VA REGIONAL OFFICE
RE: VSO HANDLING VERIFICATION REQUESTS
3333 N. CENTRAL AVE.
PHOENIX, AZ 85012

Date:
Claim #:
Co. fax #: 602/627.3039 (AZ)
Co. fax #: 612/970.5412 (MN)

To Whom It May Concern:

Claimant's Name: _____ Veteran's Name: _____

Claimant's SSN: _____ Veteran's SSN: _____

Claimant's DOB: _____ Veteran's DOB: _____

I am in the process of applying and qualifying the above-named claimant for the Arizona Long Term Care System (ALTCS)—Arizona's version of Medicaid. In order to qualify, I must verify the breakdown of the income the claimant receives from the Veterans Administration. On your own form or letterhead, please verify the following:

The total amount claimant currently receives:		$	
What portion of this amount is for:	Compensation	$	
	DIC	$	
	Pension	$	
	VA Reduced Pension	$	
	Aid & Attendance	$	
	Housebound Assistance	$	
	Clothing Allowance	$	
	Caregiver Payments	$	
	Spousal Apportionment	$	

Please respond as soon as possible. Medicaid benefits pending.

Sincerely,

Signature: _____

Address: _____

City, State, Zip: _____

Phone number:

VA representative: If using this form letter to verify the information above, please provide the following additional information:	Your name:	
	Your signature:	
	Your phone number:	