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, Survivors 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 Pensio*n (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

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

16A. 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)
16D. 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?

17A. ARE YOU NOW IN A NURSING HOME? ☐ YES ☐ NO (If "Yes," complete Items 17B and 17C and submit a statement from an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.)	17B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?
17C. 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

18A. 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)*

19A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED (Skip to Section VI if never married)

TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

19B. HOW MANY TIMES HAVE ***YOU*** BEEN MARRIED (Including current marriage)?

20A. 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)

20F. 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)*

Note - Skip to Section VI if not currently married.

TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

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

22A. 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)

22F. 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
			- ongoing	$	$ /mo
			- ongoing	$	$ /mo
			- ongoing	$	$ /mo
			- ongoing	$	$ /mo
			- ongoing	$	$ /mo
			- ongoing	$	$ /mo
			- ongoing	$	$ /mo
				$	$
				$	$
				$	$

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. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me 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 Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 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 further 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 want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

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

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)

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

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1. VETERAN/BENEFICARY NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER ___ – ___ – ____

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM/DD/YYYY)* Month ___ Day ___ Year ____

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

6. GENDER ☐ MALE ☐ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*

8. PREFERRED E-MAIL ADDRESS *(Optional)*

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

SECTION II: CLAIM INFORMATION

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

11. CLAIMANT'S SOCIAL SECURITY NUMBER ___ – ___ – ____

12. RELATIONSHIP OF CLAIMANT TO VETERAN

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

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

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

SECTION III: INFORMATION OF EXAMINATION

14. DATE OF EXAMINATION

15. HOME ADDRESS

16A. IS CLAIMANT HOSPITALIZED?

☐ YES ☐ NO *(If "Yes," complete Items 16B and 16C)*

16B. DATE ADMITTED

16C. NAME AND ADDRESS OF HOSPITAL

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

NOTE: EXAMINER PLEASE READ CAREFULLY

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

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

18A. AGE	18B. WEIGHT	18C. HEIGHT
	ACTUAL: LBS. ESTIMATED: LBS.	FEET: INCHES:

19. NUTRITION	20. GAIT

21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

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

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

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

☐ YES ☐ NO

27. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

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

☐ YES ☐ NO

29A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	29B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

☐ YES ☐ NO

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

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

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

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

36. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

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

40A. PRINTED NAME OF EXAMINING PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED

41A. NAME AND ADDRESS OF MEDICAL FACILITY	41B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

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

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

Department of Veterans Affairs

NOTICE TO SURVIVOR OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

(This notice is applicable to survivors claims for: Survivors Pension • Dependency Indemnity Compensation (DIC) • DIC under 38 U.S.C. 1151 • Increased Survivor Benefits Based on Need for Special Monthly Pension • Accrued Benefits • Benefits Based on a Veteran's Seriously Disabled Child)

Use this notice and the attached application to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. 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 DIC, Survivors Pension, and/or Accrued Benefits, 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 claiming veterans Pension benefits, use VA Form 21P-527EZ, *Application for Veterans Pension*. VA forms are available at www.va.gov/vaforms.

FDC Criteria (Claim(s) for DIC, Survivors Pension, and/or Accrued Benefits)

1. Submit your claim on a signed and completed VA Form 21P-534EZ, *Application for DIC, Survivors Pension, and/or Accrued Benefits* (Attached).

2. Submit simultaneously with your claim:

A copy of the veteran's Death Certificate (unless he or she died on active duty); **AND**

If claiming Survivors Pension:

- All necessary income and asset information; **AND**
- **If claiming Survivors 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 DIC:

- All, if any, of the veteran's relevant, private medical treatment records and an identification of any of the veteran's treatment records available at a Federal facility, such as a VA medical center, that supports your claim that a service-connected disability caused the veteran's death or the veteran's death was caused by the VA.
- Any and all Service Treatment and Personnel Records in the custody of the veteran's Guard or Reserve Unit(s).
- **If claiming DIC as the parent of the veteran**, all necessary income information and, if claiming benefits as the foster parent of the veteran, a completed VA Form 21P-524, *Statement of Person Claiming to Have Stood in Relation of Parent*.
- **If claiming DIC with special monthly DIC,** 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*

Requirements for Certain Claimants:

- **If claiming benefits as the surviving spouse of the veteran**, a copy of your marriage certificate showing your marriage to the veteran, or **if claiming benefits for a child or biological/adoptive parent of the veteran**, a copy of the birth certificate or court record of adoption showing relation to the veteran.
- **If claiming benefits for a child of the veteran 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 of the veteran,** all, if any, relevant, private medical treatment records for the child's pertinent disabilities showing the child was incapable of self-support before age 18.

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. If your claim involves a disability the veteran had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before the veteran's entry into service.

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	VA will: • Retrieve relevant records from a Federal facility that you adequately identify and authorize VA to obtain • 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.	We strongly encourage you 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

Mail or take your application and any evidence in support of your claim to the closest VA regional office. VA regional office addresses are available on the Internet at www.va.gov/directory.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See the evidence table titled...
Needs-based benefits based on the veteran's wartime service.	Survivors Pension
• The veteran's death was related to his or her service (DIC), **OR** • DIC because the veteran was receiving or entitled to receive benefits for a service-connected disability rated totally disabling.	Dependency and Indemnity Compensation (DIC)
The veteran's death was a result of VA medical treatment, vocational rehabilitation, or compensated work therapy.	DIC under 38 U.S.C. 1151
DIC and it was previously denied by VA.	Reopened DIC
Special Monthly Pension.	Increased Survivor Benefits Based on Special Monthly Pension
You are entitled to the benefits that were due to the veteran at the time of the veteran's death.	Accrued Benefits
You are eligible to benefits because a child of the veteran is severely disabled.	Child Incapable of self-support

EVIDENCE TABLES

Survivors Pension

To support your claim for **Survivors Pension**, the evidence must show:

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

   • 90 days of consecutive service, at least one day of which was during a period of war; **OR**
   • 90 days of combined service during at least one period of war;

   *(**Note** : If the veteran's 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 obligations.)*

   OR any length of active service during a period of war when:

   • At the time of death, the veteran was receiving (or entitled to receive) VA disability compensation or retirement pay for a service-connected disability; **OR**
   • The veteran was discharged from active service due to a service-connected disability.

2. Your income and assets do not exceed certain requirements.

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.

Dependency and Indemnity Compensation (DIC)

To support a claim for **Dependency and Indemnity Compensation (DIC) based on a service-connected disability:**

- The veteran died while on active service; **OR**
- The veteran had a service-connected disability(ies) that was either the principal or contributory cause of the veteran's death; **OR**
- The veteran died from non service-connected injury or disease **AND** was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling:
  - For at least 10 years immediately before death; **OR**
  - For at least 5 years after the veteran's release from active duty preceding death; **OR**
  - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999.

To support a claim for **DIC based on a disability that was not service-connected** or for which the veteran did not file a claim during his or her lifetime, the evidence must show:

- An injury or disease that was incurred or aggravated during active service, or an event in service that caused an injury or disease; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the disability associated with the cause of death and an injury, disease, or event in service. This may be shown by medical records or medical opinion or, in certain cases, by lay evidence.

EVIDENCE TABLES (Continued)

Dependency and Indemnity Compensation (DIC) *(Continued)*

To support your claim for **DIC based upon the service person's *active* duty for training**, the evidence must show:

- The service person was disabled during *active* duty for training due to a disease or injury incurred in the line of duty, and the disease or injury caused or contributed to the service person's death.

If VA granted service connection for a disease or injury during the service person's lifetime, evidence that the service-connected disease or injury caused or contributed to the service person's death may satisfy this requirement.

To support a claim for DIC based on a disability that was not service-connected or for which the service person did not file a claim during his or her lifetime, the evidence must show:

- The service person was disabled during *active* duty for training due to a disease or injury incurred in the line of duty; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the principal or contributory cause of death and the disability due to injury or disease, incurred in the line of duty. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support your claim for **DIC based upon the service person's *inactive* duty training**, the evidence must show:

- The service person died during *inactive* duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident during such training; **OR**
- The service person was disabled during *inactive* duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; and that injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

If VA granted service connection for an injury, acute myocardial infarction, or cerebrovascular accident during the service person's lifetime, evidence that the service-connected condition caused or contributed to the service person's death may satisfy this requirement.

To support a claim for DIC based on a disability that was not service-connected or for which the service person did not file a claim during his or her lifetime, the evidence must show:

- The service person was disabled during *inactive* duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; **AND**
- The injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

DIC under 38 U.S.C. 1151:

In order to support your claim for **DIC under 38 U.S.C. 1151**, the evidence must show:

- The deceased veteran died as a result of undergoing VA hospitalization, medical or surgical treatment, examination, or training; **AND**
- The death was:
  - the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment; **OR**
  - the direct result of an event that was not a reasonably expected result or complication of the VA care or treatment; **OR**
  - the direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program

Reopened DIC:

In order to reopen a claim previously denied by VA, we need new and material evidence. New and material evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.

- To qualify as new, the evidence must currently exist and be submitted to VA for the first time
- In order to be considered material, the additional existing evidence must pertain to the reason your claim was previously denied

EVIDENCE TABLES (Continued)

Increased Survivor Benefits Based on Special Monthly Pension

In order to support your claim for **increased survivor benefits based on the need for aid and attendance**, the evidence must show:

- you have corrected vision of 5/200 or less in both eyes; **OR**
- you have concentric contraction of the visual field to 5 degrees; **OR**
- you are a patient in a nursing home due to mental or physical incapacity; **OR**
- you require the aid of another person to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulations 3.352(a)); OR
- you are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulations 3.352(a)); **OR**

In order to support your claim for **increased benefits based on being housebound**, the evidence must show:

- you are substantially confined to your immediate premises because of permanent disability

Accrued Benefits:

To support a claim for **accrued benefits**, the evidence must show:

- Benefits were due the veteran based on existing ratings, decisions, or evidence in VA's possession at the time of death, but the benefits were not paid before the veteran's death; **AND**
- You are the surviving spouse, child, or dependent parent of the deceased veteran

VA pays accrued benefits in the following order of priority:

1. Spouse
2. Children of the veteran (in equal shares)
3. Dependent parents (in equal shares)

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 recognizes marriages is available at http://www.va.gov/opa/marriage/.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant a claim for Survivors benefits, the beginning date of your entitlement will generally be the date we received your claim. However, if VA receives your claim within one year after the date of the veteran's death, entitlement will be from the first day of the month in which the veteran died.

The veteran's death certificate is evidence relevant to determining the effective date of any benefits we award.

Special monthly pension may be available for a veteran's surviving spouse and/or parents who are unable to perform certain activities of daily living, are a patient in a nursing home, or are substantially confined to their immediate premises. Special monthly pension may be effective from the date 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.

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 11 before completing the form.

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

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

4. VETERAN'S SEX	5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?	6. VA FILE NUMBER
☐ MALE ☐ FEMALE	☐ YES ☐ NO (If "Yes," provide the file number in Item 6)	

7. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?	8. VETERAN'S SERVICE NUMBER	9. WHAT IS THE VETERAN'S DATE OF DEATH? (MM,DD,YYYY)
☐ YES ☐ NO		

10. WHAT IS YOUR NAME? (First, middle, last name)	11. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)
	☐ SURVIVING SPOUSE ☐ PARENT ☐ CHILD ☐ CUSTODIAN FILING FOR CHILD

12. WHAT IS YOUR SOCIAL SECURITY NUMBER?	13. WHAT IS YOUR DATE OF BIRTH? (MM,DD,YYYY)	14. ARE YOU A VETERAN?
		☐ YES ☐ NO

15A. WHAT IS YOUR ADDRESS?	15B. YOUR TELEPHONE NUMBER(S) (include Area Code)
Street address, rural route, or P.O. Box Apt. number	DAYTIME ( )
City State ZIP Code Country	EVENING ( )
	CELL PHONE ( )

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

17. WHAT ARE YOU CLAIMING? (Check all that apply)

☐ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☐ SURVIVORS PENSION ☐ ACCRUED BENEFITS

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

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

18A. DID THE VETERAN SERVE UNDER ANOTHER NAME?	18B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:
☐ YES ☐ NO (If "Yes," complete Item 18B) (If "No," skip to Item 18C)	

18C. VETERAN ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	18D. BRANCH OF SERVICE	18E. RELEASE DATE FROM ACTIVE SERVICE (MM,DD,YYYY)

18F. PLACE OF LAST SEPARATION

19A. WAS THE VETERAN ACTIVATED TO FEDERAL ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*?	19B. DATE OF ACTIVATION (MM,DD,YYYY)
☐ YES ☐ NO (If "Yes," answer Items 19B, 19C and 19D)	

19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?	19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)
	( )

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

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

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

TELL US ABOUT THE VETERAN'S MARRIAGES

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

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

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

TELL US ABOUT YOUR MARRIAGES

22A. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN? ☐ YES ☐ NO

22B. HOW MANY TIMES HAVE YOU BEEN MARRIED? (including your marriage to the veteran)

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

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

23. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE? ☐ YES ☐ NO

24. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD? ☐ YES ☐ NO

25. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH? ☐ YES ☐ NO (If "No," complete Item 26)

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

27. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID? ☐ YES ☐ NO (If "Yes," provide explanation):

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

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

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

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

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

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

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

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

☐ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN ☐ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF THE VETERAN ☐ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE ☐ DIVORCED ☐ WIDOWED

☐ NEVER MARRIED

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

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

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

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

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

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

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

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

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

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

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

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

35. WHAT BENEFIT ARE YOU CLAIMING?

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

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

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

SECTION VII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

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

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

38A. ARE YOU NOW IN A NURSING HOME?

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

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

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

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

38D. HAVE YOU APPLIED FOR MEDICAID?

☐ YES ☐ NO

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

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

IMPORTANT:

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

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

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

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

SOCIAL SECURITY RECIPIENT	GROSS MONTHLY AMOUNT
	$
	$
	$
	$
	$

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

☐ YES ☐ NO

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

Square Feet:_____

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

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

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

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

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

SECTION IX: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

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

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet on pages 12 and 13.

44. ARE YOU CLAIMING UNREIMBURSED MEDICAL EXPENSES?

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

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

SECTION X: 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 46, 47, and 48 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.

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

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

Account No.:_____ Account No.:_____

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

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

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

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

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

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

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

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

SECTION XII: WITNESSES TO SIGNATURE *(COMPLETE ONLY IF CLAIMANT SIGNED ITEM 45A WITH AN "X")*

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

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and 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.

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

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

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

(1) Eating

(2) Bathing/Showering

(3) Dressing

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

(5) Using the toilet

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

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

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

(If "NO," continue to Step 2)

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

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

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

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

☐ YES ☐ NO (If "NO," skip to Step 6)

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

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

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

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

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

(If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disabilty, and (2) describes the mental or physical disabilty)

☐ YES ☐ NO (If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

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

(If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)

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

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

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

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

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

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

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

(1) Eating

(2) Bathing/Showering

(3) Dressing

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

(5) Using the toilet

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

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

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

Follow the steps below to determine whether or not:

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

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

☐ YES ☐ NO (If "NO," skip to Step 4)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and his or her care from_____.
(Name of Attendant)

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

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available." Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next of kin using eVetRecs at http://www.archives.gov/veterans/military-service-records/.

2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **less than 62 years** ago and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STR's of persons on active duty are generally kept at the local servicing clinic, and usually are available from the Department of Veterans Affairs approximately 40 days after the last day of active duty. (See item 3, Archival Records, if the military member was discharged, retired or died in service over 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations and the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. An authorization signature, of the service member or the member's legal guardian, is needed in Section III of the SF180. Others requesting information from military personnel records and/or STR's must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, surviving next of kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **must provide proof of death**, **such as a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death; funeral director's signed statement of death, or verdict of coroner's jury.**

b. Fees for records: There is no charge for most services provided to service members or next of kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances service fees cannot be determined in advance. If your request involves a service fee, you will be notified.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 or more years** ago have been transferred to the legal custody of NARA and are referred to as "archival" records.

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next of kin is not required. However, in order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and preclude the release of some information.

b. Fees for Archival Records: Access to archival records is granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). You will be notified if there is a charge for photocopies of documents contained in the record you are requesting. For more information see http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS AS INDICATED IN THE ADDRESS LIST ON PAGE 2 OF THE SF 180.

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/*

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	**2.** SOCIAL SECURITY NO.	**3.** DATE OF BIRTH	**4.** PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent.** When was the DD Form(s) 214 issued? YEAR(S): _____
If more than one period of service was performed, even in the same branch, there may be more than one DD214.

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

An undeleted copy will be sent unless you specify a deleted copy. Indicate here if you want a deleted copy of the DD Form 214 . ☐.

The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☐ **All Documents in Official Military Personnel File (OMPF)**

☐ **Medical Records** (Includes Service Treatment Records, Health (outpatient) and dental records.) If hospitalized (inpatient), the facility name and date for each admission **must** be provided: _____

☐ **Other** (Specify): _____

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: **(***Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.) No signature required for Archival records.*

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran: _____ ***(Relationship)***
☐ Legal guardian (Must submit copy of court appointment.)
☐ Other (specify) _____

MUST HAVE PROOF OF DEATH - See item 2a on instruction sheet.

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

3. AUTHORIZATION SIGNATURE WHEN REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct. No signature required for Archival records.

Name

Signature Required - Do not print **Date**

Street Apt.

( ) Daytime phone ( ) Fax Number

City State Zip Code

Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*

LOCATION OF MILITARY RECORDS

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	ADDRESS CODE	
		Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired on or after 10/1/2004	1	11
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, retired reserve in nonpay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	13	
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired on or after 4/1/1998	14	11
	Active, reserve, or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1905	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired on or after 1/1/1999	4	11
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired after 10/16/1992	14	11
	Active enlisted, officers	7	
	Former National Guard/USAR personnel	14	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired on or after 1/1/1995	10	11
	Active, reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	**Air Force Personnel Center HQ AFPC/DPSIRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721**	**6**	**National Archives & Records Administration Old Military and Civil Records (NWCTB-Military) Textual Services Division 700 Pennsylvania Ave., N.W. Washington, DC 20408-0001**	**11**	**Department of Veterans Affairs Records Management Center P.O. Box 5020 St. Louis, MO 63115-5020**
2	**Air Reserve Personnel Center Records Management Branch (DPTARA) 18420 E. Silver Creek Ave. Bldg. 390 MS 68 Buckley AFB, CO 80011**	**7**	**US Army Human Resources Command ATTN: AHRC-PDR-V 1600 Spearhead Division Ave., Dept 420 Fort Knox, KY 40122-5402 askhrc.army@us.army.mil**	**12**	**Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852**
3	**Commander, Personnel Service Center (PSD-MR) MS7200 US Coast Guard 4200 Wilson Blvd., Suite 1100 Arlington, VA 29598-7200 http://uscg.mil/psc/adm**	**8**	***Reserved.***	**13**	***Reserved.***
4	**Headquarters U.S. Marine Corps Manpower Management Support Branch (MMSB-10) 2008 Elliot Road Quantico, VA 22134-5030**	**9**	***Reserved.***	**14**	**National Personnel Records Center (Military Personnel Records) 1 Archives Dr. St. Louis, MO 63138-1002 *e*VetRecs! *http://www.archives.gov/veterans/military-service-records/***
5	**Marine Forces Reserve 4400 Dauphine St. New Orleans, LA 70146-5400**	**10**	**Navy Personnel Command (PERS-312E) 5720 Integrity Drive Millington, TN 38055-3120**		

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
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.

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
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? ☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL

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)* ☐ YES ☐ NO	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE

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

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

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

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

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

34. 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)*

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

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

CARE PROVIDER CERTIFICATION OF SERVICES (FORM FV13)

Instructions for Filling out this Form

The purpose of this form is to provide the Department of Veterans Affairs (VA) with detailed information about the types of care support services you (the care provider) are currently providing the claimant (i.e. a veteran, the veteran's unhealthy spouse, or the surviving spouse of a veteran who is applying for a benefits). Please complete pages one and two of this form.

The claimant and the care provider supervisor or facility administrator must sign this form.

VA's Use of the Term "Medical Services"
VA uses the terms "Medical Services" and "Nursing Services" interchangeably. Below is a list of some Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Generally, services for care and a need for care involving two or more of ADLs are necessary for the claimant's ongoing care costs to be considered unreimbursed medical expenses (UMEs).

- Help with getting in and out of bed / transferring (ADL)
- Help with dressing (ADL)
- Help with ambulating / walking (ADL)
- Help with bathing / showering (ADL)
- Help with feeding (ADL)
- Help with toileting (ADL)
- Help with incontinence (ADL)
- Help with personal hygiene (ADL)
- Help with prosthetic adjustments (ADL)
- Close supervision to prevent injury, wandering, or falls (ADL)
- Preparing and serving meals (IADL)
- Providing room and board (IADL)
- Doing housework and laundry (IADL)
- Supervising or providing reminders for medication (IADL)
- Providing transportation (IADL)
- Help with answering the telephone (IADL)
- Help with keeping track of money and paying bills (IADL)
- Secured living arrangements and emergency pull cords (IADL)

Protected Environment
"Protected Environment" means professional services in a daily living arrangement for adults who are experiencing a decrease in physical or mental or social functioning and require direct supervision and support. A person requiring a protected environment could not function by himself or herself without this need for support. This daily living arrangement can be in a home or in a facility.

VA often requires a care provider to certify that the claimant is being cared for in a Protected Environment. Page two of this report will give you the opportunity to provide VA with evidence that the claimant's Protected Environment needs are being met. They will use this information to base a decision on the claimant's need for care and application for benefits.

Line 1. Name of Person Receiving Care Services

This person can either be the veteran or the non-veteran spouse of the veteran. This person can also be the single surviving spouse of a veteran.

Line 2. Name of Veteran (For VA Purposes)

This must always be the name of the veteran whether the veteran is living or dead.

Line 3. Veteran Social Security Number or VA Case (Claim) Number

This must always be the Social Security Number of the veteran whether living or dead. As a general rule, with new applications, there is no VA case (claim) number. It would only exist if the veteran or the surviving spouse had previously made a claim to VA.

Line 9. Name of Care Service Provider

This is the name of the assisted living facility, board and care, adult day, home care company or private in-home attendant.

Line 10. Complete Address and Phone Number of the Care Service Provider

This is the address and phone number of the assisted living facility, board and care, adult day, home care company or private in-home attendant. Please know that VA will likely contact you before they make a decision on the claimant's application. VA will ask questions about the care you are providing the claimant and if monthly payments for care have been and will continue to be made. Generally, a claimant is not eligible for benefits if payments for care are reduced or cease.

CARE PROVIDER CERTIFICATION OF SERVICES - Form FV13

1. Name of Person Receiving Care Services	2. Name of Veteran (For VA Purposes)		3. Veteran Social Security Number or VA Case Number	
4. Address of Person Receiving Care Services	5. City	6. State	7. Zip	8. Phone(s) and email

9. Name of Care Service Provider	10. Complete Address and Phone Number of the Care Service Provider

Check the appropriate box below for the type of service offered by the care provider.

Residential Care Facility ☐ Assisted Living ☐ Professional Home Care Company ☐

Nursing Home ☐ Adult Day (Care) Service ☐ Private In-Home Attendant ☐

Adult Foster Care ☐ Adult Family Home ☐

If care provider provides 24-hour permanent residence for the care recipient, fill in the information below.

Date service started _____

Monthly charges including room and board, extras and care services $_____

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

If care provider offers assistance during the day at a location other than the care recipient's home, fill in below.

Date service started _____

Number of hours per day of service _____

Number of days per week of service _____

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Monthly charges including meals, site-to-site transportation and care services $_____

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

If care provider offers assistance in the home of the care recipient or in the home of someone else, fill in below.

Date service started _____

Number of hours per day of service _____

Number of days per week of service _____

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Please attach a copy of the care provider contract.

Monthly charges including meals, transportation, housework and care services $ 4000

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid.")

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

Form FV13 - CARE PROVIDER CERTIFICATION OF SERVICES - Page 2

COMPLETE THIS SECTION FOR ASSISTED LIVING, HOME CARE, ADULT DAY CARE, NURSING HOME, IN-HOME ATTENDANT, etc

Please describe briefly the "**protected environment**" and/or care services being furnished for the care recipient above.

Does the care provider provide "Nursing Services" for the care recipient? Yes ☐ No ☐

DEFINITION OF NURSING SERVICES (necessary for allowing deductibility of certain costs)

(M21--1MR, Part V, Subpart iii, Chapter 1, Section G, 43) . . . "*Examples of nursing services are assisting an individual with bathing, dressing, feeding, and **other activities of daily living,***" …walking, toileting, hygiene assistance.

CARE PROVIDER -- LINE 9 ABOVE -- OFFERS THE FOLLOWING SERVICES FOR THE CARE RECIPIENT -- LINE 4 ABOVE:

ACTIVITIES OF DAILY LIVING			INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
	Yes	No		Yes	No
Provides help with getting out of bed (ADL)			Provides room and board		
Provides help with dressing (ADL)			Provides shopping services		
Provides help with bathing (ADL)			Provides emergency response staff		
Provides help with ambulating/walking (ADL)			Provides supervision and / or reminders for medications		
Provides help with toileting (ADL)			Provides housework services (cleaning, laundry, etc…)		
Provides help with incontinence (ADL)			Answers phones and / or keeps track of money and bills		
Provides help with feeding (ADL)			Provides homemaker services		
Provides supervision and properly secured living arrangements for a protected environment (ADL)			Provides meals because care recipient above is physically or mentally incapable of preparing his or her own meals		
Provides help with personal hygiene (ADL)			Provides medical or monitoring alert equipment		
Provides for frequent need of adjustment of special prosthetic or orthopedic devices (ADL)			Providing activities and an environment for necessary social stimulation		
Provides supervision to prevent person from harming self or wandering (ADL)			Physical security such as room checks, emergency pull cords, locked and/or monitored exterior doors		
Provides supervision to prevent person from harming others (ADL)			Provides transportation for doctor visits and other vital medical purposes		
Other (ADL):			Other (IADL):		

This form should be signed by the claimant and a supervisor, administrator, owner or other responsible person with the care provider. For a personal in-home attendant, the in-home attendant should sign this form.

We, the below signing persons, certify the above information is correct and true to the best of our knowledge.

Care Provider's Name & Title: _____

Care Provider 's Signature: _____

Claimant 's Signature: _____

Date Signed:_____