County of Cambria

Department of Veteran Services

200 South Center Street
Ebensburg, PA 15931
PHONE: (814) 472-1590 FAX: (814)472-1423

Dear Surviving Spouse of a Deceased Wartime Veteran,

I am truly sorry for your loss and grateful for your spouse's service and sacrifice for our Country.

Attached is a packet to help you to apply for a **survivor's pension** from the Department of Veterans Affairs (VA). The VA does not provide payments to directly reimburse or offset specific costs of surviving spouses. Instead, the VA provides a pension with tiers to provide higher levels of benefits for surviving spouses needing more care. If you are a surviving spouse who needs financial assistance, you are applying for a survivor's pension. You may be **eligible** for a survivor's pension if:

- Your spouse served on **active-duty** for at least 90 days (24 months if service was after 1980) with one of those days being in a **wartime period**. (WWII: DEC 7, 1941 – DEC 31, 1946; Korea: JUN 27, 1950 – JAN 31, 1955; Vietnam: AUG 5, 1964 – MAY 7, 1975; Vietnam (deployed to Vietnam) FEB 28 1961 - MAY 7, 1975; Gulf War/Persian Gulf: AUG 2, 1990 – Present
- Your spouse **did not get dishonorably discharged** from the service
- Your **income + assets** (excluding your home and car) are less than **< $138,489**

The process to get a survivor's pension is very detailed and specific. You must submit all the required items in the proper way to be successful. The Cambria County Veterans' Services Office is here to help you properly submit your claim.

To start the process, the **surviving spouse** of the Veteran needs to fill out and **sign** a VA Form **21-22** and VA Form **21-0966** (attached). The 21-22 authorizes this office to assist you, and the 21-0966 protects your date of claim. The date the VA receives your 21-0966 is the date the VA acknowledges that you started a claim. **Get these forms signed and submitted as soon as you can**. Please be aware that the VA does not recognize the signature of a Power of Attorney (PoA) for a surviving spouse, unless the VA has previously authorized the PoA to sign.

Next, you will need to provide the VA forms and documents to show that you are eligible for a pension. These are the following:

- A VA Form 21P-534EZ (Claim Form) signed by the surviving spouse
- A DD 214 or other discharge document showing the Veteran's dates and character of service
- All marriage, divorce, and death certificates for the Veteran and surviving spouse
- Surviving spouse's Direct Deposit Information (found on a check)
- Social Security Benefit Verification Statement (if the surviving spouse gets Social Security)
- Unreimbursed medical expense/medical insurance premium receipts and a VA Form 21-8416 Medical Expense Report (attached) signed by the surviving spouse. If the surviving spouse is in a nursing home/assisted living facility, provide a recent invoice.
- All financial/bank/investment/pension/IRA statements from the most recent reporting period and a VA Form 21P-0969 (Income and Asset Report)

Additional forms that may be required:

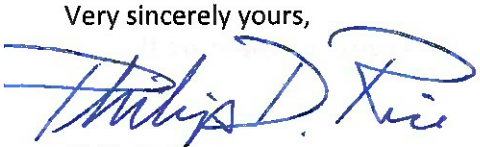
- **VA Form 21-2680 (Exam)**. For nursing home costs, assisted living costs, and/or caregiver costs to be considered unreimbursed medical expenses, a doctor needs to show that there is a medical need for that type of care on the Form 21-2680. Also, the VA uses the Form 21-2680 to determine if a claimant should be in a higher tier of the survivor's pension benefit. A medical doctor is responsible for filling out Sections III and IV. On page two, if the block asks for an explanation, please ensure that the doctor provides a MEDICAL REASON. If a required explanation is blank on page two, it may delay the claim or result in a decreased benefit. **If you are requesting** a special monthly pension for **Aid and Attendance, a doctor must complete a 21-2680** for the surviving spouse.
- **VA Form 21-0779 (Nursing Home Information).** - If the surviving spouse is a resident at a nursing home, have the facility complete this form and sign it. Make sure the administrator puts an amount in Block 15.
- **Assisted Living Facility Verification.** - If the surviving spouse is a resident at an assisted living facility, have the facility complete this form and sign it.
- **Worksheet for Assisted Living** – Page 12 of the VA Form 21P-534EZ. If the surviving spouse is living at a nursing home or assisted living facility, have the facility complete and sign this form.
- Nursing Home Letter (optional but recommended) – Nursing homes/assisted living facilities often provide a letter, on the facility's stationary, providing details about the claimant's care. This includes the name of the claimant, the date care started, the amount the claimant pays each month, details on services that the facility provides, and any other information about the claimant or care that the facility wants to ensure that the VA understands. Have an administrator at the facility sign and date the letter.
- **Worksheet for In-Home Attendant Expenses** - Page 13 of the VA Form 21P-534EZ. If the surviving spouse is getting care at home, have the company providing care, or each caregiver, complete this form and sign it.
- **Attendant Affidavit** - If the surviving spouse is getting care at home, have each caregiver complete this form and sign it. Have receipts and/or cancelled checks available to prove all caregiver payments.
- **VA Form 21-0845 (Disclosure)** – This form allows one other person to talk with the VA about the claim. The form requires the claimant's signature.

All VA forms are available online. Type the name of the form in a search box, and then select a pdf version of the form from the results. With a pdf version, you can type information directly onto the form.

I am including the basic forms you will need to start the process. If a form you need isn't here, you can find it online or request one from the Veterans' Services Office.

Once you have most of the supporting documents / proof of eligibility ready, call the office (814-472-1590) from 9 a.m. to 1 p.m. on a weekday to schedule an appointment. At the appointment, a Veterans' Service Officer will help you to put together your packet for submission to the VA. We look forward to assisting you.

Very sincerely yours,



Philip D. Rice
Cambria County
Director of Veteran Affairs

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative.* See Page 4 for information on how to submit the completed form, either by mail, in person at a VA regional office or electronically. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)* – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH Month – Day – Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☒ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☒ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
X	
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	23B. DATE SIGNED *(MM/DD/YYYY)*

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

OMB Control No. 2900-0826
Respondent Burden: 15 minutes
Expiration Date: 08/31/2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)

NOTE: Please read the Privacy Act and Respondent Burden below before completing the form.

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to expedite processing of the form.

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*

2. CLAIMANT'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)
Month Day Year

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)***

6. VETERAN'S SOCIAL SECURITY NUMBER

7. VETERAN'S SEX
☐ MALE ☐ FEMALE

8. VETERAN'S SERVICE NUMBER *(If applicable)*

9. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA?
☐ YES ☐ NO

11. TELEPHONE NUMBER *(Include Area Code)*

12. EMAIL ADDRESS *(If applicable)*

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: *VA may not be able to use this form to establish an effective date for benefits if you **do not** select one or more of the general benefits listed below.*

13. I intend to file for the general benefit(s) checked below: ***(Choose all that apply)***

☐ **COMPENSATION** ☐ **PENSION**

NOTE: Only check the box below if you are a surviving dependent of the veteran.

☒ **SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)**

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at **www.va.gov**. If you give VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits***; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE

X

14B. DATE SIGNED *(MM,DD,YYYY)*

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*

(NOTE: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

RESPONDENT BURDEN: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0004
Respondent Burden: 25 minutes
Expiration Date: 10/31/2021

Department of Veterans Affairs

APPLICATION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (First, Middle Initial, Last)

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VETERAN'S DATE OF BIRTH (MM/DD/YYYY)
Month Day Year

4. VETERAN'S GENDER
◯ MALE ◯ FEMALE

5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?
◯ YES ◯ NO (If "Yes," provide the file number in Item 6)

6. VA FILE NUMBER

7. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?
◯ YES ◯ NO

8. VETERAN'S SERVICE NUMBER

9. WHAT IS THE VETERAN'S DATE OF DEATH? (MM/DD/YYYY)
Month Day Year

10. WHAT IS YOUR NAME? (First, middle, last name)

11. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)
◯ SURVIVING SPOUSE ◯ PARENT ◯ CHILD ◯ CUSTODIAN FILING FOR CHILD

12. WHAT IS YOUR SOCIAL SECURITY NUMBER?

13. WHAT IS YOUR DATE OF BIRTH? (MM/DD/YYYY)
Month Day Year

14. ARE YOU A VETERAN?
◯ YES ◯ NO

15A. WHAT IS YOUR ADDRESS?

Street address, rural route, or P.O. Box

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

15B. YOUR TELEPHONE NUMBER(S) (include Area Code)

DAYTIME EVENING CELL PHONE

16A. YOUR PREFERRED E-MAIL ADDRESS (If applicable)

16B. YOUR ALTERNATE E-MAIL ADDRESS (If applicable)

17. WHAT ARE YOU CLAIMING? (Check all that apply)
◯ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ● SURVIVORS PENSION ◯ ACCRUED BENEFITS

SECTION II: VETERAN'S SERVICE INFORMATION (COMPLETE ONLY IF THE VETERAN WAS NOT RECEIVING VA COMPENSATION OR PENSION BENEFITS AT THE TIME OF DEATH)

(Skip to Section III if the veteran was receiving VA compensation or pension benefits at the time of his or her death)

18A. DID THE VETERAN SERVE UNDER ANOTHER NAME?
◯ YES ◯ NO (If "Yes," complete Item 18B) (If "No," skip to Item 18C)

18B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

18C. VETERAN ENTERED ACTIVE SERVICE ON (MM/DD/YYYY) Month – Day – Year	18D. BRANCH OF SERVICE	18E. RELEASE DATE FROM ACTIVE SERVICE (MM/DD/YYYY) Month – Day – Year

18F. PLACE OF LAST SEPARATION

19A. WAS THE VETERAN ACTIVATED TO FEDERAL ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*? ◯ YES ◯ NO (If "Yes," answer Items 19B, 19C and 19D)	19B. DATE OF ACTIVATION (MM/DD/YYYY) Month – Day – Year
19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?	19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

20A. WAS THE VETERAN EVER A PRISONER OF WAR? ◯ YES ◯ NO (If "Yes," complete Item 20B) (If "No," skip to Section III)	20B. DATES OF CONFINEMENT Month – Day – Year FROM: TO:

SECTION III- MARITAL INFORMATION *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)*

*(Skip to Section IV if you are **NOT** claiming benefits as the surviving spouse of the veteran)*

TELL US ABOUT THE VETERAN'S MARRIAGES

21A. HOW MANY TIMES WAS THE VETERAN MARRIED (including marriage to you)?

21B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country)	21C. TO WHOM MARRIED (first, middle, last name)	21D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21E. HOW MARRIAGE ENDED (death, divorce)	21F. DATE (month, day, year) and PLACE MARRIAGE ENDED (city/state or country)

21G. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21D, PLEASE EXPLAIN:

TELL US ABOUT YOUR MARRIAGES

22A. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN? ◯ YES ◯ NO	22B. HOW MANY TIMES HAVE YOU BEEN MARRIED? (including your marriage to the veteran)

22C. DATE (month, day, year) and PLACE OF MARRIAGE (city/state or country)	22D. TO WHOM MARRIED (first, middle, last name)	22E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	22F. HOW MARRIAGE ENDED (death, divorce, marriage has not ended)	22G. DATE (month, day, year) and PLACE MARRIAGE ENDED (city/state or country)

22H. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22E, PLEASE EXPLAIN:

23. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE? ◯ YES ◯ NO	24. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD? ◯ YES ◯ NO
25. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH? ◯ YES ◯ NO (If "No," complete Item 26)	26. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

27. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

◯ YES ◯ NO (If "Yes," provide explanation):

SECTION IV: CHILD OF THE VETERAN *(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)*

*(Skip to Section V if you are **NOT** claiming benefits for a child(ren) of the veteran)* (If necessary, attach a separate sheet)

28A. NAME OF CHILD (First, middle initial, last name)	28B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	28C. SOCIAL SECURITY NUMBER	(Check all that apply) 28D. BIOLOGICAL	28E. ADOPTED	28F. STEPCHILD	28G. 18-23 YEARS OLD (in school)	28H. SERIOUSLY DISABLED	28I. CHILD MARRIED	28J. CHILD PREVIOUSLY MARRIED
			◯	◯	◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯	◯	◯

If claiming benefits as the surviving spouse or custodian filing for a child, in items 29A through 29D tell us about the children listed in Item 28A who ***do not*** live with you.

29A. NAME OF CHILD (First, middle initial, last name)	29B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	29C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	29D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION V: VETERAN'S PARENT *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE PARENT OF VETERAN)*

*(Skip to Section VI if you are **NOT** claiming benefits as the parent of a veteran)*

30A. WHAT IS YOUR MARITAL STATUS? (Check one)

◯ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN ◯ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF THE VETERAN ◯ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE ◯ DIVORCED ◯ WIDOWED ◯ NEVER MARRIED

30B. IF YOUR MARRIAGE HAS ENDED, PLEASE SPECIFY THE DATE (month, day, year) AND HOW MARRIAGE ENDED (death, divorce, etc.)

30C. IF YOU ARE SEPARATED, WHAT WAS THE CAUSE OF THE SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION ***(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)***

31A. WHAT IS YOUR SPOUSE'S NAME? (First, middle initial, last name) (Skip to Item 32A if never married or no longer married)	31B. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (MM,DD,YYYY)	31C. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER? ___ – ___ – ____

31D. IS YOUR SPOUSE ALSO A VETERAN? ◯ YES ◯ NO (If "Yes," complete Item 31E)	31E. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? (If applicable)

32A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF *MAJORITY* (AGE 18 IN MOST STATES)? ◯ YES ◯ NO (If "Yes," skip to Item 34)	32B. DATE(S) OF PARENTAL CONTROL (If veteran did not live in your household continuously before age 18 provide the time period (dates) when he/she was under your parental control) (MM DD YYYY) *to* (MM DD YYYY) (MM DD YYYY) *to* (MM DD YYYY)

32C. WHY WASN'T THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY? (Explain fully)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

33. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL CONTROL OVER THE VETERAN OUTSIDE THE DATE(S) SHOWN IN ITEM 32B

A. NAME (FIRST, MIDDLE, LAST)	B. ADDRESS
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country

34. IF YOU ARE NOT THE BIOLOGICAL PARENT OF THE VETERAN, PROVIDE THE NAMES OF THE BIOLOGICAL PARENTS, IF DECEASED, PROVIDE THE DATE(S) OF DEATH.

A. NAME (FIRST, MIDDLE, LAST)	B. DATE OF DEATH (MM/DD/YYYY)

SECTION VI: DIC *(COMPLETE ONLY IF CLAIMING DEPENDENCY AND INDEMNITY COMPENSATION (DIC))*

*(Skip to Section VII if you are **NOT** claiming DIC)*

35. WHAT BENEFIT ARE YOU CLAIMING?

◯ DIC ◯ DIC under 38 U.S.C. 1151 (RARE)

36. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION VII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

37. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

◯ YES ◯ NO *(If "Yes," please complete and attach with this application, VA Form 21-2680, Exam for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNRP), or Clinical Nurse Specialist (CNS).)*

38A. ARE YOU NOW IN A NURSING HOME?

◯ YES ◯ NO *(If "Yes," answer Items 38B and 38C. Also, submit a statement from an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.)*

38B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?

38C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?

◯ YES ◯ NO *(If "No," complete Item 38D)*

38D. HAVE YOU APPLIED FOR MEDICAID?

◯ YES ◯ NO

SECTION VIII: INCOME AND ASSETS *(COMPLETE ONLY IF CLAIMING SURVIVORS PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming survivors pension benefits or parents DIC)*

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.
- If you are a surviving parent claimant, you must report income for yourself and your spouse.

39. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

◯ YES ◯ NO (If "YES," complete Item 40) (If "NO," skip to Item 41)

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

40. GROSS MONTHLY INCOME (Attach a separate sheet if necessary)

SOCIAL SECURITY RECIPIENT	GROSS MONTHLY AMOUNT
	$
	$
	$
	$
	$

41. DO YOU OWN YOUR PRIMARY RESIDENCE? (Parents' DIC claimants skip to Item 43A)

◯ YES ◯ NO

42A. WHAT IS THE SIZE OF THE LOT ON WHICH YOUR PRIMARY RESIDENCE SITS? (Square Feet)

Square Feet:_____

42B. COULD PART OF YOUR LOT BE SOLD *WITHOUT SELLING YOUR RESIDENCE?*

◯ YES ◯ NO (If "YES," complete and attach VA Form, 21P-0969, *Income and Asset Statement*)

IMPORTANT: VA matches income information reported with Federal tax information. Report ALL income you and your dependents receive on the appropriate sections of this form and VA Form 21P-0969, Income and Asset Statement, if appropriate.

43A. **OTHER THAN SOCIAL SECURITY**, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?

◯ YES ◯ NO

43B. **OTHER THAN SOCIAL SECURITY**, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?

◯ YES ◯ NO

43C. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN $10,000 IN ASSETS? (NOTE: Assets are all the money and property you or your dependents own. Assets ***do not*** include your primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation)

◯ YES ◯ NO

43D. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving them away, selling them, purchasing an annuity, or using them to establish a trust)

◯ YES ◯ NO

43E. DID YOU ANSWER "YES," TO ANY OF THE QUESTIONS IN ITEMS 43A THRU 43D?

◯ YES ◯ NO (If "Yes," you ***must*** also complete VA Form 21P-0969, *Income and Asset Statement*)

SECTION IX: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child. Educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all 6 criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, Medical Expense Report.

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet on pages 13 and 14.

44. ARE YOU CLAIMING UNREIMBURSED MEDICAL EXPENSES?

◯ YES ◯ NO (If "No," skip to Section X)

45A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	45B. PAID TO (Name of provider, insurance company, nursing home, etc.)	45C.PURPOSE (Medicare premiums, nursing home, etc.)	45D. DATE PAID (MM/DD/YYYY)	45E. HOURLY RATE/HOURS (In-home Provider only)	45F. AMOUNT YOU PAY

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

CONTINUED

45A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	45B. PAID TO (Name of provider, insurance company, nursing home, etc.)	45C.PURPOSE (Medicare premiums, nursing home, etc.)	45D. DATE PAID (MM/DD/YYYY)	45E. HOURLY RATE/HOURS (In-home Provider only)	45F. AMOUNT YOU PAY

SECTION X: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, ***and*** attach either a voided personal check ***or*** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

46. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

◯ CHECKING ◯ SAVINGS ◯ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.:_____ Account No.:_____

47. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	48. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION XI: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.*

I certify I have enclosed all information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR,** I have checked the box in Item 49, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

49. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

○ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

50A. CLAIMANT'S SIGNATURE **(REQUIRED)**	50B. DATE SIGNED
X	

SECTION XII: WITNESSES TO SIGNATURE *(COMPLETE ONLY IF CLAIMANT SIGNED ITEM 50A WITH AN "X")*

51A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	51B. PRINTED NAME AND ADDRESS OF WITNESS
52A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	52B. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your response is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR A SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

(If "NO," continue to Step 2)

◯ YES ◯ NO (If "YES," ***all*** payments to the facility qualify as medical expenses in Items 45A thru 45F. You are finished completing this worksheet)

STEP 2. Do ***all*** of the following apply to the facility?
- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with caregivers.

◯ YES ◯ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

◯ YES ◯ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension or special monthly DIC in Item 37?

◯ YES ◯ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the ***primary reason*** you live in the facility (or attend day care in the facility)?

◯ YES ◯ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension or special monthly DIC. Please report the amount you pay the facility for lodging and meals separate from the amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** as medical expenses in Items 45A thru 45F. Skip to Step 8)
(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay the facility for: (1) ***health care services or assistance with ADLs provided by a health care provider***; and (2) ***custodial care***. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disabilty, and (2) describes the mental or physical disabilty)
(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 7. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the ***primary reason*** the disabled person lives in the facility (or attends day care in the facility)?

◯ YES ◯ NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)
(If "NO," ***only*** claim payments you pay the facility for assistance with ***health care and/or assistance with custodial care*** as medical expenses in Items 45A thru 45F. Payment to this facility for meals and lodging ***do not*** qualify)

STEP 8. Facility Certification: Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received.

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to _____
(Name of person staying at your facility)
and his or her care at this facility _____.
(Name and address of facility)

_____ _____
(Name, Signature and Title of Person Certifying for the Facility) (Date Certified)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: Only complete this worksheet if you are claiming expenses for in-home care.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.

Follow the steps below to determine whether or not:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care

STEP 1. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

◯ YES ◯ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension in Item 37?

◯ YES ◯ NO (If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to this in-home attendant ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 45A thru 45F amounts you pay an in-home attendant for: (1) health-care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs, and (3) custodial care. Skip to Step 6)

(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," the attendant ***must be a health care provider.*** Only report payments to the in-home attendant for ***health care services or assistance with ADLs*** provided by the health care provider as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs do not qualify as medical expenses. Skip to Step 6)

STEP 5. Is the ***primary responsibility*** of the in-home attendant to provide the disabled person with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 45A thru 45F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs ***do not*** qualify as medical expenses)

STEP 6. Check all activities below that the attendant assists the veteran or disabled person with:

ADLs: ◯ EATING ◯ BATHING/SHOWERING ◯ DRESSING ◯ TRANSFERRING ◯ USING THE TOILET

IADLs: ◯ SHOPPING ◯ FOOD PREPARATION ◯ HOUSEKEEPING ◯ LAUNDERING ◯ MANAGING FINANCES ◯ HANDLING MEDICATIONS ◯ USING THE TELEPHONE ◯ TRANSPORTANTION FOR NON-MEDICAL PURPOSES

STEP 7. **In-Home Attendant Certification**: Please submit a current breakdown of the time the attendant spends assisting the veteran or disabled person with health care services, ADLs and IADLs.

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and

reflects the current environment pertaining to _____
(Name of Person Requiring Care)

and his or her care from _____.
(Name of Attendant)

_____ _____
(Name, Signature and Title of Certifying Official) (Date Certified)

OMB Control No. 2900-0161
Respondent Burden: 30 minutes
Expiration Date: 12/31/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

MEDICAL EXPENSE REPORT

1. NAME OF VETERAN (First, Middle Initial, Last)

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER (If applicable)

4. NAME OF CLAIMANT (First, Middle Initial, Last)

5. CURRENT MAILING ADDRESS OF CLAIMANT (Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

6. CHANGE OF ADDRESS (Check box if address is different from last address furnished to VA)

YES NO

7. TELEPHONE NUMBER OF CLAIMANT (Include Area Code)

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS

9. MILEAGE FOR PRIVATELY OWNED VEHICLE TRAVEL FOR MEDICAL PURPOSES

Report miles traveled to a hospital, doctor, or other medical facility in a privately owned vehicle (POV) such as a car, truck, or motorcycle. Itemize travel occurring between the dates _____ and _____. If no dates appear on this line, refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX). We will calculate the allowable deduction for your mileage based on the current POV mileage reimbursement rate for automobiles specified by the United States General Services Administration (GSA).

NOTE: You may also claim deductions for other payments related to travel for medical purposes, such as taxi fares, buses, or other forms of public transportation. Report these types of medical travel expenses in Item 11.

A. MEDICAL FACILITY TO WHICH TRAVELED	B. TOTAL ROUNDTRIP MILES TRAVELED	C. AMOUNT REIMBURSED FROM ANOTHER SOURCE (Such as a VA Medical Center)	D. DATE TRAVELED (Month/Day/Year)	E. WHO NEEDED TO TRAVEL? (Self, spouse, child)
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	

IMPORTANT: Be sure to sign and date this form in Items 12A & 12B on page 4. Unsigned reports will be returned.

10. IN-HOME ATTENDANT EXPENSES

IMPORTANT - You must complete the attached In-Home Attendant Worksheet (page 5) to claim in-home attendant expenses.
Report amounts paid between the dates _ and . If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX).

A. NAME OF PROVIDER	B. HOURLY RATE/ NUMBER OF HOURS	C. AMOUNT PAID	D. DATE PAID (Month/Day/Year)	E. FOR WHOM PAID (Self, spouse, child, etc.)
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	

11. ITEMIZATION OF MEDICAL EXPENSES

IMPORTANT - If you are claiming expenses for care in an assisted living, adult day care, or a similar facility, you must complete the appropriate worksheet (page 6).
Report medical expenses that you paid between the dates _____ and _____. If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX).

A. MEDICAL EXPENSE (Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)	B. AMOUNT PAID	C. DATE PAID (Month/Day/Year)	D. NAME OF PROVIDER (Name of doctor, dentist, hospital, lab, etc.)	E. FOR WHOM PAID (Self, spouse, child, etc.)
MEDICARE (PART B)		Month Day Year		
MEDICARE (PART D)		Month Day Year		
PRIVATE MEDICAL INSURANCE		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		

11. ITEMIZATION OF MEDICAL EXPENSES *(Continued)*

IMPORTANT - If you are claiming expenses for care in an assisted living, adult day care, or a similar facility, you must complete the appropriate worksheet (page 6). Report medical expenses that you paid between the dates _____ and _____. If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX).

A. MEDICAL EXPENSE (Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)	B. AMOUNT PAID	C. DATE PAID (Month/Day/Year)	D. NAME OF PROVIDER (Name of doctor, dentist, hospital, lab, etc.)	E. FOR WHOM PAID (Self, spouse, child, etc.)
MEDICARE (PART B)		Month Day Year		
MEDICARE (PART D)		Month Day Year		
PRIVATE MEDICAL INSURANCE		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		
OTHER MEDICAL EXPENSE (Provide other expense in space below) (i.e., travel for medical purposes by taxi, bus, etc.)		Month Day Year		

CERTIFICATION: I have not and will not receive reimbursement for these expenses. I certify that the above information is true.

12A. SIGNATURE OF CLAIMANT *(Do NOT print)*	12B. DATE SIGNED (MM/DD/YYYY)
X	☐☐/☐☐/☐☐☐☐

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Attachment to VA Forms 21P-527, 21P-527EZ, 21P-534, and 21P-534EZ)

IMPORTANT: This ***is not*** a stand-alone form. Only complete this attachment if you are directed to do so when you complete ***one*** of the following:
(1) Section VI on VA Form 21P-527 or Section VIII on VA Form 21P-527EZ.
(2) Section VII on VA Form 21P-534 or Section VIII on VA Form 21P-534EZ.

VETERAN/CLAIMANT PERSONAL INFORMATION		
1. VETERAN'S NAME *(Last, First, Middle)*	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S FILE NUMBER *(If known)*
4. CLAIMANT'S NAME *(Last, First, Middle)*	5. CLAIMANT'S SOCIAL SECURITY NUMBER	6. CLAIMANT'S TELEPHONE NUMBER

7. TYPE OF CLAIMANT *(Check only one box)*
☐ VETERAN ☐ SURVIVING SPOUSE ☐ SURVIVING CHILD ☐ PARENT

IMPORTANT INFORMATION FOR CLAIMANTS

NOTE - The term **"assets"** means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of your or your dependent's primary residence including the residential lot area, not to exceed 2 acres) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

If you are a **Veteran**, you must report income and assets for:
- yourself
- your spouse (***unless*** you live apart ***and*** you are estranged ***and*** you do not contribute to your spouse's support)
- your child or children (***unless*** you do not have custody* ***and*** you do not contribute to your child's or children's support)

If you are a **Surviving Spouse,** you must report income and assets for:
- yourself
- any child of the veteran who is in your custody*

If you are a **Surviving Child** or the **Custodian of a Surviving Child**, you must report income and assets for the:
- child
- child's custodian (unless the child's custodian is an institution)
- custodian's spouse

If you are a **Parent**, you must report income** for:
- yourself
- your spouse (even if your spouse is the veteran's other parent. If your spouse is the veteran's other parent, you must ***both*** file claims)

*Child custody for pension purposes is defined in 38 C.F.R. § 3.57(d). A natural or adoptive parent has custody of a child unless custody is legally removed. For pension purposes, a child who has attained age 18 remains in the custody of the person who had custody before the child turned age 18 unless custody is legally removed.

** Parent's DIC claimants do ***not*** need to ***report*** or ***provide*** documentation of their assets.

FEES FOR CLAIMS: Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

NOTICE

IMPORTANT: VA will compare the information you report on this form to Internal Revenue Service (IRS) and Social Security Administration (SSA) records to verify your income for the past three tax years for which information is available. Information from the IRS or SSA that conflicts with the income information you provide with your application may delay your claim and/or reduce your benefit amount.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your response is required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at: www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0829
Respondent Burden: 25 minutes
Expiration Date: 12/31/2024

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Attachment to VA Forms 21P- 527, 21P-527EZ, 21P-534, and 21P-534EZ)

SECTION I: RETIREMENT INCOME AND DISTRIBUTIONS *(If additional space is needed attach a separate sheet)*

1. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS INCLUDING, BUT NOT LIMITED TO, DISTRIBUTIONS FROM A RETIREMENT PLAN, SUCH AS:

- Military Retirement
- Civil Service Retirement
- IRA
- SEP
- Qualified Plans
- Pensions
- Annuities
- Black Lung

☐ YES ☐ NO *(If "No," skip to Section II)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHO IS THE INCOME PAYER? *(Name of business, financial institution, etc.)*	C. WHAT IS YOUR CURRENT AND/OR EXPECTED INCOME? *(Provide documentation of current income and expected income changes)*	D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME? *(Provide documentation of assets)*
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	

SECTION II - UNEMPLOYMENT INCOME *(If additional space is needed attach a separate sheet)*

2. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE UNEMPLOYMENT INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section III)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED UNEMPLOYMENT INCOME? *(Provide documentation of current income and expected income changes)*
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $

SECTION III - SAVINGS BONDS *(If additional space is needed attach a separate sheet)*

3. DO YOU OR YOUR DEPENDENTS OWN A SAVINGS BOND OR RECEIVE OR EXPECT TO RECEIVE INTEREST FROM A SAVINGS BOND WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section IV)*

A. WHO OWNS THE SAVINGS BOND? *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED ANNUAL INCOME *(interest earned)*? *(Attach a copy of the savings bond)*	C. WHAT IS THE CURRENT FACE VALUE OF THE SAVINGS BOND?
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$

SECTION IV - RENTAL PROPERTY, FARM OR BUSINESS INCOME *(If additional space is needed attach a separate sheet)*

4. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INCOME FROM RENTAL PROPERTY, FARM OR BUSINESS WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section V)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	**B. WHAT IS YOUR OR YOUR DEPENEDENTS CURRENT OR EXPECTED INCOME FROM THIS SOURCE?** *(Provide documentation of current income and expected income changes)*	**C. WHAT KIND OF INCOME IS THIS?** *(Check applicable box)*	**D. WHAT IS THE VALUE OF YOUR PORTION OF THE PROPERTY, FARM, OR BUSINESS?** *(Note: Subtract the amount of Mortgages or other encumbrances specific to the property. Provide available documentation)*
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$

SECTION V - INTEREST, ROYALTIES, AND DIVIDENDS *(If additional space is needed attach a separate sheet)*

5. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INTEREST, DIVIDENDS, OR ROYALTIES WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section VI)*

IMPORTANT: Do ***not*** report income you have already reported in Section III (Savings Bonds) or Section IV (Rental Property, Farm or Business Income).

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	**B. WHO IS THE INCOME PAYER?** *(Name of business, financial institution, etc.)*	**C. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED INCOME?** *(Provide documentation of current income and expected income changes)*	**D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME?** *(Provide documentation of assets)*
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	

SECTION VI - WAGES - INCLUDING SELF-EMPLOYMENT *(If additional space is needed attach a separate sheet)*

6. ARE YOU OR YOUR DEPENDENTS RECEIVING WAGES OR EXPECTING TO RECEIVE WAGES WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section VII)*

A. WAGE RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHAT ARE YOUR OR YOUR DEPENDENTS CURRENT WAGES AND/OR EXPECTED WAGES? *(Provide documentation of current wages and expected wage changes)*
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $

SECTION VII - DISCONTINUED INCOME IN THE PRIOR TAX YEAR *(If additional space is needed attach a separate sheet)*

7. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME ***LAST YEAR*** THAT IS NO LONGER BEING RECEIVED OR WAS A ONE-TIME PAYMENT?

☐ YES ☐ NO *(If "No," skip to Section VIII)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	**B. WHO WAS THE INCOME PAYER?** *(Name of business, financial institution, etc.)*	**C. WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?**	**D. WHEN DID THE INCOME STOP?** *(MM/DD/YYYY)*
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	

NOTE: Parent's DIC Claimants Only - You ***do not*** have to complete Sections VIII thru XI. Return to the application form. Your certification, signature and date on the application form applies to this attachment.

Pension Claimants - Continue to complete the attachment.

SECTION VIII - ASSETS PREVIOUSLY NOT REPORTED *(If additional space is needed attach a separate sheet)*

8. DO YOU OR YOUR DEPENDENTS HAVE ASSETS ***NOT*** ALREADY REPORTED, SUCH AS NON-INTEREST-BEARING ACCOUNTS, CASH, STOCKS, BONDS, OR REAL ESTATE?

☐ YES ☐ NO *(If "No," skip to Section IX)*

A. ASSET OWNER *(Veteran, Spouse, Child, Parent, Custodial, etc.)*	B. WHAT IS THE CURRENT CASH VALUE OF THE ASSET? *(Provide a bank or other official statement showing the current value. Do not report assets you have already reported in Sections I through VII)*	C. AMOUNT OWED ON THE ASSET OR AMOUNT MORTGAGED OR OTHERWISE ENCUMBERED? *(Provide documentation of mortgages or other encumbrances)*
	$	$
	$	$
	$	$
	$	$

SECTION IX - ASSET TRANSFERS *(If additional space is needed attach a separate sheet)*

9. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ASSETS?

☐ YES ☐ NO *(If "No," skip to Section X)*

A. WHO OWNED THE ASSET? *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER *(Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)*
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER *(Explain below)*	Name: Relationship:	Was the asset transferred for less than fair market value? ☐ YES ☐ NO Was an asset reported to the IRS sold? ☐ YES ☐ NO What was the original purchase price? What was the sale price? What date was the asset sold? *(MM/DD/YYYY)* What was the gain (capital gain, etc.)?
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER *(Explain below)*	Name: Relationship:	Was the asset transferred for less than fair market value? ☐ YES ☐ NO Was an asset reported to the IRS sold? ☐ YES ☐ NO What was the original purchase price? What was the sale price? What date was the asset sold? *(MM/DD/YYYY)* What was the gain (capital gain, etc.)?

SECTION IX: ASSET TRANSFERS *(Continued)*

A. WHO OWNED THE ASSET? *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER *(Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)*
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER *(Explain below)*	Name: Relationship:	Was the asset transferred for less than fair market value? ☐ YES ☐ NO Was an asset reported to the IRS sold? ☐ YES ☐ NO What was the original purchase price? What was the sale price? What date was the asset sold? *(MM/DD/YYYY)* What was the gain (capital gain, etc.)?
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER *(Explain below)*	Name: Relationship:	Was the asset transferred for less than fair market value? ☐ YES ☐ NO Was an asset reported to the IRS sold? ☐ YES ☐ NO What was the original purchase price? What was the sale price? What date was the asset sold? *(MM/DD/YYYY)* What was the gain (capital gain, etc.)?

SECTION X: ANNUITIES AND TRUSTS *(Attach a separate sheet if more than one annuity or trust is involved)*

10A. IN THE CURRENT YEAR OR THE PRIOR THREE TAX YEARS, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS TO A TRUST OR PURCHASE AN ANNUITY?

☐ YES ☐ NO *(If "No," skip to Section XI)*

10B. WHAT WAS THE MARKET VALUE OF THE ASSET AT THE TIME OF TRANSFER OR ANNUITY PURCHASE? $

10C. WHAT WAS THE DATE THE ASSET WAS TRANSFERRED? *(MM/DD/YYYY)*

10D. DID YOU PURCHASE AN ANNUITY WITH THE ASSETS?	10E. PROVIDE DATE OF PURCHASE *(MM/DD/YYYY)*	10F. PROVIDE NAME OF PERSON THE ASSET WAS PURCHASED FROM *(First-Middle-Last)*
☐ YES ☐ NO *(If "Yes," complete Items 10E through 10G)*		

10G. PROVIDE TYPE OF ANNUITY PURCHASED *(Give details and attach documentation)*

10H. WERE THE ASSETS USED TO ESTABLISH A TRUST?	10I. PROVIDE TAX NUMBER	10J. PROVIDE DETAILS AND ATTACH DOCUMENTATION
☐ YES ☐ NO *(If "Yes," complete Items 10I through 10J)*		

10K. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?

☐ YES ☐ NO

SECTION XI - WAIVER OF RECEIPT OF INCOME *(If additional space is needed attach a separate sheet)*

11. DID YOU OR YOUR DEPENDENTS WAIVE OR EXPECT TO WAIVE ANY RECEIPT OF INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "NO," skip this section. This attachment is complete. Return to the application. Your certification, signature and date on the application form applies to this attachment)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	**B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED WAIVED INCOME?** *(Provide documentation of income and expected income changes)*
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $

THIS *ATTACHMENT FORM* IS COMPLETE. RETURN TO THE *APPLICATION FORM*. YOUR CERTIFICATION, SIGNATURE AND DATE ON THE APPLICATION FORM APPLIES TO THIS ATTACHMENT.

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 09-30-2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

IMPORTANT: Please read Privacy Act and Respondent Burden information before completing the form.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM-DD-YYYY)* — —

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. SEX
- ◯ MALE
- ◯ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)* — —

8. E-MAIL ADDRESS *(Optional)*

9. PREFERRED MAILING ADDRESS *(Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

SECTION II: CLAIM INFORMATION

10. CLAIMANT'S NAME (First, Middle Initial, Last) (Complete only if you are not the veteran)

11. CLAIMANT'S SOCIAL SECURITY NUMBER — —

12. RELATIONSHIP OF CLAIMANT TO VETERAN
◯ SPOUSE ◯ SELF

13. CLAIMANT'S HOME ADDRESS

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

14. BENEFIT YOU ARE APPLYING FOR (*Choose One*)

◯ **Special Monthly Compensation (SMC) -** Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid without eligibility to compensation.

◯ **Special Monthly Pension (SMP) -** Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

SECTION III: INFORMATION OF EXAMINATION

15. DATE OF EXAMINATION *(MM-DD-YYYY)* — —

16A. IS CLAIMANT HOSPITALIZED?
◯ YES ◯ NO *(If "Yes," complete Items 16B, 17A & 17B)*

16B. DATE ADMITTED *(MM-DD-YYYY)* — —

17A. NAME OF HOSPITAL

17B. ADDRESS OF HOSPITAL

PATIENT/VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

17C. COMPLETE DIAGNOSIS (Diagnosis needs to equate to the level of assistance described in questions 25 through 39)

18A. AGE

18B. WEIGHT

ACTUAL LBS. ESTIMATED LBS.

18C. HEIGHT

FEET INCHES

19. NUTRITION

20. GAIT

21. BLOOD PRESSURE

22. PULSE RATE

23. RESPIRATORY RATE

24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? (Fill in Circle. If "No," provide explanation)

○ YES ○ NO

27. IS CLAIMANT ABLE TO PREPARE THEIR OWN MEALS? (Fill in Circle. If "No," provide explanation)

○ YES ○ NO

28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? (If "Yes," provide explanation)

○ YES ○ NO

29A. IS THE CLAIMANT LEGALLY BLIND? (If "Yes," provide explanation)

○ YES ○ NO

29B. CORRECTED VISION

LEFT EYE RIGHT EYE

30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

○ YES ○ NO

31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? (If "Yes," provide explanation)

○ YES ○ NO

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? (If "No," provide examples and rationale to support your conclusion)

○ YES ○ NO

PATIENT/VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

33. DESCRIBE POSTURE AND GENERAL APPEARANCE (Attach a separate sheet of paper if additional space is needed)

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE (Attach a separate sheet of paper if additional space is needed)

35. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREEMITY.

36. DESCRIBE RESTRICTION OF SPINE, TRUNK AND NECK

37. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

38. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

39. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? (If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 38 above)

◯ YES ◯ NO (If "YES," give distance) (Check applicable box or specify distance) ◯ 1 BLOCK ◯ 5 OR 6 BLOCKS ◯ 1 MILE OTHER (Specify distance) ____

SECTION IV: CERTIFICATION AND SIGNATURE

40A. PRINTED NAME OF PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED *(MM-DD-YYYY)*
		__ – __ – ____

41. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	42A. TELEPHONE NUMBER OF MEDICAL FACILITY
	___ – ___ – ____

42B. NAME OF MEDICAL FACILITY	42C. ADDESS OF MEDICAL FACILITY

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet pate at **http://www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 08/31/2023

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

REQUEST FOR NURSING HOME INFORMATION IN CONNECTION WITH CLAIM FOR AID AND ATTENDANCE

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden. We use this form to determine eligibility in connection with a claim for aid and attendance. For more information, contact us at **https://iris.custhelp.va.gov**, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at **www.va.gov/vaforms**. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547- 4444.**

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* — —

SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION *(Complete this section ONLY IF the claimant is NOT the veteran)*

5. CLAIMANT'S NAME *(First, Middle Initial, Last)*

6. SOCIAL SECURITY NUMBER — —

7. VA FILE NUMBER *(If applicable)*

8. DATE OF BIRTH *(MM/DD/YYYY)* — —

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

10. ADDRESS OF NURSING HOME *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

SECTION IV - GENERAL INFORMATION *(To be completed by a Nursing Home Official)*

NOTE: Your state's Medicaid program may use a different name.

11. DATE ADMITTED TO NURSING HOME *(MM/DD/YYYY)* — —

12. IS THE NURSING HOME A MEDICAID APPROVED FACILITY?
○ YES ○ NO

13. HAS THE PATIENT APPLIED FOR MEDICAID?
○ YES ○ NO

14A. IS THE PATIENT COVERED BY MEDICAID?
○ YES ○ NO *(If "YES," complete Item 14B)*

14B. DATE MEDICAID PLAN BEGAN *(MM/DD/YYYY)* — —

15. MONTHLY AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET $

16. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: *(Check one)*
○ SKILLED NURSING CARE ○ INTERMEDIATE NURSING CARE

17. NURSING HOME OFFICIAL'S NAME *(First and Last)*

18. NURSING HOME OFFICIAL'S TITLE

19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)* — —
Enter International Phone Number *(If applicable)*

SECTION V - CERTIFICATION AND SIGNATURE

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

20. SIGNATURE OF NURSING HOME OFFICIAL *(REQUIRED)*

21. DATE SIGNED *(MM/DD/YYYY)* — —

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

County of Cambria

Assisted Living Facility Verification

_____
Veteran's Name (Last, First, Middle)

_____
VA Claim # or Veteran's Social Security #

_____
Claimant's Name (Last, First, Middle)

I would like to verify that _____ has been a resident at
Claimant's Name

_____ since _____.
Facility Name Admission Date

The total monthly rate for services is $ _____. Of that amount room and board costs are $ _____ and medical costs are $ _____.

The facility provides the following assistance to the claimant:

☐ Eating ☐ Bathing/Showering ☐ Dressing ☐ Transferring ☐ Using the Toilet

☐ Shopping ☐ Food Preparation ☐ Housekeeping ☐ Laundering ☐ Managing Finances

☐ Handling Medications ☐ Using the Telephone ☐ Transportation (non-medical)

Other (Explain) _____
_____

I certify that the information concerning the facility, and the claimant's residency, costs, and care are accurate as of _____.
Date

_____ _____
Authorized Facility Representative's Signature Facility's Street Address

_____ _____
Authorized Facility Representative's Name Facility's City, State, & Zip Code

_____ _____
Authorized Facility Representative's Title Facility's Area Code & Phone Number

County of Cambria

ATTENDANT AFFIDAVIT

_____
Veteran's Name (Last, First, Middle)

_____
VA Claim # or Veteran's Social Security #

_____
Claimant's Name (Last, First, Middle)

_____

_____
Claimant's Mailing Address

_____
Claimant's City, State and Zip Code

My name is _____. I provide in home care for the above named claimant.

I provide the following assistance to the claimant:

☐ Eating ☐ Bathing/Showering ☐ Dressing ☐ Transferring ☐ Using the Toilet

☐ Shopping ☐ Food Preparation ☐ Housekeeping ☐ Laundering ☐ Managing Finances

☐ Handling Medications ☐ Using the Telephone ☐ Transportation (non-medical)

Other (Explain) _____

_____

For these services I was paid by the claimant $_____ from _____ to _____
The amount is $_____ a month.

I began providing the claimant assistance for payment on _____

_____
Provider's Signature

_____
Provider's Street Address

_____
Provider's Area Code & Phone Number

_____
Provider's City, State, Zip Code

_____
Date Signed

OMB Approved No. 2900-0736
Respondent Burden: 5 minutes
Expiration Date: 04/30/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs (VA) permission to release your personal beneficiary or claim information to a third party. This form ***may not be executed*** by any beneficiary recognized as incompetent for VA purposes, nor can VA ***accept*** this form from any beneficiary recognized as incompetent for VA purposes.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may ***either*** complete the form online or by hand. If completed by hand print the information requested in ink, neatly, and legibly to expedite processing the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER *(If known)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* — —

5. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II - BENEFICIARY/CLAIMANT'S IDENTIFICATION INFORMATION

6. NAME OF BENEFICIARY/CLAIMANT WHO IS ***NOT*** THE VETERAN *(First, Middle Initial, Last)*

7. ADDRESS OF BENEFICIARY/CLAIMANT *(Number and Street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

8. TELEPHONE NUMBER *(Include Area Code)* — —

Enter International Phone Number *(If applicable)*

9. EMAIL ADDRESS *(Optional)* ◯ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III - CONTACT INFORMATION

10. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION SPECIFIED BELOW TO ONE PERSON ***OR*** ONE ORGANIZATION LISTED BELOW. PROVIDE THE NAME AND ADDRESS OF THE PERSON YOU HAVE CHOSEN TO RECEIVE INFORMATION FROM VA IN ITEMS 10A AND 10B ***OR*** PROVIDE THE NAME AND ADDRESS OF THE ORGANIZATION YOU HAVE CHOSEN AND THE NAME OF THE ORGANIZATION'S REPRESENTATIVE IN ITEMS 10C AND 10D.

A. NAME OF PERSON *(First, Middle Initial, Last Name)*

B. ADDRESS OF PERSON

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

NOTE: An organization may have more than one representative. Include the first and last name of any additional representatives.

C. NAME OF ORGANIZATION *(Include name of representative(s))*

VETERAN'S SSN ___ – ___ – ____

D. ADDRESS OF ORGANIZATION

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code –

11. I, THE BENEFICIARY/CLAIMANT AUTHORIZE VA TO CONTACT THE PERSON ***OR*** ORGANIZATION LISTED IN ITEM 10A OR 10C FOR THE PURPOSE OF PROVIDING THE FOLLOWING INFORMATION PERTAINING TO MY VA RECORD *(Check only one box below to tell VA the specific benefit or claim information you want disclosed)*

◯ LIMITED INFORMATION (Go to Item 12) ◯ ANY INFORMATION (Go to Item 13)

12. IF YOU SELECTED "LIMITED INFORMATION", FILL ALL THAT APPLY

◯ Status of pending claim or appeal ◯ Amount of money owed VA ◯ Other (Specify below)

◯ Current benefit and rate ◯ Request a benefit payment letter

◯ Payment history ◯ Change of address or direct deposit

13. IF YOU SELECTED "ANY INFORMATION", THE TERMS OF SUCH RELEASE OF INFORMATION WILL BE:

◯ One time only ◯ From the date of signing below until – – *(Specify date - MM, DD, YYYY)*

◯ Ongoing until written notice is given to VA to terminate

14. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY ***ONE*** SECURITY QUESTION BOX IN ITEM 14A AND PROVIDE THE ANSWER IN ITEM 14B.

A. SECURITY QUESTION	B. ANSWER
◯ The city and state your mother was born in	
◯ The name of the high school you attended	
◯ Your first pet's name	
◯ Your favorite teacher's name	
◯ Your father's middle name	

SECTION IV - DECLARATION OF INTENT

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

15. VETERAN SIGNATURE (REQUIRED)

16. DATE SIGNED *(MM,DD,YYYY)* – –

PRIVACY ACT INFORMATION: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain.** If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.