

## What is in this packet?

- **VA Pension Worksheet** give you information about applying for the benefit. Also includes the "formula" to see if the veteran will qualify.
- VA Form 21P-527ez, page 14 this page only needs to be completed *IF* you are paying someone to come into the home to assist the veteran with daily living needs.
- Attendant Affidavit only complete this page *IF* you are paying someone to come into the house to assist the veteran with daily living needs.
- VA Form 21p-527ez, page 13 this page is to be completed by the assisted living facility, adult day care or other similar facility. Will also need a letter from that facility stating when the veteran entered the facility, how much they are paying and what all the facility assists with.
- VA Form 21-0779 this is a NURSING HOME to complete if applicable.
- VA Form 21-2680 this form has to be completed by veterans' physician.
- VA Form 21p-527ez, page 12 this form needs to be signed by the veteran.
- VA Form 21-22 Highlighted information needs to be completed by the veteran and signed.

Once you have all needed information together - please call 803.283.2469.

## **VA Pension Worksheet**

Veterans Name:	
Address:	
SSN:	
Date of Birth:	

VA INCOME LIMITS (MAPR)	
Single Veteran	\$14,753.00
Single Veteran Housebound	\$18,029.00
Single Veteran A&A	\$24,610.00
Veteran w/1 dependent	\$19,320.00
Veteran w/1 dependent housebound	\$22,596.00
Veteran w/1 dependent A&A	\$29,175.00

### **Asset Limitation = 138,489.00**

5 % RULE FOR 2020	
Single Veteran	\$737.00
Veteran w/1 dependent	\$966.00

WAR TIME PERIO	D
WWII	December 7, 1941 to December 31, 1946
KOREA	June 27, 1950 to January 31, 1955
VIETNAM	February 28, 1961 to May 7, 1975
GULF/IRAQ/ AFGHANISTAN	August 1, 1990 to present

## Will I Qualify?

This example is for a veteran with 1 dependent that does not need aid and attendance and is not housebound:

Total household income = 29,000.00 Total household med. exp. = 15,000.00 5% rule = 966.00 Vet w/1 dependent (MAPR) = 19,320.00

29,000.00 - 15,000.00 - 966.00 = 13,034.00

19,320.00 - 13,034.00 = 6,286.00

6,286.00/12(months) = \$523.84 is approximate monthly amount veteran would receive in pension.

# PLEASE COMPLETE THE BACK SIDE OF THIS PAGE IN FULL.

You will need to supply the following:

- ⇒ DD-214
- ⇒ All Marriage licenses. You will have to provide a complete marital history for you and your spouse. To include dates, places and names.
- ⇒ Divorce Decrees
- ⇒ Birth Certificate for dependent CHIL-DREN ONLY
- ⇒ Direct Deposit Information
- ⇒ Work History
- ⇒ Completed VA Form 21-2680(doctor to complete), Sitter's Fee form, and VA Form 21-0779 (all attached and if applicable)

Before September 7, 1980, Veteran must have served at least 90 days of active duty, with at least 1 day during a war time period. After September 7, 1980, Veteran must have served at least 24 months or the full period for which called or ordered to active duty with at least 1 day during a war time period. Veterans discharge from service under other than dishonorable conditions. VA Pensions are eligible to Veterans with lower income who are to disabled to work.

## **EXACT FIGURES ONLY**

HOUSEHOLD INCOME	MONTHLY
Veteran Employment	\$
Veteran Social Security	\$
Veteran Retirement	\$
Veteran Interest/Dividend (to	\$
Veteran Other Source of Income	\$
Spouse Employment	\$
Spouse Social Security	\$
Spouse Retirement	\$
Spouse Interest/Dividend (to in-	\$
Spouse Other Source of Income	\$
DEPENDENT CHILDREN	\$
(A) TOTAL INCOME times 12 =	\$

ASSETS	TOTAL
Veteran Checking Acct.	\$
Veteran Savings Acct.	\$
Veteran Stocks, Bonds, etc.	\$
Veteran IRA, Money Mgmt., etc.	\$
Spouse Checking Acct.	\$
Spouse Savings Acct.	\$
Spouse Stocks, Bonds, etc.	\$
Spouse IRA, Money Mgmt., etc.	\$
Other Assets	\$
TOTAL ASSESTS	\$
Additional property other than primary residence	Lot size=
If you have assets, complete —	21P-0969

Revision 12/14/2021

MEDICAL EXPENSES	1000	MONTHLY
Veteran Medicare Premiums	\$	
Veteran Private Medical Insurance	\$	
Veteran Supplemental Ins. Rx	\$	
Veteran Supplemental Ins.	\$	
Veteran Assisted Living Facility	\$	
Veteran Nursing Home Costs	\$	
Veteran Sitter Fee (private in-home care)	\$	
Spouse Medicare Premiums	\$	
Spouse Supplemental Ins.	\$	
Spouse Supplemental Ins. Rx	\$	
Spouse Supplemental Ins. Other	\$	=
Spouse Assisted Living Facility	\$	
Spouse Nursing Home Cost	\$	
Spouse Sitter Fee (private in-home care)	\$	
TOTAL MEDICAL EXPENSES times 12 =	\$	-
MINUS 5% RULE (Table on Front Page)	\$	
Equals (B) MEDICAL DIFFERENCE	\$	

### Complete Steps below to find out approx. monthly benefit.

		· ····o·······························
STEP 1	STEP 2	STEP 3
Subtract (A) Total	Subtract Net Income	Divide Yearly Pen-
Income \$	(STEP 1) \$	sion Amount (STEP
from (B) Medical	from MAPR (table on	2) \$ by
Difference \$	front page) \$	12 months to get
to equal Net Income	to equal Yearly Pension	approx. monthly
= \$	Amount = \$	benefit amount=
	(If amount is negative -	\$
	no benefit is allowed)	

I hereby certify to the best of my knowledge and ability that the above information is true. I understand that the Department of Veterans Affairs will complete an income match with the IRS and the Social Security Administration. I further understand that if this information is not true and the benefit is granted it will create a debt with the Department of Veterans Affairs.

Signature of Veteran	Date

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
<ul> <li>Custodial Care is regular -</li> <li>assistance with two or more ADLs, or</li> <li>supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.</li> </ul>
<b>IMPORTANT:</b> 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?  STEP 1. Are you (the veteran) the disabled person?  STEP 1. Are you (the veteran) the disabled person?
Tyes No. (If "No." skip to Step 4)  STEP 2. Did you claim special monthly pension on Page 5, Item 14A of the attached form?
(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?  (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.)
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 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?  (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)
YES NO (If "NO," the attendant <i>must be a health care provider</i> . Only report payments to the in-home attendant for <i>health care services or assistance with ADLs</i> 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?  (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items  30A - 30F)
YES NO (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
ADLS: 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.
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)
(Signature of Certifying Official) (Name of Certifying Official)
Title of Certifying Official)



## ATTENDANT AFFIDAVIT

		Veterans Name - Last, F	irst, Middle		
STATES OF	A. C.	VA Claim or Social Secu	rity Number		
		Claimants Name			
		China da Adda a (da			
		Claimants Address (stree	et)		
		Claimants State, Zip Cod	łe	-	
		, and I pro 	vide heath care for th	e above named claimant. I	began
he services which	h I provide a	are:			
Yes	No	Assistance with bathing	Other (Please des	cribe below)	
Yes	No	Standing and sitting			
Yes	No	Getting in and out of bed			
Yes	No	Eating	<u>-</u>		
Yes	No	Walking			
Yes	No	Dressing and undressing			
Yes	No	Taking medications			
For these services	, I was paid	by the claimant \$	from	to	
Signature of prov	ider				
Street Address					
City, State, and Z	ip Code				
Phone Number (i	ncluding are	ea code)			
		w, that the listed information is trusted. (If claimant signs with his/he			
Signature		Date			
Witness		Date	Witness	Dat	

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 -
<ul> <li>assistance with two or more ADLs, or</li> <li>supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.</li> </ul>
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 30A -30F. You are finished completing this worksheet)
STEP 2. Do all of the following apply to the facility?
<ul> <li>The facility is licensed (if the State or Country requires it)</li> <li>The facility's staff (or the facility's contracted staff) provides the disabled person with</li> </ul>
health care or custodial care or both.
<ul> <li>If the facility is residential, it is staffed 24 hours per day with caregivers</li> </ul>
YES NO (If "NO," payments to the facility <i>do not</i> 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?  (If "NO," payments to this facility for meals and lodging <i>do not</i> qualify as medical expenses. <i>Only</i> claim amounts you pay the facility for YES NO 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)?  (If "YES," all payments to this facility <i>may</i> qualify as medical expenses <i>if</i> VA rates you as eligible for special monthly pension. Please
YES NO report separately in Items 30A - 30F applicable amounts you pay the facility for (1) <i>lodging and meals</i> , (2) <i>health care services or assistance</i> with ADLs provided by a health care provider, and (3) <i>custodial care</i> . 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 disability, and (2) describes the mental or
YES NO physical disability) (If "NO," claim payments you pay this facility for <i>health care services or assistance with ADLs provided by a health care provider</i> 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)?  (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 30A - 30F) (If "NO," only claim
YES NO 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.
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 of Facility)
at (Address of Facility (Line 1))
(Address of Facility (Line 2))
, , , , , , , , , , , , , , , , , , , ,
(Signature of Person Certifying for the Facility)  (Signature of Person Certifying for the Facility)  (Date Certified)

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

Expiration Date: 08/31/2023

## Department of Veterans Affairs

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

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

**VA DATE STAMP** (Do Not Write In This Space)

Allalis, Evidence Ilitake Center, F.O. Dox 44-	14, Janesville, VVI, JJJ47- 4444.	
	SECTION I - VETERAN'S IDENTIFICATION	
NOTE: You may complete the form online or by hand. I of the form.	f completing by hand, print neatly and legibly in inl	x, and completely fill in each applicable circle to help expedite processing
1. VETERAN'S NAME (First, Middle Initial, Last)		
2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. DATE OF BIRTH (MM/DD/YYYY)
		undurani anti anti anti anti anti anti anti a
	FICATION INFORMATION (Complete this	section ONLY IF the claimant is NOT the veteran)
5. CLAIMANT'S NAME (First, Middle Initial, Last)		
6. SOCIAL SECURITY NUMBER	7. VA FILE NUMBER ( <i>If applicable</i> )	8. DATE OF BIRTH (MM/DD/YYYY)
	SECTION III - NURSING HOME INFO	RMATION
9. NAME OF NURSING HOME		
10. ADDRESS OF NURSING HOME (Number and street	t or rural route, P.O. Box, City, State, ZIP Code and Co	ountry)
No. &		
Street		
Apt./Unit Number	City	
State/Province Country	ZIP Code/Postal Code	-
SECTION IV - G	ENERAL INFORMATION (To be complete	ed by a Nursing Home Official)
NO	TE: Your state's Medicaid program may use	e a different name.
11. DATE ADMITTED TO NURSING HOME (MM/DD/	YYYY) 12. IS THE NU	IRSING HOME A MEDICAID APPROVED FACILITY?
	C YES	C vo
13. HAS THE PATIENT APPLIED FOR MEDICAID?	14A. IS THE PATIENT COVERED BY MEDICA	ID? 14B. DATE MEDICAID PLAN BEGAN (MM/DD/YYYY)
C YES C NO	YES NO (If "YES," complete It	(tem 14B)
New 147		THE REPORT OF THE PARTY OF THE
15. MONTHLY AMOUNT PATIENT IS RESPONSIBLE		IVEICAL DICADILITY AND IS DECENTING. (Cheek and
Andrew St.		HYSICAL DISABILITY AND IS RECEIVING: (Check one)
O SKILLED NURSING CARE O INTERMEDIA	ATE NURSING CARE	
17. NURSING HOME OFFICIAL'S NAME (First and Las	51)	леоприментальный учения при
18. NURSING HOME OFFICIAL'S TITLE		19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER (Include Area Code)
		NOWIDE TYPE THE THE COLEY
		Enter International Phone
	SECTION V - CERTIFICATION AND S	Number (If applicable)
I CERTIFY THAT the statements on this form are true		
I CERTIFI THAT the statements on this form are true	and correct to the best of my knowledge and belie	·
20 SIGNATURE OF NURSING HOME OFFICIAL (RE	OUIRED)	21. DATE SIGNED (MM/DD/YYYY)
20. SIGNATURE OF NURSING HOME OFFICIAL (RE	QUIRED)	21. DATE SIGNED (MM/DD/YYYY)
		any statement or evidence of a material fact you know to be false, or for

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 HOUSEBO NEED FOR REGULAR	OUND STATUS OR PERMAN AID AND ATTENDANCE	NENT							
IMPORTANT: Please read Privacy Act and Respondent &	Burden information before completing the	form.							
SECTION I: VETERAN'S IDENTIFICATION INFORMATION									
NOTE: You can either complete the form online o	or by hand. Please print the informat	ion requested in ink, neatly and legibly to help process the form.							
1. VETERAN'S NAME (First, Middle Initial, Last)									
2. SOCIAL SECURITY NUMBER 3. VA FILE NUMBER (If applicable) 4. DATE OF BIRTH (MM-DD-YYYY)									
5. VETERAN'S SERVICE NUMBER (If applicable)	6. SEX 7. TELEPHO	ONE NUMBER (Include Area Code)							
	C MALE								
8. E-MAIL ADDRESS (Optional)									
9. PREFERRED MAILING ADDRESS (Number and stre	eet or rural route, P. O. Box, City, State,	ZIP Code and Country)							
No. &			200000000000000000000000000000000000000						
Apt./Unit Number	City		······································						
State/Province Country									
SECTION II: CLAIM INFORMATION									
10. CLAIMANT'S NAME (First, Middle Initial, Last) (Comp	plete only if you are not the veteran)								
11. CLAIMANT'S SOCIAL SECURITY NUMBER	and an annual annua	12. RELATIONSHIP OF CLAIMANT TO VETERAN							
	0000000000000	C SPOUSE C SELF							
13. CLAIMANT'S HOME ADDRESS									
No. & Street									
Apt./Unit Number City	у								
State/Province Country	ZIP Code/Postal Code								
14. BENEFIT YOU ARE APPLYING FOR (Choose One)  Special Monthly Compensation (SMC) - Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid without eligibility to compensation.									
Special Monthly Pension (SMP) - Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.									
· · · · · · · · · · · · · · · · · · ·	SECTION III: INFORMATION								
участь сельня при	6A. IS CLAIMANT HOSPITALIZED?	16B. DATE ADMITTED (MM-DD-YYYY)							
	YES NO (If "Yes," complete Iten	To the second se							
17A. NAME OF HOSPITAL		17B. ADDRESS OF HOSPITAL							

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PATIENT/VETERAN'S SOC			·eur		200	li in the second	nonmen	_	1	Åmne			nnnnn	_	_	_	_		_	_	_						_	
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21. BLOOD PRESSURE	22. PULSE R	(ATE	2	23. RE	.SPIRA	ATORY	RATI	E	24. W	/HA	T DIS	SABIL	LITIE	ES RE	ESTF	RICT	THE	E LIS	;TED	AC	TIVIT	'IES/	/FUI	NCTIO	ONS'	?		
			anniqualpapen,																									
25. IF THE CLAIMANT IS From 9 PM to 9 AM:		Fr	rom 9 A	AM to 9	9 PM:																							
26. IS THE CLAIMANT A	BLE TO FEED	HIM/HER	(SELF?	/ (Fill i	in Circ	le. If "N	io," pr	rovide	e expl	lana	ation)		eğereren		·ş·······	·*·····	~~~~~	~ <u>*</u>		************	<u>*</u>	******	*******			*********	***********	wanne
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27. IS CLAIMANT ABLE	TO PREPARE	THEIR O'	WN MF	EALS?	(Fill i	in Circle	a. If "N	Vо," г	provid	ie ex	xplan	ation	1)													- wegan		
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PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

VA FORM 21-2680, SEP 2018

Page 3

#### 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 <u>do not</u> 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 pensic automatically consider a claim submitted on this form for rapid processing your claim considered for rapid processing under the FDC Program b	under the FDC Program. Check the below box ONLY if you DO NOT want
I DO NOT want my claim considered for rapid processing under the F	DC Program because I plan to submit further evidence in support of my claim.
35A. PRINTED NAME	
35B. VETERAN'S SIGNATURE (REQUIRED)	35C. DATE SIGNED (MM-DD-YYYY)
SECTION XI: WITNESSES TO SIGNATURE (MUST COMPL	ETE ONLY IF VETERAN SIGNED ITEM 35A WITH AN "X")
36A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	37A. SIGNATURE OF WITNESS (If veteran signed above using an "X")
36B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:	37B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:

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 <a href="www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA FORM 21P-527EZ, JAN 2021 Page 12

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

Department of Veterans Affairs

**VA DATE STAMP** (DO NOT WRITE IN THIS SPACE)

AS CLAIMANT'S RE		<b>'</b>								
<b>IMPORTANT</b> : Please read the Privacy Act and 3 before completing the form.	Page									
<b>NOTE:</b> If you prefer to have an individual assist complete VA Form 21-22, <i>Appointment of Indivi</i> form to the appropriate intake center address shadows.	idual as Claimant's Representative.	When completed y	ou can mail or fax	x this						
S	SECTION I: VETERAN'S INFORMA	ATION								
NOTE: You can either complete the form online or by hand. If completed b	by hand, print the information requested in ink, neatly	, and legibly to expedite proc	essing of the form.							
1. VETERAN'S NAME (First, Middle Initial, Last)										
2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. VETE	4. VETERAN'S DATE OF BIRTH							
		Mor	nth Day	Year -						
5. VETERAN'S SERVICE NUMBER (If applicable)	6. INSURANCE NUMBER(S) (If applied	cable) (Include letter	prefix)							
7. CURRENT MAILING ADDRESS (Number and street	t or rural route, P.O. Box, City, State, Z	IP Code and Country)	)							
No. & Street										
Apt./Unit Number City										
State/Province Country	ZIP Code/Postal Code									
8. VETERAN'S TELEPHONE NUMBER (Include Area	Code) 9. VETERAN'S EMAIL ADDI	RESS (Optional)								
SECTION II: (	CLAIMANT'S INFORMATION (If ot	ther than veteran)								
10. CLAIMANT'S NAME (First, Middle Initial, Las	it)									
11. CURRENT MAILING ADDRESS <i>(Number and stre</i> No. & Street	et or rural route, P.O. Box, City, State, 2	ZIP Code and Country	γ)							
Apt./Unit Number City										
State/Province Country	ZIP Code/Postal Code									
12. CLAIMANT'S TELEPHONE NUMBER (Include Are	ea Code) 13. CLAIMANT'S EMAIL AI	DDRESS (Optional)	14. RELATIONS	HIP TO VETERAN						
	I III: SERVICE ORGANIZATION IN									
15. NAME OF SERVICE ORGANIZATION RECOGNIZ organization)	ED BY THE DEPARTMENT OF VETER	RANS AFFAIRS <i>(See</i>	list on Page 3 befor	re selecting						
074 - The American Legion										
16A. NAME OF OFFICIAL REPRESENTATIVE ACTIN ORGANIZATION NAMED IN ITEM 15 (This is an and does not indicate the designation of only this the organization)	16B. JOB TITLE OF	FPERSON NAMED	IN ITEM 16A							
17. EMAIL ADDRESS OF THE ORGANIZATION NAME	18. DATE OF THIS APPOINTMENT (MM/DD/YYYY)									

### **SECTION IV: AUTHORIZATION INFORMATION**

the state of the company of the control of the cont										
19. AUTHORIZATION FOR REPRESENTATIVE'S ACCE checking the box below I authorize VA to disclose to the somy file relating to treatment for drug abuse, alcoholism or a cell anemia.	ervice organization	named on this appointme	ent form any records that may be in							
I authorize the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.										
20. LIMITATION OF CONSENT- I authorize disclosure of record	ls related to treatmen	t for all conditions listed in Ite	em 19 except:							
☐ DRUG ABUSE ☐ INFECTION	WITH THE HUMAN	IMMUNODEFICIENCY VIR	US (HIV)							
ALCOHOLISM OR ALCOHOL ABUSE SICKLE CE	LL ANEMIA									
21. AUTHORIZATION TO CHANGE CLAIMANT'S ADD 15 to act on my behalf to change my address in my VA re	RESS - By checkin	g the box below, I author	ize the organization named in Item							
I authorize any official representative of the organiz records. This authorization does not extend to any oremain in effect until the earlier of the following ever or (3) I have been determined unable to manage my appointed fiduciary.	other organization v nts: (1) I file a writte	vithout my further written en revocation with VA; or	consent. This authorization will (2) I appoint another representative,							
I, the claimant named in Items 1 <i>or</i> 10, hereby <i>appoint</i> the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. <i>Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match. Signed and accepted subject to the foregoing conditions.</i>										
SECT	ΓΙΟΝ V: SIGNA	TURES								
NOTE: THIS POWER OF ATTORNEY DO	ES NOT REQUIRE	EXECUTION BEFORE	A NOTARY PUBLIC							
22A. SIGNATURE OF VETERAN OR CLAIMANT (Do Not Print)	7	22B	. DATE SIGNED (MM/DD/YYYY)							
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (Do Not Print)  23B. DATE SIGNED (MM/DD/YYYY)										
<b>NOTE:</b> As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.										
VA USE ONLY  COPY OF VA FORM 21-22 SENT TO:  VR&E FILE  EDU FILE  INSURANCE FILE	DATE SENT	ACKNOWLEDGED (Date)	REVOKED (Reason and date)							
PENALTY: The law provides severe penalties which inclu	ude fine or imprisor	nment, or both, for the wil	Iful submission of any statement of							

a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

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