Sheboygan County Veterans Service Office

Todd Richter
Director

Craig Stewart
Deputy Director

Jonathan Belval
Veterans Benefit Specialist

VA HEALTHCARE ENROLLMENT WORKSHEET

This is not an application. This is a worksheet designed to gather all the needed enrollment information. Please complete this worksheet and schedule an appointment with the Sheboygan County Veterans Service Office to complete an application for VA Healthcare. Please bring this completed worksheet along with your DD FORM 214 to the appointment.

Veteran's Full Name (include maiden name, if applicable):____

Date of Birth:_____________ Place of Birth:_______________________ Social Security:________________________________

Service Branch:__________________ Dates of Service:______________ to _________________

Home address: _____________________________________City:______________________________

State: ____________ Zip Code: _______________________ County:__________________________

Telephone Number: _________________________________ Religion:__________________________

Mothers Maiden Name:____

Maritial Status:_______________________________________

Spouse Full Name: ___________________________________ Date of Birth: ______________

Social Security Number: ______________________________

Date of Marriage: _________________ City and State of Marriage: __________________________

Next of Kin Name:____ Relationship: ___________________________________

Address: ____ City___________________________________State________

Zip Code: _____________________________ Telephone Number:_____________________________________

SERVING THOSE WHO SERVED SINCE 1935

Telephone (920) 459-3053
Facsimile (920)467-4195

650 Forest Ave.
Sheboygan Falls, WI. 53085

Veterans.Services@SheboyganCounty.com
www.SheboyganCounty.com

Health Insurance Company name:____

Address: ______________________________ City:______________________________State:___________

Zip Code: _____________________________ Telephone:________________________________

Name of Policy Holder:____

Policy Number:__________________________________ Group Code:______________________________

Are you eligible for Medicaid? ☐ YES ☐ NO

Medicare Type A Effective Date: __________________

Veteran's Employment Status: ___________________ Company: _________________________________

Company Address:______________________________City: ____________________________State:_____

Company Telephone: ____________________________ Date of Retirement: _______________________

Income (Previous Calendar Year):	**VETERAN**	**SPOUSE**
Gross annual income from employment:	______________________	________________________
Net income from your farm, property or business:	_______________________	_______________________
Other(social security, compensation, Pension, Interest, dividends):	_______________________	______________________

Deductible expenses (Previous Calendar Year):

Non-Reimbursed medical expenses paid by you or your spouse(deductibles, medications, Medicare, health insurance, hospital or nursing home __________________________

Funeral and Burial Expenses (Deceased Spouse or dependent child): __________________________

College or Vocational Education Expenses (tuition, books, fees, materials,) Do Not List Dependent Educational Expenses: __________________________

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