Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Veteran's Referral

DSHS OFFICE	TELEPHONE	CASE NUMBER	CASE NAME

A. FOR CLIENT ACTION:

NAME AND ADDRESS OF CLIENT	NAME AND ADDRESS OF PERSONAL CONTACT
TELEPHONE NUMBER	RELATIONSHIP TELEPHONE NUMBER

B. CHECK THE ITEMS BELOW THAT APPLY TO YOU OR THE PERSON YOU ARE APPLYING FOR:

1. ☐ **Veteran** (Served in the Military)
2. ☐ **Surviving Spouse** of a Veteran
3. ☐ **Surviving Parent** of a Veteran
4. ☐ **Child** of a Deceased/Disabled Veteran

C. CHECK THE ITEM(S) BELOW THAT APPLY TO YOU OR THE PERSON YOU ARE APPLYING FOR:

1. ☐ Needs Medical Care
2. ☐ Care in a Nursing Home or Medical Institution
3. ☐ Applying for Assisted Living or In-Home Care (COPES)
4. ☐ DDD Services/Waiver

D. COMPLETE THIS SECTION:

NAME OF VETERAN (LAST, FIRST, MIDDLE)	VETERAN'S SOCIAL SECURITY NUMBER	VA CLAIM NUMBER (IF KNOWN)

E. If any items in Section B are marked, as a necessary part of the application or reapplication process, you are required to contact the Veterans Services Office at **1-800-562-2308** on or before _____

F. Read the following carefully. Sign, date and return this form to your DSHS office.
Failure to return this form may result in denial of DSHS benefits.

I declare that the information given above is correct, true and complete to the best of my knowledge. I understand that I may be required to contact a Veterans Service Office as a necessary part of the application process. I hereby authorize DSHS and Veterans Service Office to release information necessary to determine eligibility for benefits.

If I think that DSHS is wrong in asking for this information, I can ask for a fair hearing within 90 days from the date of this referral by writing to: Department of Social and Health Services, Office of Appeals, PO Box 42489, Olympia, Washington 98507-2465.

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE	DATE

For DSHS Office Use Only

DSHS OFFICE FINANCIAL SECTION	INCOME	CLIENT PAYMENT	MARITAL STATUS

OTHER MEDICAL EXPENSES	LIVING ARRANGEMENT:

COMMENTS:

SIGNATURE OF DSHS REPRESENTATIVE	TITLE	DATE

FOR VETERANS SERVICE OFFICE USE ONLY. Complete the following and return this form to the DSHS office listed below.

☐ Ineligible for benefits
☐ Receiving entitlement. If yes, complete the following:
Type _____ Effective Date: _____ $_____ / month
☐ Failed or Refused to cooperate.
☐ Claim for benefits filed.

COMMENTS:

DSHS 14-162 (REV.02/2008)

DISTRIBUTION: Original - CSO Copy - Case Record Copy - Client