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| IM-3121Rev. 01-17 |
| **Veteran’s Administration-KDHE INFORMATION SYSTEM** |
| To: | Kansas Regional Office of Veteran’s Affairs |
|   | PO Box 4444 |
|  | Jamesville, WI 53547 |
| I. TO BE COMPLETED BY KDHE STAFF |
| Client’s Name | Name of Dependent(s)/Survivors(s) |
|  |  |
| Veteran’s Name (If Different From Above) |  |
| VA Claim Number |  |
| Veteran’s Social Security Number |  |
| Veteran’s Date of Birth |  |
| The above-named veteran and/or dependent(s)/survivor(s) are clients of the Kansas Department of Health and Environment for medical assistance. |
| In determining eligibility and/or the correct amount of assistance, we must verify the amount of VA benefits the clients are receiving. Therefore, we would appreciate your providing the following information: |
|  |  | Monthly benefit amount currently provided by the VA, including the aid and attendance and  |
|  unusual medical expense amounts. |
|  |  | Monthly benefit amount for the period |  | to |  |
|  (Month/Year) (Month/Year) |
|  |  | Total benefit amount which has been provided by the VA since |  |
|  |  (Month/Year) |
| KDHE Staff Signature |  | Date |  |