*** Office Use Only ***	
Appointment with (Curt or Jennifer):	
Date:	Time:

Clay County Veterans Service Office
715 11th Street North, Suite 103
Moorhead, MN 56560
Phone: 218.299.5041 Fax: 218.291.5801

Veteran

Last Name:	First Name:	Middle Name:	
Address:	City:	State:	Zip:
Sex (Male/ Female):	Race (White, American Indian/Alaska Native, Black/African American, Native Hawaiian/Pacific Islander, Spanish/Hispanic/Latino, Asian):		
Home Phone:	Cell Phone:		
Date of Birth:	Place of Birth (City, State):	Email Address:	
Date of Death:	Place of Death (City, State):	Branch of Service:	
Social Security Number:	Maiden Name:		
	Serve Under Any other Name:		
Marital Status (Single/Married/Divorced/Widowed):	Date of Marriage:	Place of Marriage (City, State):	
	Date of Divorce:	Place of Divorce (City, State):	
Living with Spouse? (Yes/No):			

Veteran Employment

Employer:	Occupation:	
Employer Address:		
City:	State:	Zip:
Phone:	Fax:	
Job Title:	Dates of Employment:	

Spouse

Last Name:	First Name:	Middle Initial:	
Sex (Male/ Female):	Social Security Number:	Maiden Name:	
Cell Phone:	Work Phone:	Previously Married (Yes/No):	
		Also a Veteran (Yes/No):	
Date of Birth:	Place of Birth (City, State):	Email Address:	
Date of Death:	Place of Death (City, State):		

Spouse Employment

Employer:	Occupation:	
Employer Address:		
City:	State:	Zip:
Phone:	Fax:	
Job Title:	Dates of Employment:	

Important Note: After completing and printing the form, make sure you CLEAR the form by clicking the "CLEAR FORM" button at the end of the form. If you do not CLEAR the form, your information will be disclosed to those persons subsequently using the computer.

Dependent (1)

Last Name:	First Name:	Middle Initial:	
Social Security Number:	Date of Birth:	Place of Birth (City, State):	Sex (Male/Female):
Relation to Veteran (Biological/Step Child/Adopted):			
Student? (Yes/No):	Adult? (Yes/No):	Disabled? (Yes/No):	
Name of School:	Disability:		

Dependent (2)

Last Name:	First Name:	Middle Initial:	
Social Security Number:	Date of Birth:	Place of Birth (City, State):	Sex (Male/Female):
Relation to Veteran (Biological/Step Child/Adopted):			
Student? (Yes/No):	Adult? (Yes/No):	Disabled? (Yes/No):	
Name of School:	Disability:		

Next of Kin

Last Name:	First Name:	Middle Name:	
Street Address:	City:	State:	Zip Code:
Daytime Phone:	Evening Phone:		
Relation to Veteran:			

Emergency Contact

Last Name:	First Name:	Middle Name:	
Street Address:	City:	State:	Zip Code:
Daytime Phone:	Evening Phone:		
Relation to Veteran:			

Medicare

Name as it appears on Medicare Card:	
Medicare A? (Yes /No):	Effective Date:
Medicare B? (Yes /No):	Effective Date:
Medicare D? (Yes /No):	Effective Date:

Health Insurance

Type of Insurance (Medicaid/Private):			
Name of Company:			
Insurance Address:	City:	State:	Zip Code:
Policy/Identification Number:	Group Number:		
Policy Listed Under:	Coverage Ending Date:		

Clear Form

** Please provide **photocopies** of your Military Discharge (DD214) and Insurance Card(s)

Print Form

Important Note: After completing and printing the form, make sure you CLEAR the form by clicking the "CLEAR FORM" button. If you do not CLEAR the form, your information will be disclosed to those persons subsequently using the computer.