What is in this packet?

- **VA Widows Pension Worksheet** – give you information about applying for the benefit. Also includes the "formula" to see if the widow will qualify.
- **VA Form 21P-534ez, page 13** – this page only needs to be completed ***IF*** you are paying someone to come into the home to assist the surviving spouse with daily living needs.
- **Attendant Affidavit** – only complete this page ***IF*** you are paying someone to come into the house to assist the surviving spouse with daily living needs.
- **VA Form 21p-534ez, page 12** – 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 surviving spouse entered the facility, how much they are paying and what all the facility assists with.*
- **VA Form 21-0779** – this is for a NURSING HOME to complete if applicable.
- **VA Form 21-2680** – this form has to be completed by the surviving spouses' physician.
- **VA Form 21p-534ez, page 11** – this form needs to be signed by the surviving spouse.
- **VA Form 21-22** – Highlighted information needs to be completed by the surviving spouse and signed. Make sure the address of this form is the address that the mail will need to go to.

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

VA Widows Pension Worksheet

Veterans Name:_____

SSN:_____ Date of Birth:_____

Surviving Spouse Name:_____

SSN:_____ Date of Birth:_____

Address:_____

VA INCOME LIMITS (MAPR)	
Single Widow	$9,896.00
Single Widow Housebound	$12,094.00
Single Widow A&A	$15,816.00
Widow w/1 dependent	$12,951.00
Widow w/1 dependent housebound	$15,144.00
Widow w/1 dependent A&A	$18,867.00

Asset Limitation = 138,489.00

5 % RULE FOR 2020	
Single Widow	$494.00
Widow w/1 dependent	$647.00

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

Will I Qualify?

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

Total household income = 22,000.00
Total household med. exp. = 15,000.00
5% rule = 647.00
Widow w/1 dep. (MAPR) = 12,951.00

22,000.00 - 15,000.00 - 647.00 = 6,353.00

12,951.00 - 6,353.00 = 6,598.00

6,598.00/12(months) = $549.84 is approximate monthly amount widow would receive in pension.

PLEASE COMPLETE THE BACK SIDE OF THIS PAGE IN FULL.

You will need to supply the following:

⇒ DD-214
⇒ Veteran's Death Certificate
⇒ 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 *CHILDREN ONLY*
⇒ *Direct Deposit Information*
⇒ *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 Widow Pensions are eligible to surviving spouses with lower income who are to disabled to work.

Updated 12/14/2021

EXACT FIGURES ONLY

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

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

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

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 Surviving Spouse

_____

Date

Complete Steps below to find out approx. monthly benefit.

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

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.

Custodial Care is regular -

- 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

ATTENDANT AFFIDAVIT

_____
Veterans Name - Last, First, Middle

_____
VA Claim or Social Security Number

_____
Claimants Name

_____
Claimants Address (street)

_____
Claimants State, Zip Code

My name is _____, and I provide heath care for the above named claimant. I began employment on_____.

The services which I provide are:

Yes	No	Assistance with bathing	Other (Please describe below)
Yes	No	Standing and sitting	_____
Yes	No	Getting in and out of bed	_____
Yes	No	Eating	_____
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 provider

_____
Street Address

_____
City, State, and Zip Code

_____
Phone Number (including area code)

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

_____
Signature Date

_____ _____
Witness Date Witness Date

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?

☐ YES ☐ NO (If "NO," continue to Step 2)
(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)?

(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

☐ YES ☐ NO 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 disability, and (2) describes

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

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

(If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F) (If "NO,"

☐ YES ☐ 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)

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

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

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

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

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER — –

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* – –

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

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

6. SOCIAL SECURITY NUMBER — –

7. VA FILE NUMBER *(If applicable)*

8. DATE OF BIRTH *(MM/DD/YYYY)* – –

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

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

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

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

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

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

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

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

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

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

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

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

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

18. NURSING HOME OFFICIAL'S TITLE

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

Enter International Phone Number *(If applicable)*

SECTION V - CERTIFICATION AND SIGNATURE

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

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

21. DATE SIGNED *(MM/DD/YYYY)* – –

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

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE

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

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM-DD-YYYY)*

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

6. SEX
- ◯ MALE
- ◯ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*

8. E-MAIL ADDRESS *(Optional)*

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

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

SECTION II: CLAIM INFORMATION

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

11. CLAIMANT'S SOCIAL SECURITY NUMBER

12. RELATIONSHIP OF CLAIMANT TO VETERAN
- ◯ SPOUSE
- ◯ SELF

13. CLAIMANT'S HOME ADDRESS

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

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

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

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

SECTION III: INFORMATION OF EXAMINATION

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

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

16B. DATE ADMITTED *(MM-DD-YYYY)*

17A. NAME OF HOSPITAL

17B. ADDRESS OF HOSPITAL

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

NOTE: EXAMINER PLEASE READ CAREFULLY

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

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

18A. AGE

18B. WEIGHT

ACTUAL LBS. ESTIMATED LBS.

18C. HEIGHT

FEET INCHES

19. NUTRITION

20. GAIT

21. BLOOD PRESSURE

22. PULSE RATE

23. RESPIRATORY RATE

24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

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

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

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

◯ YES ◯ NO

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

◯ YES ◯ NO

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

◯ YES ◯ NO

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

◯ YES ◯ NO

29B. CORRECTED VISION

LEFT EYE

RIGHT EYE

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

◯ YES ◯ NO

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

◯ YES ◯ NO

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

◯ YES ◯ NO

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

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

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

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

36. DESCRIBE RESTRICTION OF SPINE, TRUNK AND NECK

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

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

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

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

SECTION IV: CERTIFICATION AND SIGNATURE

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

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

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

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

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

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

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 Account No.: _____ ☐ Savings Account No.: _____ ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

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

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

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

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

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization please complete VA Form 21-22, *Appointment of Individual as Claimant's Representative*. When completed you can mail or fax this form to the appropriate intake center address shown on Page 4. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

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

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

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. VETERAN'S DATE OF BIRTH Month Day Year - -
5. VETERAN'S SERVICE NUMBER *(If applicable)*	6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*	

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*	9. VETERAN'S EMAIL ADDRESS *(Optional)*

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

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

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

12. CLAIMANT'S TELEPHONE NUMBER (Include Area Code)	13. CLAIMANT'S EMAIL ADDRESS *(Optional)*	14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

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

074 - The American Legion

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*	16B. JOB TITLE OF PERSON NAMED IN ITEM 16A
17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15	18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

VETERAN'S SOCIAL SECURITY NO.

SECTION IV: AUTHORIZATION INFORMATION

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

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

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

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

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

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

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

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

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

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

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

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

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