State of California Veteran Reintegration Project

Veteran Information Questionnaire

First Name _____ MI ____ Last _____

Mailing Address after Separation _____ City _____ State ____ Zip Code _____

Email _____

Branch of Srvc _____ Telephone (___)___-____ Date of Discharge __/__/__

My concerns/priorities include: _____

- ❑ State Benefits
- ❑ Education
- ❑ Employment
- ❑ CalVet Home Loans
- ❑ TBI/PTSD
- ❑ Healthcare
- ❑ Transportation
- ❑ Women Veterans Roster
- ❑ Disabled Veterans Business Enterprise
- ❑ Financial Assistance
- ❑ Compensation & Pension Benefits
- ❑ Veterans License Plate Program
- ❑ Legal Assistance
- ❑ College Fee Wavier for Dependents

I request and authorize release of the above information to the California Department of Veterans Affairs and the Employment Development Department. I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand this information shall be used solely for outreach and to assist me receive my veteran benefits and shall not be subject to public disclosure.
NOTE: Out of state veterans information will be forwarded to their State's Department of Veteran's Affairs.

Signature of Veteran:_____ Date: __/__/__

Send completed form to California Department Veterans Affairs, ATTN: Veterans Services

Mail To: VETERANS SERVICES DIVISION 1227 O Street, Room 105,
Sacramento, CA 95814 OR **FAX:** (916)653-2563

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