

# Dependency and Indemnity

## Compensation (DIC) Intake Form

*You may be entitled to dependency and indemnity compensation (DIC), which is a monthly payment that is available to eligible surviving spouses, children and dependent parents when the VA determines that the veteran's death was service connected and in some other circumstances. The following questions will help you and your advocate organize the information you need to apply. If additional room is needed to complete an answer, please attach a separate piece of paper. Do not send this form to the VA; give it to your accredited service officer.*

Date \_\_\_\_\_

(1) Name of veteran: \_\_\_\_\_  
First                  Middle                  Last

(2) Name used in service, if different \_\_\_\_\_

(3) Applicant's name: \_\_\_\_\_  
First                  Middle                  Last

(4) Relationship to veteran \_\_\_\_\_

(5) Address: \_\_\_\_\_  
Number                  Street                  Apt. No.

\_\_\_\_\_ City                  State                  Zip Code

(6) Mailing address: \_\_\_\_\_  
Number                  Street                  Apt. No.

\_\_\_\_\_ City                  State                  Zip Code

(7) Telephone:  
 Home (\_\_\_\_\_) \_\_\_\_\_          Work (\_\_\_\_\_) \_\_\_\_\_

Mobile (\_\_\_\_\_) \_\_\_\_\_

(8) Veteran's Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month   Day   Year

(9) Veteran's Social Security number: \_\_\_\_\_

(10) Applicant's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month   Day   Year

(11) Applicant's Social Security number: \_\_\_\_\_



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- (12) Applicant's current marital status:  
Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )
- (13) Are you receiving Social Security Disability, Supplemental Social Security, or other forms of government assistance? If you are, please specify:

\_\_\_\_\_  
\_\_\_\_\_

- (14) Do you have dependents? yes( ) no( )  
If yes, how many? \_\_\_\_\_

Please list your dependents' names, how they are related to you, dates of birth, and Social Security numbers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- (15) Did the veteran have any dependents? yes( ) no( )  
If yes, how many? \_\_\_\_\_

Please list the veteran's dependents' names, how they are related to the veteran, dates of birth, and Social Security numbers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Information Related to Service

- (16) Do you have a copy of the veteran's military discharge form, DD Form 214? yes( ) no( )

*If yes, please attach a copy of the DD Form 214. If you do not have a copy of the DD Form 214, please obtain from your advocate and complete and attach Standard Form (SF) 180, Request Pertaining to Military Records, to obtain a copy of the DD Form 214.*

- (17) To what branch of the service (Army, Navy, Air Force, Marines, Coast Guard, other) did the veteran belong? \_\_\_\_\_

\_\_\_\_\_

- (18) In what era (World War II, Korea, Vietnam, Persian Gulf, or other) did the veteran serve?

\_\_\_\_\_

- (19) Please list the veteran's dates of service, if known:

Entry \_\_\_ / \_\_\_ / \_\_\_ Discharge \_\_\_ / \_\_\_ / \_\_\_

Entry \_\_\_ / \_\_\_ / \_\_\_ Discharge \_\_\_ / \_\_\_ / \_\_\_

Entry \_\_\_ / \_\_\_ / \_\_\_ Discharge \_\_\_ / \_\_\_ / \_\_\_

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(20) Please state the veteran's type of discharge (honorable, general, dishonorable, etc.), if known:

\_\_\_\_\_

(21) Did the veteran have combat service?  
yes( ) no( )

(22) Was the veteran wounded in service?  
yes( ) no( )

If so, where on the body? \_\_\_\_\_

(23) Was the veteran treated for any injury, disability, or disease in service?  
yes( ) no( )

If yes, briefly describe the disability or disease. \_\_\_\_\_

\_\_\_\_\_

### Information Related to VA Benefits

(24) Did the veteran ever apply for VA benefits?  
yes( ) no( ) unknown( )

If yes, check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Compensation              | <input type="checkbox"/> Pension            |
| <input type="checkbox"/> Medical care              | <input type="checkbox"/> Education          |
| <input type="checkbox"/> Vocational rehabilitation | <input type="checkbox"/> Nursing home care  |
| <input type="checkbox"/> Domiciliary care          | <input type="checkbox"/> Home loan guaranty |
| <input type="checkbox"/> Other (please specify):   |   |

*If this is a new claim, ask your advocate about filing a intent to file a claim.*

(25) Have you previously applied for DIC or another VA benefit:  
yes( ) no( )

(26) If you or the veteran filed a claim before, please give the claim number that the VA assigned:

\_\_\_\_\_

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- (27) Was the veteran receiving VA benefits at the time of death?  
yes( ) no( ) unknown ( )
- If yes, check all that apply:
- |  |   |
|--|---|
| <input type="checkbox"/> Compensation                            | <input type="checkbox"/> Pension            |
| <input type="checkbox"/> Pension plus aid and attendance benefit | <input type="checkbox"/> Education          |
| <input type="checkbox"/> Pension plus housebound benefit         | <input type="checkbox"/> Nursing home care  |
| <input type="checkbox"/> Medical care                            | <input type="checkbox"/> Home loan guaranty |
| <input type="checkbox"/> Vocational rehabilitation               | <input type="checkbox"/> Domiciliary care   |
| <input type="checkbox"/> Other (please specify):                 |   |
- (28) Are you receiving or have you received any VA benefits?  
yes( ) no( )
- If yes, check all that apply:
- |  |   |
|--|---|
| <input type="checkbox"/> Dependency and Indemnity Compensation         | <input type="checkbox"/> Death pension      |
| <input type="checkbox"/> Death pension plus aid and attendance benefit | <input type="checkbox"/> Education          |
| <input type="checkbox"/> Death Pension plus housebound benefit         | <input type="checkbox"/> Burial benefits    |
| <input type="checkbox"/> Medical care                                  | <input type="checkbox"/> Home loan guaranty |
| <input type="checkbox"/> Vocational rehabilitation                     |   |
| <input type="checkbox"/> Other (please specify):                       |   |
- (29) Veteran's date of death: \_\_\_\_\_  
*Please provide a copy of the veteran's death certificate*
- (30) In your opinion, did a disease or injury that the veteran incurred in service, or that was made worse in service, cause or contribute to the veteran's death?  
yes( ) no( )
- (31) Did the veteran die from a service-connected disability?  
yes( ) no( )
- (32) At time of his or her death, was the veteran receiving or entitled to receive 100 percent service-connected benefits (including 100 percent benefits based on entitlement to individual unemployability)?  
yes( ) no( )
- (33) If yes, was the veteran rated 100 percent disabled continuously for 10 years or more immediately preceding death (or would the veteran have been so rated except for clear and unmistakable error by the VA)?  
yes( ) no( )
- (34) If no, was the veteran rated 100 percent disabled continuously for at least 5 years from the date of his or her discharge from the military (or would the veteran have been so rated except for clear and unmistakable error by the VA)?  
yes( ) no( )



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- (35) If no, was the veteran a former prisoner of war rated 100% disabled continuously for at least one year prior to death (or would the veteran have been so rated except for clear and unmistakable error by the VA)?
- yes(    )                      no(    )

### Information About the Claimant

- (36) If you are the spouse or surviving spouse of the veteran, please give the date of your marriage to the veteran:

*Please provide a copy of the marriage certificate or other proof of marriage. (If you are married to someone other than the veteran, you are ineligible for DIC unless you are one of the veteran's parents.)*

- (37) Were you and the veteran separated at the time of his or her death?

yes(    )                      no(    )

- (38) If yes, did the veteran provide reasonable support?

yes(    )                      no(    )

- (39) Was the separation caused by the misconduct of the veteran, such as spousal abuse?

yes(    )                      no(    )

- (40) Was the separation without fault on the part of the veteran's spouse?

yes(    )                      no(    )

- (41) If you are the veteran's surviving spouse, since the death of the veteran, have you remarried or held yourself out to be the spouse of another?

yes(    )                      no(    )

- (42) If you remarried after the death of the veteran, did the remarriage end due to divorce, annulment, or death of the second spouse?

yes(    )                      no(    )

- (43) If you held yourself out to be the spouse of another after the death of the veteran, did you stop living with the other person or stop holding yourself out to be that person's spouse?

yes(    )                      no(    )

- (44) If you are still remarried, at what age were you when you married your current spouse?

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## Dependency and Indemnity Compensation

*If the applicant is a child, please provide a copy of a birth certificate or other proof showing that the veteran was the claimant's parent and complete the following:*

- (45) Is the child the veteran's biological child, legally adopted child, or stepchild who joined the veteran's family before reaching the age of 18?  
yes( )                      no( )
- (46) Was the child a member of the household at the time of the veteran's death?  
yes( )                      no( )
- (47) Is the child unmarried?  
yes( )                      no( )
- (48) Is the child currently under 18 years of age?  
yes( )                      no( )
- (49) Did the child become permanently incapable of self-support before his or her 18<sup>th</sup> birthday?  
yes( )                      no( )
- (50) Is the child currently between the ages of 18 and 23 and pursuing a course of instruction at an educational institution?  
yes( )                      no( )

