Veterans Means Test Data Form

The purpose of this form is to gather some basic information so that we can evaluate your possible eligibility to receive VA benefits**. This information is held confidential and will not be released in any form.** Please be as detailed as possible in filling out this form. Without a complete overview of your current financial state we will be unable to properly evaluate your current situation. This information is needed to build a financial plan necessary to accomplish your stated personal goals. (**PLEASE PRINT**)

Veteran's Name: _____ Birth Date: _____/_____/_____
Veteran's Health: Good □ Fair □ Poor □ Deceased □
Spouse's Name: _____ Birth Date: _____/_____/_____
Spouse's Health: Good □ Fair □ Poor □ Deceased □
Address: _____ City: _____ State: _____Zip: _____
County: _____ Phone: (_____) _____-_____
Name of Contact Person (if different than above): _____
Relationship to Veteran: _____
Address: _____City: _____ State: _____ Zip: _____
County: _____ Phone (_____) _____-_____
E-mail:_____
Branch of Service _____ From: _____/____/_____ To: ____/____/_____
Military Svc. #_____ Military Occupation _____
*Service Related Injuries: Yes □ No □ Type of Injuries*_____
Registered in VA System: Yes □ No □ % of Disability _____ VA File # _____
Are you receiving any benefits through the VA? Yes □ No □
If answered yes above please list type of benefit(s): _____

How did you hear about us? _____

HOUSEHOLD INCOME:	***Source Income***	***Monthly Amount***
Veteran's Social Security	_____	$_____
Spouse's Social Security	_____	$_____
Interest / Dividends	_____	$_____
Pension & Annuity	_____	$_____
Other Income	_____	$_____
Other Income	_____	$_____

NON-REIMBURSED MEDICAL EXPENSES

Expense Item	**Monthly expense**	**Expense Item**	**Monthly expense**
Health Insurance Premiums	$_____	Co-Pays	$_____
LTC Insurance Premiums	$_____	Deductibles	$_____
Assisted Living/Nursing home	$_____	Health/Hygiene Supplies	$ _____
In Home Care Costs	$ _____	Medical Mileage	$ _____
Medicare B Expenses	$_____	Dental Expenses	$ _____
Prescription Drugs	$_____	Eyeglass/Vision Expenses	$ _____

Please list all other NON-REIMBURSED MEDICAL EXPENSES below.

_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

CURRENT ASSETS:

TYPE OF ACCOUNT/ ASSET	OWNER NAME	APPROXIMATE VALUE
HOME: Are you planning on selling within the year? Y or N		
AUTO:		
OTHER PROPERTY:		
SAVINGS ACCOUNT:		
CHECKING ACCOUNT:		
ANNUITIES:		
RETIREMENT ACCOUNTS:		
INVESTMENTS:		
IRA'S:		
OTHER:		
OTHER:		
OTHER:		

Please complete …

What are your current concerns?

_____

Number of Children ____ Are Children involved in Financial Decisions: **Yes ☐No☐**

Do you have any of the following?

Will: Yes □ No □ Dated: ____/_____/_____ **Living Trust:** Yes □ No □ Dated: ___/___/___

Power of Atty. (Financial) Yes □ No □ Dated: _____/_____/_____

Power of Atty. (Medical) Yes □ No□ Dated: _____/_____/_____

Long Term Care Insurance: Yes □ No □ **Declaration of Guardian:** Yes □ No□

Do you anticipate an Inheritance: Yes □ No □ **Approximate Value:** $_____

The information that I have provided above is true, correct and as accurate as possible. I am in no way obligated to comply with or follow any advice or procedures that may be proposed by The Sawyer Group and/ or its representatives. I understand that I may not be entitled to any VA benefits and that I have not been promised that I will receive or even qualify for any benefits under the Veterans Administration System. I understand that there is **NO COST** to me for this service.

PRIMARY SIGNATURE: _____ ***DATED:*** _____

(Veteran, Power of Attorney, Representative)

Please Return to:

Charles W. Sawyer, Jr.
100 Painters Mill Road, Suite 420
Owings Mills, MD 21117
OR
Fax to: 410-356-9263

Additional Notes *(please feel free to add additional pages):*_____

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