ENCLOSED IS THE REQUESTED PACKET TO APPLY FOR VA BENEFITS.

PLEASE COMPLETE AND SEND THE FOLLOWING FORMS AS SOON AS POSSIBLE – THESE FORMS RESERVE THE DATE OF INTENT TO FILE:

- VA FORM 21-0966 (INTENT TO FILE)
- VA FORM 21-22 (POWER OF ATTORNEY)
- MILITARY DISCHARGE PAPERS

ALL ADDITIONAL PAPERWORK MAY BE COMPLETED AND MAILED AT YOUR CONVENIENCE WITHIN ONE YEAR.

THANK YOU

ANY QUESTIONS, CALL 412-395-6230

527EZ – NON-SERVICE CONNECTED PENSION

THE AMERICAN LEGION
DEPARTMENT OF PENNSYLVANIA
Federal Building, 1000 Liberty Avenue
Suite 1607
Pittsburgh, PA 15222
Telephone: (412) 395-6230 Fax (412) 395-6234

In order to file for **Fully Developed Claims (NSC Pension)** with the VA, we need the following documents:

1. _____ The ***original or a court-certified*** copy of the veteran's discharge papers.
2. _____ A ***copy*** of all marriage certificates and divorce decrees.
3. _____ A ***copy*** of spouses death certificate (if applicable)
4. _____ A ***copy*** of a recent bank statement.
5. _____ A ***copy*** of the most recent Social Security Award Letter.
6. _____ VA form 21-22 (Power of Attorney)
7. _____ VA form 21P-527EZ (Application) must be completed in as much detail as possible and signed. **Do NOT fill in any spaces with "N/A", use "$0" for dollar amounts that do not apply or write NONE.**
8. _____ VA form 21P-0969 (Income & Asset Statement in Support of Claim. . .) must be completed if required.
9. _____ VA form 21-2680 (Exam for HB or A&A) must be completed by your doctor in detail.
10. _____ VA form 21-686c (Declaration or Status of Dependents)
11. _____ A statement from the facility or care-giver showing the amount you pay for their care to include **Activities of Daily Living (ADL's)** and a start date/admittance date. The facility also completes VA form 21-0779.
12. _____ **AT HOME CARE-GIVERS must complete** Statement of Care – shows proof of ADL's and payment of care.
13. _____ If a diagnosis of Dementia or Alzheimer's is listed on the doctor's exam report, please complete the enclosed VA form 21-4138 (Due Process Waiver) and (can the VA Appoint a Fiduciary Now sheet).

Read the forms carefully and fill out as completely as possible. **Try not to leave anything blank.

****PLEASE COMPLETE PAPERWORK IN IT'S ENTIRETY AS INCOMPLETE PAPERWORK WILL DELAY THE PROCESSING OF YOUR CLAIM.**

****Claimant** must sign all forms *except* forms **21-2680** and **21-0779**. If claimant is unable to sign, they must make an "X" that is witnessed and signed by two people. A person who is a POA cannot sign for the claimant.

Please send these items to the above address as soon as possible. If you need assistance completing any of the above forms, please call our office at 412-395-6230.

Graham H. Wieland
Department Service Officer
The American Legion

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 08/31/2018

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, " Appointment of Individual as Claimant's Representative." VA Forms are available at www.va.gov/vaforms.

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM.

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER *(Include prefix)*

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

AMERICAN LEGION

3B. NAME AND JOB TITLE OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 3A *(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)*

GRAHAM H. WIELAND, DSO, AMERICAN LEGION

3C. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 3A

GRAHAM.WIELAND@VA.GOV

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER (OR SERVICE NUMBER, IF NO SSN)	5. INSURANCE NUMBER(S) *(Include letter prefix)*
6. NAME OF CLAIMANT *(If other than veteran)*	7. RELATIONSHIP TO VETERAN
8. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*	9. CLAIMANT'S TELEPHONE NUMBERS *(Include Area Code)*
	A. DAYTIME / B. EVENING
	10. EMAIL ADDRESS *(If applicable)*
	11. DATE OF THIS APPOINTMENT

12. 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 3A 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 above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT - I authorize disclosure of records related to treatment for all conditions listed in Item 12 except:

☐ DRUG ABUSE
☐ ALCOHOLISM OR ALCOHOL ABUSE
☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
☐ SICKLE CELL ANEMIA

14. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 3A to act on my behalf to change my address in my VA records.

☐ I authorize any official representative of the organization named in Item 3A 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 3A is not my appointed fiduciary.

I, the claimant named in Items 1 or 6, hereby appoint the service organization named in Item 3A 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 12 and 13), 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 20.608. *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.

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

15. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	16. DATE SIGNED
17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B *(Do Not Print)*	18. DATE SIGNED

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)*

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.

RECOGNIZED SERVICE ORGANIZATIONS

Membership in an organization is not a prerequisite to appointment of the organization as claimant's representative.

The following is a listing of national, regional, or local organizations recognized by the Secretary of Veterans Affairs in the preparation, presentation, and prosecution of claims under laws administered by the Department of Veterans Affairs.

African American PTSD Association
American Legion
American Red Cross
AMVETS
American Ex-Prisoners of War, Inc.
American GI Forum, National Veterans Outreach Program
Armed Forces Services Corporation
Army and Navy Union, USA
Associates of Vietnam Veterans of America
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Disabled American Veterans
Fleet Reserve Association
Gold Star Wives of America, Inc.
Italian American War Veterans of the United States, Inc.
Jewish War Veterans of the United States
Legion of Valor of the United States of America, Inc.
Marine Corps League
Military Officers Association of America (MOAA)
Military Order of the Purple Heart
National Amputation Foundation, Inc.
National Association of County Veterans Service Officers, Inc.
National Association for Black Veterans, Inc.
National Veterans Legal Services Program
National Veterans Organization of America
Navy Mutual Aid Association
Paralyzed Veterans of America, Inc.
Polish Legion of American Veterans, U.S.A.
Swords to Plowshares, Veterans Rights Organization, Inc.
The Retired Enlisted Association
The Veterans Assistance Foundation, Inc.
The Veterans of the Vietnam War, Inc. & The Veterans Coalition
United Spanish War Veterans of the United States
United Spinal Association, Inc.
Veterans of Foreign Wars of the United States
Veterans of World War I of the U.S.A., Inc.
Vietnam Era Veterans Association
Vietnam Veterans of America
West Virginia Department of Veterans Assistance
Wounded Warrior Project

Although agency titles vary, the following States and possessions maintain veterans service agencies which are recognized to present claims.

Alabama	Hawaii	Minnesota	North Dakota	Tennessee
American Samoa	Idaho	Mississippi	Northern Mariana Islands	Texas
Arizona	Illinois	Missouri	Ohio	Utah
Arkansas	Iowa	Montana	Oklahoma	Vermont
California	Kansas	Nebraska	Oregon	Virginia
Colorado	Kentucky	Nevada	Pennsylvania	Virgin Islands
Connecticut	Louisiana	New Hampshire	Puerto Rico	Washington
Delaware	Maine	New Jersey	Rhode Island	West Virginia
Florida	Maryland	New Mexico	South Carolina	Wisconsin
Georgia	Massachusetts	New York	South Dakota	Wyoming
Guam	Michigan	North Carolina		

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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is considered relevant and necessary to recognize a service organization as your representative and/or identify disclosable records. 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. 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 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 recognize the service organization you name to act on your behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902). We will also use the information to identify any VA records that we may disclose to the service organization (38 U.S.C. 5701(b)). 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.

OMB Control No. 2900-0826
Respondent Burden: 15 minute
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 through eBenefits at www.ebenefits.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

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 Vocational Rehabilitation 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.

Department of Veterans Affairs

NOTICE TO VETERAN OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR VETERANS PENSION BENEFITS

(This notice is applicable to veterans claims for: Veterans Pension (a needs based benefit) • Special Monthly Pension • Benefits Based on a Veteran's Seriously Disabled Child)

Use this notice and the attached application to submit a claim for veterans pension. This notice informs you of the evidence necessary to substantiate your claim.

Want your claim processed faster? The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed and there is no risk to participate! To participate in the FDC Program, if you are making a claim for veterans pension, simply submit your claim in accordance with the "FDC Criteria" shown below. If you are making a claim for veterans disability compensation or related compensation benefits, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. If you are making a claim for survivor benefits, use VA Form 21P-534EZ, *Application for DIC, Survivor's Pension, and/or Accrued Benefits*. VA forms are available at www.va.gov/vaforms.

FDC Criteria (Claim(s) for Veterans Pension Benefits

1. Submit your claim on a signed and completed VA Form 21P-527EZ, *Application for Veterans Pension* (attached).

2. Submit simultaneously with your claim:

   - All necessary income and asset information; AND
   - All, if any, relevant, private medical treatment records and an identification of any relevant treatment records available at a Federal facility, such as a VA medical center.

   Note: Read the Important note below and attach current medical evidence showing that you are permanently and totally disabled, if necessary.

   IMPORTANT: If you are a veteran who is claiming pension and you are age 65 or older, or determined to be disabled by the Social Security Administration, you DO NOT have to submit medical evidence with your application unless you are claiming special monthly pension. Special monthly pension is an increased amount paid to individuals who, due to mental or physical disability, require the aid of another person to perform activities of daily living, are a patient in a nursing home, have severe visual problems, or are substantially confined to his or her home.

   Special Circumstances

   Under the special circumstances shown below, you must also submit simultaneously with your claim:

   - **If claiming veterans pension with special monthly pension,** a completed VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*, or (if a patient in a nursing home) a completed VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance;*
   - **If claiming a child in school between the ages of 18 and 23,** a completed VA Form 21-674, *Request for Approval of School Attendance;*
   - **If claiming benefits for a seriously disabled child,** all, if any, relevant, private medical treatment records for the child's pertinent disabilities.

3. Report for any VA medical examinations VA determines are necessary to decide your claim.

The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed, and there is no risk to participate! Participation in the FDC Program is optional and will not affect the quality of care you receive or the benefits to which you are entitled. If you file a claim in the FDC Program and it is determined that other records exist and VA needs the records to decide your claim, then VA will simply remove the claim from the FDC Program (Optional Expedited Process) and process it in the Standard Claim Process. See below for more information. If you wish to file your claim in the FDC Program, see FDC Program (Optional Expedited Process). If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process.

WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession.

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Submit your claim in accordance with the "FDC Criteria" (see page 1)	You must: • If you know of evidence not in your possession and want VA to try to get it for you, give VA enough information about the evidence so that we can request it from the person or agency that has it If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. ***It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.***

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

FDC Program (Optional Expedited Process)	Standard Claim Process
VA will: • Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain • Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim	VA will: • Retrieve relevant records from a Federal facility such as a VA medical center, that you adequately identify and authorize VA to obtain • Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim • Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from State or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records or records from current or former employers

WHEN YOU SHOULD SEND WHAT WE NEED

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Send the information and evidence simultaneously with your claim If you submit additional information or evidence after you submit your "fully developed" claim, then VA will remove the claim from the FDC Program Expedited Process and process it in the Standard Claim Process. If we decide your claim before one year from the date we receive the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.	You are strongly encouraged to: • Send any information or evidence as soon as you can You have up to one year from the date we receive the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we receive the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim.

WHERE TO SEND INFORMATION AND EVIDENCE

When you have completed this application, mail *or* fax it to the appropriate Pension Center listed on Page 10. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and all supporting material you submit to VA before mailing or faxing it.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See the evidence table titled...
Veterans Pension (a needs-based benefit)	Veterans Pension
Special Monthly Pension	Veterans Pension with Special Monthly Pension
Benefits because your child is severely disabled	Child Incapable of self-support

EVIDENCE TABLES

Veterans Pension

To support a claim for **veterans pension**, the evidence must show:

1. You met certain minimum active service requirements during a period of war. Generally, those requirements are:

   - 90 days of service during a period of war; OR
   - 90 days of consecutive service at least one day of which was during a period of war; OR
   - 90 days of combined service during more than one period of war:

   (Note: If your service began after September 7, 1980, additional length of service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligation)

   - OR, any length of active service during a period of war with a discharge due to a service-connected disability

2. You are age 65 or older *or* are permanently and totally disabled. Your disability or disabilities do not have to be related to your military service. You are considered permanently and totally disabled if medical evidence shows you are:

   - A patient in a nursing home for long-term care or medical foster home; OR
   - Receiving Social Security disability benefits; OR
   - Unemployable due to a disability reasonably certain to continue throughout your lifetime; OR
   - Suffering from a disability that is reasonably certain to continue throughout your lifetime that would make it impossible for an average person to follow a substantially gainful occupation; OR
   - Suffering from a disease or disorder that VA determines causes persons who have that disease or disorder to be permanently and totally disabled

3. Your income and assets are within established limits. 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 (unless custody has been legally removed by a court and you do not contribute to your child's support *or* the child's income is not reasonably available to you).

   Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the 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.

Veterans Pension with Special Monthly Pension

To support a claim for **increased pension eligibility based on the need for aid and attendance**, the evidence must show:

- You have corrected visual acuity of 5/200 or less in both eyes; OR
- You have concentric contraction of the visual field to 5 degrees or less; OR
- You are a patient in a nursing home due to mental or physical incapacity; OR
- You need the aid of another person to perform activities of daily living (ADLs), such as bathing or showering, dressing, eating, toileting, and transferring (e.g. getting in and out of bed); OR
- You require regular supervision because you are unsafe if you are left alone due to a mental disorder, OR
- You are bedridden, in that your disability requires that you remain in bed apart from any prescribed course of convalescence or treatment.

To support your claim for **increased pension eligibility based on being housebound**, the evidence must show:

- You have a single permanent disability evaluated as 100 percent disabling; AND due to such disability, you are permanently and substantially confined to your immediate premises; OR
- You have a single permanent disability evaluated as 100 percent disabled, AND you have an additional disability or disabilities rated 60 percent or higher.

Child Incapable of Self-Support

To support a claim for **benefits based on a veteran's child being incapable of self-support**, the evidence must show that the child, before his or her 18th birthday, became permanently incapable of self-support due to a mental or physical disability.

IMPORTANT

If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognized marriages is available at http://www.va.gov/opa/marriage/.

How VA Determines the Effective Date

If we grant your claim, the beginning date of your entitlement will generally be based on when we received your claim.

Special monthly pension may be assigned for disabilities that affect your ability to perform certain activities of daily living or the ability to leave your home. Special monthly pension may be effective from the date the medical evidence first shows entitlement.

For more information on the FDC Program, visit our web site at http://benefits.va.gov/transformation/fastclaims/.
For more information on VA benefits, visit our web site at www.va.gov, contact us at https://iris.custhelp.com, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.
VA forms are available at www.va.gov/vaforms.

IMPORTANT

If you wish to make a claim for veterans disability compensation and/or related compensation benefits, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. VA forms are available at www.va.gov/vaforms. If you cannot access this form, write the words "Will claim compensation - send VA Form 21-526EZ" in Item 8 *or* at the top of the attached application and VA will send you the form.

OMB Control No. 2900-0002
Respondent Burden: 25 minutes
Expiration Date: 10/31/2021 .

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 9 before completing the form.

SECTION I: VETERAN'S PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (Last, First, Middle)	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH (MM,DD,YYYY)

4. HAVE YOU EVER FILED A CLAIM WITH VA?	5. VA FILE NUMBER
☐ YES ☐ NO (If "Yes," provide your file number in Item 5)	

6A. MAILING ADDRESS	6B. TELEPHONE NUMBERS (Include Area Code)
Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country	DAYTIME ( ) EVENING ( ) CELL PHONE ( )

7A. PREFERRED E-MAIL ADDRESS (If applicable)	7B. ALTERNATE E-MAIL ADDRESS (If applicable)

8. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING?

A. DISABILITY(IES)	B. DATE DISABILITY(IES) BEGAN

9. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

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

SECTION II: VETERAN'S SERVICE INFORMATION *(MUST COMPLETE)*

10A. DID YOU SERVE UNDER ANOTHER NAME?	10B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER
☐ YES (If "Yes," complete Item 10B) ☐ NO (If "No," skip to Item 11A)	

11A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	11B. BRANCH OF SERVICE	11C. RELEASE DATE FROM ACTIVE SERVICE

11D. SERVICE NUMBER	11E. PLACE OF LAST SEPARATION

12A. HAVE YOU EVER BEEN A PRISONER OF WAR?	12B. DATES OF CONFINEMENT ON (MM,DD,YYYY)
☐ YES ☐ NO (If "Yes," complete Item 12B) (If "No," skip to Item 13A)	From: To:

SECTION III: VETERAN'S DISABILITY(IES) AND BACKGROUND *(MUST COMPLETE)*

NOTE: You do not have to submit medical evidence or list disabilities if you are age 65 or older, unless you are housebound, or require the regular assistance of another person.

13A. WHAT DISABILITY(IES) PREVENT YOU FROM WORKING?	13B. WHEN DID THE DISABILITY(IES) BEGIN? (MM, DD, YYYY)

14A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?	14B. ARE YOU NOW OR HAVE YOU RECENTLY BEEN HOSPITALIZED OR GIVEN OUTPATIENT OR HOME CARE DUE TO THE DISABILITY(IES) LISTED IN ITEM 13A?
☐ YES ☐ NO (If "Yes," 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 (CNP), or Clinical Nurse Specialist (CNS.))	☐ YES ☐ NO

15A. DATE(S) OF RECENT HOSPITALIZATION OR CARE	15B. NAME AND MAILING ADDRESS OF FACILITY OR DOCTOR

SECTION III: VETERAN'S DISABILITY(IES) AND BACKGROUND *(MUST COMPLETE)* CONTINUED

)TE: In the table below, tell us about all of your employment, including self-employment, for one year before you became disabled to the present.

3A. ARE YOU NOW EMPLOYED? ☐ YES ☐ NO	16B. WHEN DID YOU LAST WORK? (MM,DD,YYYY)	16C. WERE YOU SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLE? ☐ YES ☐ NO (If "Yes," complete Items 16D and 16E)
3D. WHAT KIND OF WORK DID YOU DO?	16E. ARE YOU STILL SELF-EMPLOYED? ☐ YES ☐ NO (If "Yes," complete Item 16F)	16F. WHAT KIND OF WORK DO YOU DO NOW?

7A. ARE YOU NOW IN A NURSING HOME? ☐ YES ☐ NO "Yes," complete Items 17B and 17C and submit a statement from an official 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 onthly charge you are paying out-of-pocket for your care.)	17B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?
7C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS? ☐ YES ☐ NO (If "No," complete Item 17D)	17D. HAVE YOU APPLIED FOR MEDICAID? ☐ YES ☐ NO

8A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	18B. WHAT WAS YOUR JOB TITLE?	18C. WHEN DID YOUR JOB BEGIN?	18D. WHEN DID YOUR JOB END?	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
					$
					$

SECTION IV: MARITAL STATUS *(MUST COMPLETE)*

)A. WHAT IS YOUR MARITAL STATUS? *(Check one)*
☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED (Skip to Section VI if never married)

ELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

)B. HOW MANY TIMES HAVE *YOU* BEEN MARRIED (Including current marriage)?

A. DATE (Month, Day, Year) AND PLACE OF MARRIAGE (City and State or Country)	20B. TO WHOM MARRIED (First, Middle, Last Name)	20C. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, or Other)	20D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)	20E. DATE (Month, Day, Year) AND PLACE MARRIAGE ENDED (City and State or Country)

)F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 20C, PLEASE EXPLAIN:

SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)*

ote - Skip to Section VI if not currently married.

ELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

. HOW MANY TIMES HAS *YOUR SPOUSE* BEEN MARRIED (Including current marriage)?

A. DATE (Month, Day, Year) AND PLACE OF MARRIAGE (City and State or Country)	22B. TO WHOM MARRIED (First, Middle, Last Name)	22C. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, or Other)	22D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)	22E. DATE (Month, Day, Year) AND PLACE MARRIAGE ENDED (City and State or Country)

2F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22C, PLEASE EXPLAIN:

23A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (Month, Day, Year)	23B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?	23C. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO (If "Yes," complete Item 23D)	23D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (If any)?

SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)* CONTINUED

23E. DO YOU LIVE WITH YOUR SPOUSE?	23F. WHAT IS YOUR SPOUSE'S ADDRESS? (Number and street or rural route, city or P.O. State, ZIP Code and country)
☐ YES ☐ NO (If "Yes," skip to Section VI) (If "No," complete items 23F, 23G and 23H)	
23G. TELL US THE REASON YOU ARE NOT LIVING WITH YOUR SPOUSE (i.e.; illness, work, etc.)	23H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? $

SECTION VI: DEPENDENT CHILDREN *(COMPLETE IF YOU HAVE DEPENDENT CHILDREN)*

Note - Skip to Section VII if you have no dependent children.

24A. NAME OF DEPENDENT CHILD (First, Middle Initial, Last)	24B. DATE AND PLACE OF BIRTH (City and State or Country)	24C. SOCIAL SECURITY NUMBER	(Check all that apply) 24D. BIOLOGICAL	24E. ADOPTED	24F. STEPCHILD	24G. 18-23 YEARS OLD (in school)	24H. SERIOUSLY DISABLED	24I. CHILD MARRIED	24J. CHILD PREVIOUSLY MARRIED
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

Note - In Items 25A through 25D, tell us about the children listed in Item 24A who *do not* live with you.

25A. NAME OF DEPENDENT CHILD (First, middle initial, last)	25B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	25C. NAME OF PERSON THE CHILD LIVES WITH (if applicable)	25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION VII: QUESTIONS REGARDING INCOME AND ASSETS *(If you need more space, attach a separate sheet.)*

26. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?
☐ YES ☐ NO (If "Yes," complete Items A and B) (If "No," skip to Item 27)

A. SOCIAL SECURITY RECIPIENT	B. GROSS MONTHLY AMOUNT
	$
	$
	$
	$
	$

27. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?
☐ YES ☐ NO (If "Yes," complete Items 28A and 28B) (If "No," skip to Item 29A)

28A. WHAT IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS?	28B. COULD ANY PART OF THE LOT BE SOLD *WITHOUT SELLING THE RESIDENCE*?
_____ Square feet	☐ YES ☐ NO (If "Yes," also complete 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.

29A. *OTHER THAN SOCIAL SECURITY*, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?
☐ YES ☐ NO

29B. *OTHER THAN SOCIAL SECURITY*, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?
☐ YES ☐ NO

29C. 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/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation).
☐ YES ☐ NO

29D. 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

SECTION VII: QUESTIONS REGARDING INCOME AND ASSETS (If you need more space, attach a separate sheet) CONTINUED

29E. DID YOU ANSWER "YES" TO ANY OF THE ITEMS IN 29A - 29D?

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

SECTION VIII: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL 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, dependents you are under obligation to support, 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 at any time prior to the end of the year following the year of death. 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 or your dependents were/will be reimbursed. Please make sure to complete all 6 criteria below (if applicable). If more space is needed, 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(s) on pages 11 and 12.

30. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?

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

A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	B. PAID TO (Name of Provider, Insurance company, Nursing home, etc.)	C. PURPOSE (Medicare premiums, Nursing Home,etc.)	D. DATE PAID (Month, Day, Year)	E. HOURLY RATE/ HOURS (In-home Provider Only)	F. AMOUNT YOU PAY
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

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

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 31, 32, and 33 to enroll in direct deposit. If you *do not* have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

31. 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.:_____

32. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	33. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION X: 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. authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department o Veterans Affairs any information about me and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected Pension Benefits.*

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federa 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 34 indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit furthe evidence in support of my claim.

34. 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 below box ONLY if you DO NOT wan **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.

35A. VETERAN'S SIGNATURE (REQUIRED)	35B. DATE SIGNED

SECTION XI: WITNESSES TO SIGNATURE *(MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 35A WITH AN "X")*

36A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	36B. PRINTED NAME AND ADDRESS OF WITNESS
37A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	**37B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to 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 Vocational Rehabilitation 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 obligation to respond 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.

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Milwaukee Pension Center
P.O. Box 5192
Janesville, WI 53547-5192
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Alabama	Arkansas	Illinois	Indiana
Kentucky	Louisiana	Michigan	Mississippi
Missouri	Ohio	Tennessee	Wisconsin

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Philadelphia Pension Center
P.O. Box 5206
Janesville, WI 53547-5206
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Connecticut	Delaware	Florida	Georgia
Maine	Maryland	Massachusetts	New Hampshire
New Jersey	New York	North Carolina	Pennsylvania
Rhode Island	South Carolina	Vermont	Virginia
West Virginia	District of Columbia	Puerto Rico	Canada
Countries outside of North, Central or South America			

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: St. Paul Pension Center
P.O. Box 5365
Janesville, WI 53547-5365
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Alaska	Arizona	California	Colorado
Hawaii	Idaho	Iowa	Kansas
Minnesota	Montana	Nebraska	Nevada
New Mexico	North Dakota	Oklahoma	Oregon
South Dakota	Texas	Utah	Washington
Wyoming	Mexico	Central America	South America
Caribbean			

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR 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?

☐ YES ☐ NO (If "NO," continue to Step 2)
(If "YES," all payments to the facility qualify as medical expenses in Items 30A - 30F. 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 veteran) the disabled person?

☐ YES ☐ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

☐ YES ☐ NO (If "NO," payments to this facility for meals and lodging *do not* qualify as medical expenses. *Only* claim amounts you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 30A - 30F. 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 *if* VA rates you as eligible for special monthly pension. Please report separately in Items 30A - 30F applicable amounts you pay the facility for (1) ***lodging and meals,*** (2) ***health care services or assistance with ADLs provided by a health care provider,*** and (3) ***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 disability, and (2) describes the mental or physical disability)
(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 30A - 30F. 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 30A - 30F)
(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 30A - 30F. 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 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)

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 veteran) the disabled person?

☐ YES ☐ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

☐ 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 30A - 30F 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 30A - 30F *if* VA rates you as eligible for special monthly pension. Please report separately in Item 30A - 30F 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 30A - 30F 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 30A - 30F. 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 30A - 30F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 30A - 30F. Payment for assistance with IADLs *do not* qualify as a medical expense)

STEP 6. Check all activities below with which 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)

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, 21P-534EZ, and 21-526)

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 VII on VA Form 21P-527EZ
2. Section VII on VA Form 21P-534 or Section VIII on VA Form 21P-534EZ
3. Section VIII on VA Form 21-526

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.

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.

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, 21P-534EZ, and 21-526)

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

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 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 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 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 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 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 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 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 AND EXPECTED INCOME AMOUNT $

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

. 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)

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?
	WHAT IS THE GROSS ANNUAL INCOME?	$	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO	
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$	
	WHAT IS THE GROSS ANNUAL INCOME?	$	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO	
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$	
	WHAT IS THE GROSS ANNUAL INCOME?	$	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO	
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$	
	WHAT IS THE GROSS ANNUAL INCOME?	$	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO	
	DATE INCOME WILL CHANGE 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, FARI OR BUSINESS? (Note: Subtract the amount of Mortgage: other encumbrances specific to the prope 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 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 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 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 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 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 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 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 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 WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE WILL CHANGE AND EXPECTED WAGE AMOUNT $

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

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 that was 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 that was 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)

A. 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)

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

C. 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	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 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 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 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 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 minut
Expiration Date: 5-31-2018

Department of Veterans Affairs

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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT	3. RELATIONSHIP OF CLAIMANT TO VETERAN

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER

6. DATE OF EXAMINATION	7. HOME ADDRESS

8A. IS CLAIMANT HOSPITALIZED?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*		

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.

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

11A. AGE	11B. SEX	12. WEIGHT ACTUAL: LBS. ESTIMATED: LBS.	13. HEIGHT FEET: INCHES:

14. NUTRITION	15. GAIT

16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

20. 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:

21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*
☐ YES ☐ NO

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*
☐ YES ☐ NO

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*
☐ YES ☐ NO

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*
☐ YES ☐ NO

26. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*
☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*
☐ YES ☐ NO

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

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

). DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND ONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER XTREMITY.

. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

. 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 32 above)*

☐ YES
☐ NO *(If "YES," give distance) (Check applicable box or specify distance)* ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____ .

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

RIVACY 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 74 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research idies, 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 livery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, nsion, Education and Vocational Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. ving 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 ll 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, d still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are nsidered 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 rpose 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 ogram administered by the Department of Veterans Affairs.

ESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) d (e), 1115(1)(e), 1311(e) 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 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 mber 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 MB 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 ggestions about this form.

OMB Approved No. 2900-004
Respondent Burden: 15 minute
Expiration Date: 06/30/2020

Department of Veterans Affairs

DECLARATION OF STATUS OF DEPENDENTS

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 o 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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your and your dependents' SSN account information is mandatory. Applicants are required to provide their SSN and the SSN of any dependents for whom benefits are claimed under Title 38 USC 5101 (c)(1). 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. 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 marital status and eligibility for an additional allowance for dependents under 38 U.S.C. 1115. 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.

INSTRUCTIONS: Print all answers clearly. Make sure you sign and date this form (Items 17 and 18). Note: Unless the claimant is the veteran's surviving spouse, the veteran must sign in Item 17. When you have completed this form, mail it or take it to a VA regional office.

IMPORTANT: If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

1A. FIRST - MIDDLE - LAST NAME OF VETERAN	2A. NAME OF CLAIMANT *(If other than veteran)*	3. FILE NUMBER
1B. VETERAN'S SOCIAL SECURITY NUMBER	2B. CLAIMANT'S SOCIAL SECURITY NUMBER	C-

4A. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*

4B. E-MAIL ADDRESS OF CLAIMANT *(If applicable)*

5A. MARITAL STATUS *(Check one)*

☐ MARRIED ☐ DIVORCED ☐ NEVER MARRIED *"(If checked, skip to Item 14)"*
☐ WIDOWED ☐ SEPARATED

5B. IF MARRIED, SPOUSE'S DATE OF BIRTH

_____
month day year

NOTE: You must furnish complete information about all your and your current spouse's previous marriages. If you or your spouse have been married more than three times, list additional marriages in Item 16, "Remarks," or attach a separate sheet.

SECTION I - VETERAN'S MARRIAGES

6. HOW MANY TIMES HAVE YOU BEEN MARRIED? *(Including current marriage)*

7A. DATE AND PLACE OF MARRIAGE *(City/State or Country)*	7B. TO WHOM MARRIED *(First, middle, last name)*	7C. SOCIAL SECURITY NUMBER	7D. HOW MARRIAGE TERMINATED *(Death, Divorce)*	7E. DATE AND PLACE TERMINATED *(City/County/State or Country)*
_____ *month day year* *Place:*				
_____ *month day year* *Place:*				_____ *month day year* *Place:*
_____ *month day year* *Place:*				_____ *month day year* *Place:*

SECTION II - SPOUSE'S PREVIOUS MARRIAGES

8. HOW MANY TIMES HAS THE VETERAN'S CURRENT SPOUSE OR SURVIVING SPOUSE BEEN MARRIED? *(Including current marriage)*

9A. DATE AND PLACE OF MARRIAGE	9B. TO WHOM MARRIED *(First, middle, last name)*	9C. HOW MARRIAGE TERMINATED *(Death, Divorce)*	9D. DATE AND PLACE TERMINATED
_____ *month day year* *Place:*			_____ *month day year* *Place:*
_____ *month day year* *Place:*			_____ *month day year* *Place:*
_____ *month day year* *Place:*			_____ *month day year* *Place:*

10A. IS YOUR SPOUSE ALSO A VETERAN?

☐ YES ☐ NO *(If "Yes," answer Item 10B also. If "No," skip to Item 11.)*

10B. WHAT IS YOUR SPOUSE'S VETERAN SERVICE NUMBER? (If applicable)

11. DO YOU LIVE WITH YOUR SPOUSE?

☐ YES ☐ NO *(If "Yes," skip to Item 14A. If "No, answer Items 12 and 13 also.)*

12. WHAT IS YOUR SPOUSE'S ADDRESS?

13. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT?

$

SECTION III - VETERAN'S UNMARRIED CHILDREN

NOTE: If any child is claimed as "seriously disabled" (Item 14H), it must be shown that the child became permanently unable to support him/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

Note: In Items 14A through 14I, check all boxes that apply.

14A. NAME OF CHILD *(first, middle initial, last)*	14B. DATE AND PLACE OF BIRTH *(city, state or country)*	14C. SOCIAL SECURITY NUMBER	14D. BIO - LOGICAL	14E. ADOPT - ED	14F. STEP - CHILD	14G. 18-23 YRS. OLD AND IN SCHOOL	14H. SERIOUSLY DISABLED	14I. CHILD PREVIOUSLY MARRIED
	_____ *mo day yr* *PLACE:*		☐	☐	☐	☐	☐	☐
	_____ *mo day yr* *PLACE:*		☐	☐	☐	☐	☐	☐
	_____ *mo day yr* *PLACE:*		☐	☐	☐	☐	☐	☐

14J. IF YOU CHECKED "STEPCHILD," IS THE STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE? ☐ YES ☐ NO

Note: If any of the children listed above don't live with you, complete Items 15A through 15C.

15A. NAME OF CHILD *(First, middle initial, last)*	15B. CHILD'S COMPLETE ADDRESS	15C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable)*

16. REMARKS

I HEREBY CERTIFY THAT the information I have given above is true and correct to the best of my knowledge and belief.

17. SIGNATURE OF CLAIMANT *(Claimant, please sign in ink)*	18. DATE	19. TELEPHONE NUMBER(S) *(Include Area Code)*	
		A. DAYTIME	B. NIGHTTIME

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 to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

STATEMENT OF CARE

Veteran's Name: _____

Veteran's Social Security Number: _____

1. Facility / Caregiver Name: _____

Address: _____

_____

Phone Number: _____

2. I / We have been providing services to:

_____

from: _____ to: _____ (Please provide exact dates)

3. I / We provide the following services: (circle all services provided)

____ assistance with showering/bathing
____ assistance with toiletries
____ assistance dressing/undressing
____ meal preparation and/or feeding
____ medication management

Other: _____

_____

_____

4. I / We have received the following payments from _____ for services:

Amount: _____ Date: _____ Amount: _____ Date: _____

Amount: _____ Date: _____ Amount: _____ Date: _____

Amount: _____ Date: _____ Amount: _____ Date: _____

Amount: _____ Date: _____ Amount: _____ Date: _____

5. ____ Place a check mark if these are ongoing expenses.

If there are any changes in caregivers or caregivers' fees, the VA requires notification.

Signature of Facility Administrator / Caregiver: _____

Print Name of Authorizing Official / Caregiver: _____

Date: _____

ATTENDANT AFFIDAVIT

VETERAN'S NAME – LAST, FIRST, MIDDLE _____

VA CLAIM OR SOCIAL SECURITY NUMBER _____

Claimant's Name _____

Claimant's Address (STREET) _____

CITY, STATE AND ZIP CODE _____

My name is _____, and I provide health care for the above named claimant.

The services which I provide are:

__ Yes __ No	Assistance with bathing	__ Yes	__ No	Eating
__ Yes __ No	Standing and sitting	__ Yes	__ No	Walking
__ Yes __ No	Getting in and out of bed	__ Yes	__ No	Taking medication
__ Yes __ No	Dressing and undressing			

__ Other (Please describe)

_____

_____

___ Place a check mark if these are ongoing expenses

For these services, I am paid by the claimant_____ per day/week/month/year (please circle only one)

I began employment on _____

Signature of provider _____

Street address _____

City ,State ,Zip _____

Phone number (are code) _____

I CERTIFY, under the penalty of law, that the above information is true and correct, that I do pay the above referenced sitter the amount listed for the services listed. (if claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

OMB Approved No: 2900-065
Respondent Burden: 10 Minute
Expiration Date: 02/29/2020

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: If you have any questions about completing this form, call VA toll-free at 1-800-827-1000 (Hearing Impaired TDD federal relay number is 711).

Section I - VETERAN/CLAIMANT'S IDENTIFICATION 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 the form.

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

2. VETERAN/CLAIMANT'S SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

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

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

SECTION II - NURSING HOME INFORMATION

6. NAME OF NURSING HOME

7. 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 III - GENERAL INFORMATION *(To be completed by a Nursing Home Official)*

8. DATE ADMITTED TO NURSING HOME *(MM DD YYYY)*
Month — Day — Year

9. IS THE NURSING HOME FACILITY MEDICAID OR EQUIVALENT APPROVED?
☐ YES ☐ NO

10. HAS THE PATIENT APPLIED FOR MEDICAID?
☐ YES ☐ NO

11A. IS THE PATIENT COVERED BY MEDICAID OR EQUIVALENT PLAN?
☐ YES ☐ NO *(If "YES," complete item 11B)*

11B. DATE MEDICAID OR EQUIVALENT PLAN BEGAN
Month — Day — Year

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

13. 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

14. NURSING HOME OFFICIAL'S NAME *(First and Last) (Please print)*

15. NURSING HOME OFFICIAL'S TITLE *(Please print)*

16. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)*

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.

17. SIGNATURE OF NURSING HOME OFFICIAL *(Sign in ink)*

18. DATE SIGNED *(MM,DD,YYYY)*

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 5, Code of Federal Regulations 1.526 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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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 you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Care Provider Statement

Name of Claimant:	Social Security #:
Name of Veteran:	Social Security #:

Facility/Agency Information (to be completed by a Facility/Agency Official)

Name of Care Facility/Agency:	Address:
Phone #:	

Type of service provided: *(please circle)* Skilled Nursing Home | Assisted Living Facility | Rest Home (Senior Living Facility) | Home Care Agency

Date services began *(Month, Day, Year)*	Does Medicaid pay any portion of the monthly care expense:
_____/_____/_____	YES / NO *(if yes, provide a breakdown on a separate page)*
Amount claimant is responsible for out of pocket each Month	Amount claimant is expected to pay out of pocket in the next 12 months
$_____	$_____

This facility/agency provides the following services:

Services:	Yes	No
Assistance with Activities of Daily Living (dressing, bathing, toileting, hygiene)	☐	☐
Daily monitoring of claimant to ensure health, safety, nutrition, etc.	☐	☐
24 hours on-sight staff to monitor and respond to emergency alert system	☐	☐
"Protected environment" to protect the claimant from the hazards and dangers of daily living	☐	☐
"Secure environment" – entry and exit of the facility is monitored 24 hours/day	☐	☐
Medication management	☐	☐
Meal preparation	☐	☐
Assistance with ambulating	☐	☐
Homemaker services	☐	☐
Transportation to medical appointments	☐	☐

I certify that the claimant requires the services of this facility/agency because of mental or physical disabilities and is receiving such care/services.

Signature of official:	Title:
Official's Printed Name:	Date Signed:

OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 12/31/2020

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Read the Privacy Act and Respondent Burden on Page 2 before completing the form. Complete as much of Section I as possible. The information requested will help process your claim for benefits. If you need any additional room, use the second page.

SECTION I: VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

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

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

2. VETERAN'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 SERVICE NUMBER *(If applicable)*

6. TELEPHONE NUMBER *(Include Area Code)*

7. E-MAIL ADDRESS *(Optional)*

8. 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: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

SECTION II: REMARKS *(Continued)*

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

SECTION III: DECLARATION OF INTENT

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

. SIGNATURE *(Sign in ink)*	10. DATE SIGNED *(MM-DD-YYYY)*

:NALTY: 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, owing it to be false.

:IVACY ACT INFORMATION: 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, de 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 : 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 rsonnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, blished in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that ur 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. e 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 l in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 01). Information submitted is subject to verification through computer matching programs with other agencies.

:SPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this ormation. 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 ormation 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 ated 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 m.

CAN THE VA APPOINT A FIDUCIARY NOW?

If you agree with the VA's finding of incompetency and would like to waive to 60 day predetermination period, please sign, date and return this page with the following statement to the VA immediately.

I have read the above correspondence, agree to the finding of incompetency, and waive the required 60-day predetermination period. I hereby certify that this information is true and correct to the best of my knowledge. Please take immediate action to proceed with appointing a fiduciary to handle my VA pension accordingly.

Claim #: _____

SSN#: _____

Name: _____

Date: _____

Signature: _____

I am requesting that the following representative be appointed my fiduciary:

Name: _____

Address: _____

_____

Phone: _____

Relationship: _____

WITNESS TO "X" SIGNATURE OR THUMBPRINT OF CLAIMANT

CLAIMANT NAME:_____ VA CLAIM #_____

I hereby certify that the information on this form is true and correct to the best of my knowledge and belief.

_____

MARK OF THUMBPRINT OF CLAIMANT

_____

WITNESS # 1

_____ _____

PRINTED NAME OF WITNESS SIGNATURE OF WITNESS

ADDRESS OF WITNESS # 1_____

_____

PHONE NUMBER _____

WITNESS # 2

_____ _____

PRINTED NAME OF WITNESS SIGNATURE OF WITNESS

ADDRESS OF WITNESS # 1_____

_____

PHONE NUMBER _____

DATED_____