VA-DCF INFORMATION SYSTEM

o: Veteran's Administrati	ion Regional Office (or Center)
TO BE COMPLETED E	BY DCF STAFF
Client's Name	
Veteran's Name (If Different From Abov	/e)
VA Claim Number	Name(s) of Dependent(s)/Survivor(s)
Veteran's Social Security Number	
Veteran's Date of Birth	
The above named vete Families for:	eran and/or dependent(s)/survivor(s) are clients of the Department for Children and
☐ Food Assistanc	ee Cash Assistance Medical Assistance
•	y and/or the correct amount of assistance, we must verify the amount of VA benefitsing. Therefore, we would appreciate your providing the following information:
1 1	amount currently provided by the VA, including the aid and attendance edical expense amounts.
☐ Monthly benefit	amount for the period to Month/Year Month/Year
☐ Total benefit an	nount which has been provided by the VA since Month/Year
DCF Staff Signature	Date
DCF Office Address	

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This form supersedes Form IM-3121, Rev. 9-92.

VA PAYMENT AMOUNT TO VETERAN/WIDOW(ER) (UNAUGMENTED)

Name	Repetit	Paid in Mo/Yr to Mo/Yr	Attendance or Home	Designated for Unusual Medical	Educational	Medical Benefits?	Total Benefit Since Date Indicated on Page 1

AUGMENTED AMOUNT OF VA PAYMENT ATTRIBUTABLE TO DEPENDENT(S) / SURVIVOR(S)

Name	Ronofit	Paid in Mo/Yr to Mo/Yr	Total Benefit Since Date Indicated on Page 1

Date	
	Date