN'S MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

IS THIS VETERAN PERMANENTLY UNABLE TO WORK BECAUSE OF DISABILITY? ☐ YES ☐ NO

DID THIS VETERAN SUFFER AN IN-SERVICE UNJURY OR ILLNESS THAT CAUSES A CURRENT DISABILITY: ☐ YES ☐ NO

VETERAN'S GROSS MONTHLY INCOME: $

SPOUSE'S GROSS MONTHLY INCOME: $

IS ANYONE IN LONG-TERM CARE: ☐ YES ☐ NO IF YES, (✔) BELOW: ☐ VETERAN ☐ SPOUSE ☐ OTHER

IS ANYONE BLIND, OR IS HOME CARE NEEDED TO FEED, BATHE, OR DRESS A HOUSEHOLD MEMBER: ☐ YES ☐ NO IF YES, (✔) BELOW: ☐ VETERAN ☐ SPOUSE ☐ OTHER

SECTION II

NAME OF CLAIMANT:	RELATIONSHIP TO VETERAN:	BIRTH DATE:	SOCIAL SECURITY NUMBER:	ADDRESS:

SECTION III

I hereby authorize the welfare department to release the above information to the County Veterans Service Office and the Veterans Administration for purposes of identifying or obtaining benefits available to the persons identified above. I also authorize the County Veterans Service Office and Veterans Administration to release their findings (to be noted below).

SIGNATURE (OR MARK) OF VETERAN/DEPENDANT:	DATE:	SIGNATURE OF WITNESS TO MARK:	DATE:

SECTION IV *(To be completed by the County Welfare Department and the County Veterans Service Office)*

The County Welfare Department requests the County Veterans Service Office to:

☐ Verify any VA benefits received by the veteran and/or dependent(s):

	1-Veteran	2-Claimant	3-Claimant	4-Claimant
Monthly Benefit	$	$	$	$
Beginning Date (*Month/Day/Year*)				
Ending Date (*Month/Day/Year*)				
Lump Sum Payment (*Past 6 Months*)	$	$	$	$

☐ Determine veteran/dependent's eligibility for veteran's benefits:

(✔) If monthly benefit is paid,
- ☐ Compensation
- ☐ Pension
- ☐ Other *(see remarks)*
- ☐ Includes A & A benefits of $__________

(✔) Eligibility status:
- ☐ No basic eligibility
- ☐ Claim initiated
- ☐ Claim being reviewed
- ☐ Claim denied

REMARKS: *(For official use only)*

CVSO REPRESENTATIVE: (PRINT)	PHONE #:	DATE:

Name and Address of County Human Services Office

INSTRUCTIONS FOR COUNTY USE AND COMPLETION OF VETERAN'S BENEFITS VERIFICATION AND REFERRAL FORM CW 5

USE THE CW 5:

1. To verify the status amount of the veteran's benefits being received.
2. To refer applicants or recipients to the County Veterans Service Office (CVSO).
3. To obtain new veteran benefits when the information on the Statement of Facts forms for the following programs indicates possible eligibility for benefits or county general assistance or relief:
   - California Work Opportunity and Responsibility to Kids (CalWORKs)
   - Medi-Cal
   - State-Run County Medical Services Program
   - Food Stamps
   - AFDC-Foster Care
   - Kin GAP
   - Healthy Families
   - Other Program Statement of Facts forms

DO NOT COMPLETE THIS FORM IF THE SERVICE PERSON IS STILL ON ACTIVE DUTY, OR NONE OF THE FOLLOWING INFORMATION IS KNOWN:

1. Veteran's Social Security Number (SSN) and Date of Birth;
2. Veteran's Military Serial Number;
3. Veterans Administration (VA) Claim Number.

If either of the above applies, **do not** initiate a CW 5. Do make an entry in the "County Use Only" section of the SAWS 2 or the MC 210 or the "ELIGIBILITY WORKER ONLY": section of the FC 2 form stating why a referral was not made and place the form in the case file.

INSTRUCTIONS FOR COMPLETION OF CW 5:

1. Enter name and address of County Veterans Service Office (CVSO) in upper left-hand corner of the address box.
2. Enter name and address of County Welfare Department (CWD) in lower left-hand address box.
3. Check the appropriate request box to verify or determine benefits.
4. Enter worker and applicant/recipient case information in upper right-hand box.

Section I - Have applicant enter all known veteran and, if applicable, claimant information. At least one is required: (a) Veteran's SSN and date of birth, (b) Veteran's military serial number, or (c) VA claim number.

Section II - Have applicant enter all claimant information.

Section III - Have the veteran, dependent/claimant of foster care representative read, sign and date the authorization statement (attach a copy of placement order in foster care cases).

Section IV - This section will be filled in by the CVSO.

DISTRIBUTION AND FILING OF THE CW 5:

Complete original and photocopy 5 copies of the form. Distribute as follows:

- Original and 3 copies to CVSO. Have the veteran, dependent/claimant, or foster care representative hand carry 4 copies of the form along with medical documents, military papers, etc, to the CVSO. Referral by mail may be used if hand carry method is not possible.
- One copy for case file to be retained until original is completed and returned to CWD by CVSO. CWD will keep the completed original CW 5 as a permanent record and discard the copy.
- A copy of the completed original will be kept by CVSO.

If Veterans Affairs Aid and Attendance Benefits have been granted to the veteran, widow or parent of the veteran, CVSO will also send a copy of the completed original to: Department of Health Services, Recovery Branch, Health Insurance Unit 105, P.O. Box 1287, Sacramento, CA 95806.

VERIFICACION Y REFERENCIA DE BENEFICIOS PARA VETERANOS

NOTE: No complete este formulario a menos que tenga uno de los siguientes:

- **Número de Seguro Social y fecha de nacimiento del veterano**
- **Número de orden militar**
- **Núm. de reclamo de la Administración de Beneficios para Veteranos (VA)**

Tiene que darnos su Número de Seguro Social (SSN) y el de cualquier miembro de su hogar para quien solicite asistencia. Los SSN se usan para establecer su elegibilidad y el no cooperar puede resultar en que se le niegue o descontinúe la asistencia. Autoridad: 45 Código de Ordenamientos Federales, Sección 205.52, y Código de Bienestar Público e Instituciones, Sección 11268(a).

Name and Address of County Veterans Service Office

NOMBRE DEL CASO:

NUMERO DEL CASO (INCLUYENDO EL CODIGO PARA ASISTENCIA MEDS):

NUMERO DE TELEFONO DEL SOLICITANTE/RECIPIENTE :

TRABAJADOR DEL CASO:

NUMERO DE TELEFONO. DEL TRABAJADOR #:

SECCION I

NOMBRE DEL VETERANO (APELLIDO, NOMBRE, NOMBRE QUE USA EN MEDIO):

FECHA DE NACIMIENTO:

LUGAR DONDE NACIO:

¿VIVE? ☐ SI ☐ NO

SI HA FALLECIDO: FECHA EN QUE FALLECIO: LUGAR DONDE FALLECIO:

DOMICILIO DEL VETERANO: (NUMERO, CALLE, CUIDAD, ESTADO, CODIGO POSTAL)

¿VIVE EN EL HOGAR DE USTED ESTE VETERANO? ☐ SI ☐ NO

NUMERO DE RECLAMO VA: ____________

NUMERO DE SEGURO SOCIAL: ____________

NUMERO DE ORDEN MILITAR: ____________

RAMA DEL SERVICIO:

FECHA DE INGRESO:

FECHA DE SEPARACION:

TIPO DE SEPARACION: ☐ HONRABLE ☐ GENERAL ☐ MEDICA ☐ OTRO NO HONRABLE ☐ DESCONOCIDO

ESTADO CIVIL DEL VETERANO: ☐ SOLTERO ☐ CASADO ☐ DIVORCIADO ☐ SEPARADO ☐ VIUDO

¿NO PUEDE TRABAJAR PERMANENTEMENTE ESTE VETERANO DEBIDO A SU INCAPACIDAD? ☐ SI ☐ NO

¿SUFRIO ESTE VETERANO UNA LESION O ENFERMEDAD DURANTE SU SERVICIO LA CUAL ES LA CAUSA DE SU INCAPACIDAD ACTUAL?: ☐ SI ☐ NO

INGRESOS BRUTOS MENSUALES DEL VETERANO: $

INGRESOS BRUTOS MENSUALES DEL CONYUGE: $

¿ESTÁ ALGUIEN RECIBIENDO CUIDADO A LARGO PLAZO? ☐ SI ☐ NO SI SI, (✔) A CONTINUACION: ☐ VETERANO ☐ CONYUGE ☐ OTRO

¿ESTÁ ALGUIEN CIEGO O SE NECESITA CUIDADO EN CASA PARA ALIMENTAR, BAÑAR, O VESTIR A UN MIEMBRO DEL HOGAR? ☐ SI ☐ NO SI SI, (✔) A CONTINUACION: ☐ VETERANO ☐ CONYUGE ☐ OTRO

SECCCION II

NOMBRE DEL RECLAIMANTE:	PARENTESCO CON EL VETERANO:	FECHA DE NACIMIENTO	NUMERO DE SEGURO SOCIAL:	DIRECCION:

SECCION III

Por este medio autorizo al departamento de bienestar público que le dé la información anterior a la Oficina del Condado de Servicios para Veteranos y a la Administracion de Beneficios para Veteranos con el propósito de identificar y obtener los beneficios disponibles para las personas que se identifican arriba. También autorizo que la Oficina del Condado de Servicios para Veteranos y la Administración de Beneficios para Veteranos compartan la información con (se anotará a continuación).

FIRMA (O MARCA) DEL VETERANO/DEPENDIENTE:	FECHA:	FIRMA DEL TESTIGO SI SE FIRMO CON UNA X:	FECHA:

SECCION IV *(To be completed by the County Welfare Department and the County Veterans Service Office)* ***(sólo para uso del condado y la oficina del condado de servicios para veteranos)***

The County Welfare Department requests the County Veterans Service Office to:

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