

NEW JERSEY CATASTROPHIC ENTITLEMENT APPLICATION

Permanent Service-Connected Disabled Veterans and Their Surviving Spouses In Accordance with N.J.S.A. 38:18A-1 and 38:18-1

TO BE COMPLETED BY VETERAN SERVICE OFFICER	TYPE OF BENEFITS APPLIED FOR (CHECK APPROPRIATE BOX)
_____ APPLICATION DATE	<input type="checkbox"/> VETERAN'S APPLICATION
_____ VA CLAIM NUMBER	<input type="checkbox"/> SURVIVING SPOUSE APPLICATION
_____ COMPLETED BY VSO (NAME)	

COMPLETE THIS SECTION FOR BOTH VETERAN'S AND SURVING SPOUSE'S APPLICATION

NAME OF VETERAN _____	NAME OF SPOUSE _____
ADDRESS _____	MAILING ADDRESS _____ (IF DIFFERENT)
SOCIAL SECURITY # _____	SOCIAL SECURITY # _____
DATE OF BIRTH _____	DATE OF BIRTH _____
TELEPHONE # _____ (HOME/DAY)	TELEPHONE # _____ (HOME/DAY)

S.S#: Social Security Number- The Privacy Act of 1974 {U.S.C. 522a} and Social Security Act {42 U.S.C. 405} state disclosure of social security numbers cannot be made mandatory. However, the Privacy Act does provide that federal, state or local agencies may request that you voluntarily submit social security numbers when written notice is given to you according to this Act. The state of New Jersey application for Veterans and Spouse Catastrophic Entitlement pursuant to New Jersey Statutes Annotated 38:18-1 et seq. requests that social security number of the veteran and/or the spouse. The information will be used by both the New Jersey Department of Veterans Affairs and the Department of Treasury to ensure the accuracy of your benefits.

**FOR VETERAN'S APPLICATION: SUBMIT WD53 OR DD214
CURRENT UTILITY OR TELEPHONE BILL
VA AWARD LETTER AND VA RATING SHEET**

**FOR SPOUSE APPLICATION: SUBMIT WD53 OR DD214
MARRIAGE CERTIFICATE
DEATH CERTIFICATE
CURRENT UTILITY OR TELEPHONE BILL**

COMPELTE FOR VETERAN APPLICATION ONLY

1. VA PERMANENT SERVICE-CONNECTED DISABILITY FOR ☐ **LOSS OF SIGHT** ☐ **AMPUTATION** OF BOTH HANDS, BOTH FEET OR ONE HAND AND ONE FOOT; ☐ **HEMPLEGIA** & PERMANENT PARALYSIS OF ONE LEG AND ONE ARM OR EITHER SIDE OF THE BODY; ☐ **PARAPLEGIA** & PERMANENT PARALYSIS OF BOTH LEGS AND LOWER PARTS OF THE BODY; ☐ **OSTEOCHONDRITIS** & PERMANENT LOSS OF THE USE OF BOTH LEGS; ☐ **QUADRIPLEGIA**; ☐ **MULTIPLE SCLEROSIS** AND THE LOSS OF USE OF BOTH FEET OR BOTH LEGS

2. HOME ADDRESS AT INITIAL/SECOND ENTRY _____
IN ARMED FORCES _____

3. CHARACTER OF DISCHARGE ☐ HONORABLE ☐ DISHONRABLE ☐ OTHER _____

4. BRANCH OF SERVICE _____ SERVICE NUMBER _____
DATE OF ENTRY _____ DATE OF SEPARATION _____

COMPELTE FOR SURVIVING SPOUSE APPLICATION ONLY

1. WAS VETERAN IN RECEIPT OF CATASTROPHIC ENTITLEMENT PRIOR TO DEATH?

☐ YES ☐ NO

2. VETERAN'S NEW JERSEY CPF# _____

3. DATE AND PLACE OF MARRIAGE _____
(DATE) (PLACE)

4. DATE OF DEATH OF VETERAN _____

COMPLETE THIS SECTION FOR BOTH VETERANS AND SURVIVING SPOUSES APPLICATION

1. RESIDENT OF NEW JERSEY? ☐ YES ☐ NO () YEARS () MONTHS
2. FOR SPOUSES ONLY...IF YOU ARE NOT RESIDENT OF NEW JERSEY, WHY DID YOU MOVE?

3. ARE YOU PRESENTLY RECEIVING IN PATIENT OR DOMICILIARY CARE? ☐ YES ☐ NO
IF YES LIST THE NAME AND ADDRESS OF THE INSTITUTION

4. DOSE ANYONE HOLD YOUR COURT APPOINTED POWER OF ATTORNEY FOR FINANCIAL REASON?
☐ YES ☐ NO

IF YES, SUBMIT A COPY OF COURT APPOINTED POWER OF ATTORNEY {POA}

The responses on this for are considered CONFIDENTIAL as provided by the Privacy Act. The information requested by this form is considered relevant and necessary to determine eligibility entitlement as established by N.J.S.A.38:18-1 et. seq.

I authorize the New Jersey Department of Veterans Affairs access and a limited power of attorney to my VA claim folder for the purpose of obtaining the following information: Secure a copy of discharge (DD214) and verify that the member is entitled to the benefit as defined in N.J.S.A. 38:18A-1 and N.J.S.A. 38:18-1; verify the service-connected disability and whether this condition is permanent in nature; VA Claim number; current home address; and home address at time of entry into service. I also authorize to any and all records from any State or Federal agencies pertaining to myself and/or my spouse to determine eligibility.

I certify that the statements on this form are true and correct to the best of my knowledge and belief.

APPLICANT MUST COMPLETE EITHER SECTION I OR II

I. I CERTIFY THAT THE STATEMENTS ARE
TRUE AND CORRECT TO THE BEST OF
MY KNOWLEDGE.

IF APPLICANT SIGNS WITH A MARK,
TWO WITNESSES MUST SIGN

WITNESS 1 _____

SIGNATURE OR MARK OF APPLICANT

WITNESS 2 _____

DATE

DATE

II. _____

SIGNATURE OF COURT APPOINTED POWER OF ATTORNEY

PRINT NAME _____ ADDRESS _____

Mail or email completed application and supporting copied documents to:

**NJ Department of Veterans Affairs
ATTN: DVS-VBB
PO Box 340
Trenton, NJ 08625-0340**

VBB@dva.nj.gov

FOR OFFICIAL USE ONLY		
<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED	EFFECTIVE DATE OF ENTITLEMENT_____
REASON FOR DECISION_____		
_____ SIGNATURE OF AUTHORIZING AGENT	_____ TITLE	_____ DATE

Revised: 9 January 2026