



# 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?** \_\_\_\_\_

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

## NON-REIMBURSED MEDICAL EXPENSES

<b>Expense Item</b>	<b>Monthly expense</b>	<b>Expense Item</b>	<b>Monthly expense</b>
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): \_\_\_\_\_

**The Sawyer Group, Inc., 100 Painters Mill Road, Suite 420, Owings Mills, MD 21117**  
**Phone: 410-356-9230; Toll Free: 800-276-8043**  
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