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Department of Veteran Services

200 South Center Street

Ebensburg, PA 15931

PHONE: (814) 472-1590 FAX: (814) 472-1423

Dear Wartime Veteran,

Thank you for your service to our Country!

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

- You served on **active-duty** for at least **90 days** (24 months if service was after 1980) with one of those days being in a **wartime period**. (WWII: DEC 7, 1941 – DEC 31, 1946; Korea: JUN 27, 1950 – JAN 31, 1955; Vietnam Era: AUG 5, 1964 – MAY 7, 1975; Vietnam (deployed to Vietnam): NOV 1, 1955 - MAY 7, 1975; Gulf War/Persian Gulf: AUG 2, 1990 – Present
- You **did not get dishonorably discharged** from the service
- Your **income + assets** (excluding your home and car) are less than **< \$155,356**
- You are **at least 65 years old**, **or**, you have a permanent and total **disability**, **or**, you are a patient in a nursing home for **long-term care** because of a disability, **or**, you get Social Security Disability or Supplemental Security Income.

The process to get a Veteran's Pension is very detailed and specific. You must submit all the required items in the proper way to be successful. The Cambria County Veterans' Services Office is here to help you properly submit your claim. To start the process, the **Veteran** needs to fill out and **sign** a VA Form **21-22** and VA Form **21-0966** (attached). The 21-22 authorizes this office to assist you, and the 21-0966 protects your date of claim. The date the VA receives your 21-0966 is the date the VA acknowledges that you started a claim. **Get these forms signed and submitted as soon as you can.** Please be aware that the VA does not recognize the signature of a Power of Attorney (PoA) for a Veteran, unless the VA has previously authorized the PoA to sign.

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

- A VA Form 21P-527EZ (Claim Form) signed by the Veteran
- A DD 214 or other discharge document showing the Veteran's dates and character of service
- **All** marriage, divorce, and death certificates for the Veteran and the Veteran's dependents
- The Veteran's Direct Deposit Information (found on a check)
- Social Security Benefit Verification Statement for the Veteran and the Veteran's dependents (if the Veteran/dependent gets Social Security)
- Unreimbursed medical expense/medical insurance premium receipts for the Veteran and the Veteran's dependents, and a VA Form 21-8416 Medical Expense Report (attached) signed by the Veteran. If the Veteran and/or spouse is in a nursing home/assisted living facility, provide a recent invoice.
- All financial/bank/investment/pension/IRA statements from the most recent reporting period for the Veteran and the Veteran's dependents, and a VA Form 21P-0969 (Income and Asset Report).

Additional forms that may be required:

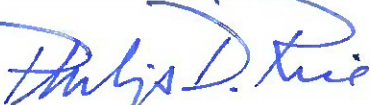
- **VA Form 21-2680 (Exam)**. For nursing home costs, assisted living costs, and/or caregiver costs to be considered as unreimbursed medical expenses, a doctor needs to show that there is a medical need for that type of care on the Form 21-2680. Also, the VA uses the Form 21-2680 to determine if a claimant should be in a higher tier of the Veteran's Pension benefit. A medical doctor is responsible for filling out Sections III and IV. On page two, if the block asks for an explanation, please ensure that the doctor provides a MEDICAL REASON. If a required explanation is blank on page two, it may delay the claim or result in a decreased benefit. **If you are requesting a special monthly pension for Aid and Attendance, a doctor must complete a 21-2680** for the Veteran and/or dependent.
- **VA Form 21-0779 (Nursing Home Information)**. - If the Veteran and/or dependent is a resident at a nursing home, have the facility complete this form and sign it. Make sure the administrator puts an amount in Block 15.
- **Worksheet for a Residential Care Facility** – Page 16 of the VA Form 21P-527EZ. If the Veteran and/or dependent is living at a nursing home or assisted living facility, have the facility complete and sign this form.
- **Nursing Home Letter (optional but recommended)** – Nursing homes/assisted living facilities often provide a letter, on the facility's stationary, providing details about the claimant's care. This includes the name of the claimant, the date care started, the amount the claimant pays each month, details on services that the facility provides, and any other information about the claimant or care that the facility wants to ensure that the VA understands. Have an administrator at the facility sign and date the letter.
- **Worksheet for In-Home Attendant Expenses** - Page 17 of the VA Form 21P-527EZ. If the Veteran and/or dependent is getting care at home, have the company providing care, or each caregiver, complete this form and sign it. Have a worksheet for each paid caregiver.
- **VA Form 21-0845 (Disclosure)** – This optional form allows one other person to talk with the VA about the claim. The form requires the claimant's signature.

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

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

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

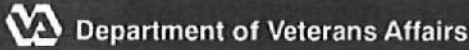
Very sincerely yours



Philip D. Rice

Director

Cambria County Veterans' Services



APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

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

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: <https://www.va.gov/ogc/apps/accreditation/index.asp>. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. For more information, you can contact us through Ask VA: <https://ask.va.gov/>, or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

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)

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2. SOCIAL SECURITY NUMBER (SSN)	3. VA FILE NUMBER (If applicable)	4. VETERAN'S DATE OF BIRTH (MM/DD/YYYY)
		Month Day Year

5. VETERAN'S SERVICE NUMBER (If applicable)	6. INSURANCE NUMBER(S) (If applicable) (Include letter prefix)

7. 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. TELEPHONE NUMBER (Include Area Code)	9. EMAIL ADDRESS (Optional)

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

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

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11A. CLAIMANT'S DATE OF BIRTH	11B. RELATIONSHIP TO VETERAN
Month Day Year	

12. 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 -

13. TELEPHONE NUMBER (Include Area Code)	14. EMAIL ADDRESS (Optional)

SECTION III: SERVICE ORGANIZATION INFORMATION

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

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

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15	18. DATE OF THIS APPOINTMENT (MM/DD/YYYY)

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:

- | | |
|--|--|
| <input type="checkbox"/> DRUG ABUSE | <input type="checkbox"/> INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) |
| <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE | <input type="checkbox"/> SICKLE CELL ANEMIA |

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

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

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

SECTION V: SIGNATURES

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

22A. SIGNATURE OF VETERAN OR CLAIMANT (Required)

22B. DATE SIGNED (MM/DD/YYYY)

23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (Required)

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:	DATE SENT (MM/DD/YYYY)	ACKNOWLEDGED (Date) (MM/DD/YYYY)	REVOKED (Reason and date (MM/DD/YYYY))
	<input type="checkbox"/> VR&E FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> LG FILE <input type="checkbox"/> INSURANCE FILE			

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 III: GENERAL BENEFIT ELECTION

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

19. I INTEND TO FILE FOR THE GENERAL BENEFIT(S) CHECKED BELOW: (Choose all that apply)

COMPENSATION PENSION

NOTE: ONLY CHECK THE BOX BELOW IF YOU ARE A SURVIVING DEPENDENT OF THE VETERAN.

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

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at www.va.gov. If you give VA a completed application for the selected general benefit within *one* year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the *first* completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file (VA Form 21-0966) for each general benefit. Please complete as much of this form as possible, as VA cannot process this form if we cannot identify the claimant and/or veteran.

SECTION IV: DECLARATION OF INTENT AND SIGNATURE

By filing this form, I **HEREBY INDICATE MY INTENT** to apply for one or more general benefits under the laws administered by VA.

I acknowledge that:

- (1) this is **not a claim for benefits**,
- (2) I must file a complete application for each general benefit with VA before VA will process my claim; and
- (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

20. SIGNATURE OF VETERAN/CLAIMANT/AUTHORIZED AGENT (REQUIRED)

[Signature box]

21. DATE SIGNED (MM/DD/YYYY)

[Date box: MM - DD - YYYY]

22. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION (VSO) (Please Print)

NOTE: This form may only be completed by a VSO, attorney, or agent if a valid power of attorney has been completed.

[Name box]

Where to Send Correspondence - After completing this form, mail to:

Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Janesville, WI 53547- 4444

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.

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

RESPONDENT BURDEN: We need this information to determine the intent of the claimant and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



VA DATE STAMP
 (DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1B. VETERAN'S SOCIAL SECURITY NUMBER

1C. VETERAN'S DATE OF BIRTH (MM/DD/YYYY)

1D. HAVE YOU EVER FILED A CLAIM WITH VA?
 YES NO (If NO, skip question 1E)

1E. VA FILE NUMBER (If applicable)

SECTION II: VETERAN'S CONTACT INFORMATION

2A. MAILING ADDRESS

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

2B. TELEPHONE NUMBER (Include Area Code)

International Phone Number (If applicable)

2C. VETERAN'S E-MAIL ADDRESS (Optional)

SECTION III: VETERAN'S SERVICE INFORMATION (MUST COMPLETE)

3A. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER (If None, leave blank)

3B. DATE INITIALLY ENTERED ACTIVE DUTY (MM/DD/YYYY)

3C. FINAL RELEASE DATE FROM ACTIVE DUTY (MM/DD/YYYY)

3D. YOUR SERVICE NUMBER

3E. BRANCH OF SERVICE
 ARMY NAVY AIR FORCE
 COAST GUARD MARINE CORPS
 SPACE FORCE USPHS NOAA

3F. PLACE OF YOUR LAST SEPARATION

3G. HAVE YOU EVER BEEN A PRISONER OF WAR?
 YES NO (If "NO," skip to question 4A)

3H. DATES CONFINEMENT STARTED (MM/DD/YYYY)

3I. DATES CONFINEMENT ENDED (MM/DD/YYYY)

SECTION IV: PENSION INFORMATION

4A. ARE YOU OVER THE AGE OF 65 OR HAVE YOU BEEN DETERMINED TO BE DISABLED BY SOCIAL SECURITY ADMINISTRATION?
 YES NO (If "YES," skip question 4B)

4B. ARE YOU MEDICALLY INCAPABLE OF WORKING?
 YES NO (If "YES," you must submit medical evidence with this application)

4C. DO YOU LIVE IN A NURSING HOME?
 YES NO (If "NO," skip question 4D)

4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED FOR MEDICAID?
 YES NO (If "YES," please have an official from your nursing home complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance)

4E. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL IMPAIRMENT OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?
 YES NO (If "YES," complete and attach with this application, VA Form 21-2680, Examination 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))

4F. HAVE YOU RECEIVED TREATMENT FROM A VA MEDICAL CENTER? <input type="radio"/> YES <input type="radio"/> NO Specify Facility: _____	4G. HAVE YOU RECENTLY RECEIVED TREATMENT FROM ANY FEDERAL MEDICAL FACILITIES (Military base, etc.)? <input type="radio"/> YES <input type="radio"/> NO Specify Facility: _____
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SECTION V: EMPLOYMENT HISTORY

5A. ARE YOU CURRENTLY EMPLOYED?
 YES NO (If "NO," skip questions 5B and 5C)

5B. WHAT KIND OF WORK ARE YOU CURRENTLY DOING?

5C. HOW MANY HOURS PER WEEK DO YOU AVERAGE?

5D. WHEN DID YOU LAST WORK? (MM/DD/YYYY) <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	5E. HOW MANY HOURS PER WEEK DID YOU AVERAGE? <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>
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5F. WHAT WAS YOUR JOB TITLE? _____

5G. WHAT KIND OF WORK DID YOU DO? _____

SECTION VI: MARITAL STATUS (MUST COMPLETE)

6A. WHAT IS YOUR MARITAL STATUS? (Check one)
 MARRIED SEPARATED NOT MARRIED (Widowed or Never Married - Skip to Section VIII)

6B. SPOUSE'S CURRENT LEGAL NAME (First, Middle Initial, Last)

6C. SPOUSE'S BIRTH DATE (MM/DD/YYYY) <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>	6D. SPOUSE'S SOCIAL SECURITY NUMBER <input style="width: 30px;" type="text"/> - <input style="width: 30px;" type="text"/> - <input style="width: 30px;" type="text"/>
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6E. DATE AND PLACE OF MARRIAGE (MM/DD/YYYY) CITY AND STATE OR COUNTRY
 / / _____

6F. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.)
 CEREMONIAL OTHER (Specify) _____

6G. IS YOUR SPOUSE ALSO A VETERAN? <input type="radio"/> YES <input type="radio"/> NO (If "NO," skip question 6H)	6H. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? (If any) <input style="width: 60px;" type="text"/>
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6I. IF YOU ARE SEPARATED, PLEASE TELL US THE REASON YOU ARE SEPARATED (Illness, work, etc.)
 MEDICAL REASON MARITAL DISCORD WORK OTHER (Specify) _____

6J. SPOUSE'S MAILING ADDRESS (If separated)

No. & Street _____

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code -

6K. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? (If separated)
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SECTION VII: PRIOR MARITAL HISTORY

Tell us about your and your spouse's previous marriages. If you have never been married or your current marriage is yours and your spouse's only marriage skip to Section VIII.

VETERAN'S PRIOR MARRIAGES (If None, skip to question 7L)

7A. WHO WERE YOU MARRIED TO? (First, Middle Initial, Last)

7B. HOW DID YOUR PREVIOUS MARRIAGE END? (Death, divorce, etc.) <input type="radio"/> DEATH <input type="radio"/> DIVORCE <input type="radio"/> OTHER (Specify) _____	7C. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY) START: <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> END: <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/>
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7D. PLACE OF MARRIAGE (City and State or Country)

7E. PLACE OF MARRIAGE TERMINATION (City and State or Country)

SECTION VIII: DEPENDENT CHILDREN (CONTINUED)

8K. WHAT IS THE CHILD'S STATUS? (Select all that apply)

- BIOLOGICAL
 STEPCCHILD
 SERIOUSLY DISABLED
 18-23 YEARS OLD (in school)
 PREVIOUSLY MARRIED
 ADOPTED
 DOES NOT LIVE WITH YOU BUT CONTRIBUTES \$.

8L. CHILD'S NAME (First, Middle Initial, Last)

8M. CHILD'S BIRTH DATE (MM/DD/YYYY)

/ /

8N. CHILD'S SOCIAL SECURITY NUMBER

- -

8O. PLACE OF BIRTH (City and State or Country)

8P. WHAT IS THE CHILD'S STATUS? (Select all that apply)

- BIOLOGICAL
 STEPCCHILD
 SERIOUSLY DISABLED
 18-23 YEARS OLD (in school)
 PREVIOUSLY MARRIED
 ADOPTED
 DOES NOT LIVE WITH YOU BUT CONTRIBUTES \$.

8Q. DO ALL OF YOUR CHILDREN THAT ARE NOT LIVING WITH YOU AS ANSWERED ABOVE RESIDE AT THE SAME ADDRESS?

- YES
 NO (If "NO," Please submit a VA Form 21-4138, Statement in Support of Claim, with the following information: Who the child is currently living with, and the full address of where the child resides.)

8R. PLEASE PROVIDE THE NAME OF THE CUSTODIAN AND THE ADDRESS OF CHILDREN NOT LIVING WITH YOU

NAME OF CUSTODIAN (First, Middle Initial, Last)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

-

SECTION IX: QUESTIONS REGARDING INCOME AND 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.

9A. DO YOU AND YOUR DEPENDENTS HAVE OVER \$25,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?

- YES
 NO (If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.))

\$, .00 (If "NO," please estimate the total value of your assets)

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)

- YES
 NO (If "YES," please submit VA Form 21P-0969)

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

- YES
 NO (If "NO," skip to Item 9G)

9D. IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

- YES
 NO (If "NO," skip to Item 9G)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES? (Do not include the value of the residence or the first 2 acres.)

\$, , .00

9F. IS THE LAND OVER 2 ACRES (87, 120 SQ FT) REPORTED IN QUESTION 9E MARKETABLE?

- YES
 NO (If "YES," please submit VA Form 21P-0969)

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

- YES
 NO (If "YES," please submit VA Form 21P-0969 and ONLY report your Social Security Income below)

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C., by questions 9A through 9G, we only require Social Security income reported below. All other income should be reported on VA Form 21P-0969. Income will be counted as reported, do not duplicate.

NOTE: If reporting income in 9H through 9K, any items skipped or left blank will be considered as an unspecified income and could require a request for further information, potentially delaying your claim. If you leave the entire question blank, we will assume you have no income to report.

9H(1) WHO IS THE INCOME RECIPIENT? (Select one)

- VETERAN
 SPOUSE
 CHILD (Specify)

9H(2) SPECIFY THE TYPE OF INCOME

- SOCIAL SECURITY
 INTEREST/DIVIDENDS
 CIVIL SERVICE
 PENSION/RETIREMENT
 OTHER (Specify type of income)

9H(3) SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

9H(4) CURRENT GROSS MONTHLY INCOME

\$, .

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS (Continued)

<p>9I(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i></p> <p><input type="radio"/> VETERAN</p> <p><input type="radio"/> SPOUSE</p> <p><input type="radio"/> CHILD <i>(Specify)</i></p> <hr/>	<p>9I(2) SPECIFY THE TYPE OF INCOME</p> <p><input type="radio"/> SOCIAL SECURITY <input type="radio"/> INTEREST/DIVIDENDS</p> <p><input type="radio"/> CIVIL SERVICE <input type="radio"/> PENSION/RETIREMENT</p> <p><input type="radio"/> OTHER <i>(Specify type of income)</i></p>	<p>9I(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i></p> <hr/> <p>9I(4) CURRENT GROSS MONTHLY INCOME</p> <p>\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>9J(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i></p> <p><input type="radio"/> VETERAN</p> <p><input type="radio"/> SPOUSE</p> <p><input type="radio"/> CHILD <i>(Specify)</i></p> <hr/>	<p>9J(2) SPECIFY THE TYPE OF INCOME</p> <p><input type="radio"/> SOCIAL SECURITY <input type="radio"/> INTEREST/DIVIDENDS</p> <p><input type="radio"/> CIVIL SERVICE <input type="radio"/> PENSION/RETIREMENT</p> <p><input type="radio"/> OTHER <i>(Specify type of income)</i></p>	<p>9J(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i></p> <hr/> <p>9J(4) CURRENT GROSS MONTHLY INCOME</p> <p>\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>9K(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i></p> <p><input type="radio"/> VETERAN</p> <p><input type="radio"/> SPOUSE</p> <p><input type="radio"/> CHILD <i>(Specify)</i></p> <hr/>	<p>9K(2) SPECIFY THE TYPE OF INCOME</p> <p><input type="radio"/> SOCIAL SECURITY <input type="radio"/> INTEREST/DIVIDENDS</p> <p><input type="radio"/> CIVIL SERVICE <input type="radio"/> PENSION/RETIREMENT</p> <p><input type="radio"/> OTHER <i>(Specify type of income)</i></p>	<p>9K(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i></p> <hr/> <p>9K(4) CURRENT GROSS MONTHLY INCOME</p> <p>\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>

SECTION X: 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 that you expect to pay indefinitely (including the Medicare deduction) for yourself, any claimed dependents who are under your obligation for support, or any relatives who are members of your household. In some circumstances we can consider medical expenses up to one year prior to your initial date of entitlement. 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 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 criteria below (if applicable). If more space is needed, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?

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

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed in questions 10B through 10J. Do not include expenses paid by other family members, insurance, etc.

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or residential care, adult daycare, or similar care facility, you must complete the applicable worksheet(s) on pages 16 and 17 for each provider.

<p>10B(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i></p> <p><input type="radio"/> VETERAN</p> <p><input type="radio"/> SPOUSE</p> <p><input type="radio"/> CHILD <i>(Specify)</i></p>	<p>10B(2). NAME OF PROVIDER AND TYPE OF CARE <i>(Select one)</i></p> <p><input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDANT</p>	<p>10B(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> PER HOUR</p> <p><input type="text"/> <input type="text"/> HOURS WORKED PER WEEK</p>
<p>10B(4). PROVIDER START AND END DATE <i>(MM/DD/YYYY)</i></p> <p>START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="radio"/> NO END DATE</p>	<p>10B(5). PAYMENT FREQUENCY</p> <p><input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY</p>	<p>10B(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED</p> <p>\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>

<p>10C(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i></p> <p><input type="radio"/> VETERAN</p> <p><input type="radio"/> SPOUSE</p> <p><input type="radio"/> CHILD <i>(Specify)</i></p>	<p>10C(2). NAME OF PROVIDER AND TYPE OF CARE <i>(Select one)</i></p> <p><input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDANT</p>	<p>10C(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> PER HOUR</p> <p><input type="text"/> <input type="text"/> HOURS WORKED PER WEEK</p>
<p>10C(4). PROVIDER START AND END DATE <i>(MM/DD/YYYY)</i></p> <p>START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/></p> <p>END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="radio"/> NO END DATE</p>	<p>10C(5). PAYMENT FREQUENCY</p> <p><input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY</p>	<p>10C(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED</p> <p>\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>

IN-HOME CARE OR CARE FACILITY (Continued)		
10D(1). WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10D(2). NAME OF PROVIDER AND TYPE OF CARE (Select one) <input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDANT	10D(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR? \$ [] [] [] . [] [] PER HOUR [] [] HOURS WORKED PER WEEK
10D(4). PROVIDER START AND END DATE (MM/DD/YYYY) START: [] [] / [] [] / [] [] [] [] END: [] [] / [] [] / [] [] [] [] <input type="radio"/> NO END DATE	10D(5). PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY	10D(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED \$ [] [] [] [] [] []
OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES		
10E(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10E(2) PAID TO (Name of Provider, Insurance Company, etc.) 10E(3) PURPOSE (Insurance premium, medical supplies, etc.)	10E(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10E(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10E(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []
10F(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10F(2) PAID TO (Name of Provider, Insurance Company, etc.) 10F(3) PURPOSE (Insurance premium, medical supplies, etc.)	10F(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10F(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10F(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []
10G(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10G(2) PAID TO (Name of Provider, Insurance Company, etc.) 10G(3) PURPOSE (Insurance premium, medical supplies, etc.)	10G(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10G(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10G(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []
10H(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10H(2) PAID TO (Name of Provider, Insurance Company, etc.) 10H(3) PURPOSE (Insurance premium, medical supplies, etc.)	10H(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10H(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10H(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []
10I(1). WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10I(2) PAID TO (Name of Provider, Insurance Company, etc.) 10I(3) PURPOSE (Insurance premium, medical supplies, etc.)	10I(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10I(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10I(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES (Continued)		
10J(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10J(2) PAID TO (Name of Provider, Insurance Company, etc.) 10J(3) PURPOSE (Insurance premium, medical supplies, etc.)	10J(4) DATE COSTS INCURRED (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/> 10J(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10J(6) AMOUNT YOU PAY (Based on Frequency selected) \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

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

11A. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit sent)

11B. TYPE OF ACCOUNT (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 I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

11C. ROUTING NUMBER

11D. ACCOUNT NO.

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

I CERTIFY THAT 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 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 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 12A 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.

12A. 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.

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.

12B. SIGNATURE OR MARK

12C. DATE SIGNED (MM/DD/YYYY)
 / /

SECTION XIII: WITNESSES TO SIGNATURE
 (TWO (2) WITNESS SIGNATURES ARE REQUIRED IF THE CLAIMANT SIGNED ITEM 12B WITH AN "X")

13A. SIGNATURE OF THE FIRST WITNESS (If claimant signed above using an "X")

13B. PRINTED NAME AND ADDRESS OF FIRST WITNESS
 Name:
 Address:

13C. SIGNATURE OF THE SECOND WITNESS (If claimant signed above using an "X")

13D. PRINTED NAME AND ADDRESS OF SECOND WITNESS
 Name:
 Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE

14B. DATE SIGNED (MM/DD/YYYY)

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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.

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 if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the federal register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA Benefits, 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 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 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 suggestion about this form.

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, Medical Expense Report. In addition, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

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2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

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3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

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4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

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5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

	-		-	
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6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

--

Apt./Unit Number

--

 City

--

State/Province

--

 Country

--

 ZIP Code

--

 -

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7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

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8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR

D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT, PLEASE CHECK THE BOX IF THE STATEMENT IS TRUE FOR THE FACILITY.

THE STATE OR COUNTRY REQUIRES THIS FACILITY TO BE LICENSED

THE FACILITY IS LICENSED

THE FACILITY IS RESIDENTIAL

THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)

YES NO, Care is being provided by a third-party provider. NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each in-home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:5%; text-align: center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:5%; text-align: center;">/</td> <td style="width:70%; height: 20px;"></td> </tr> </table>		/		/		12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:5%; text-align: center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:5%; text-align: center;">/</td> <td style="width:70%; height: 20px;"></td> </tr> </table> <input type="checkbox"/> INDEFINITE		/		/	
	/		/								
	/		/								

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

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 PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the care recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)	15. DATE SIGNED (MM/DD/YYYY) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:5%; text-align: center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:5%; text-align: center;">/</td> <td style="width:70%; height: 20px;"></td> </tr> </table>		/		/	
	/		/			

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, Medical Expense Report. In addition, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? *(Name of Care Recipient, either the Claimant or Dependent)*

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2. WHO IS COMPLETING THIS WORKSHEET? *(In-Home Care Attendant or Agency Administrator, Provider)*

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3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)

YES NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

YES NO *(If "NO," skip to question 7)*

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

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6. WHAT IS THE AGENCY TELEPHONE NUMBER?

	-		-	
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7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

--

Apt./Unit Number

--

 City

--

State/Province

--

 Country

--

 ZIP Code

--

 -

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8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR
 D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

A. SHOPPING B. FOOD PREPARATION C. NON-MEDICAL TRANSPORTATION
 D. LAUNDERING E. USING TELEPHONE F. MANAGING FINANCES
 G. HOUSEKEEPING H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE?
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)

YES NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT.
(MM/DD/YYYY)

	/		/				
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12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)*
(Select "Indefinite" if the care you provide is not temporary.)

	/		/				
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INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

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 PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

--

 HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER *(From question 2)*

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16. DATE SIGNED *(MM/DD/YYYY)*

	/		/				
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INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

VA may be able to pay you a higher benefit rate if you report medical expenses for VA to deduct from your income. Your benefit rate is calculated based on your income. Your out-of-pocket payments for medical, optical and dental expenses may be deductible.

This form is used to report any medical expenses that you paid for yourself or for a relative who is a dependent member of your household (spouse, child, grandchild, parent, etc.), for which you were not reimbursed and do not expect to be reimbursed. Below are examples of expenses you may include, if applicable:

- Hospital expenses
- Doctor's office fees
- Dental fees
- Prescription/non-prescription drug costs
- Vision care costs
- Medical insurance premiums
- Nursing home costs
- Hearing aid costs
- Home health service expenses
- Expenses related to transportation to a hospital, doctor or other medical facility
- Monthly Medicare deduction

THE FORM IS COMPRISED OF 8 SECTIONS. BE SURE TO ANSWER THE QUESTION(S) IN EACH SECTION AS REQUIRED.	
SECTION I: VETERAN'S IDENTIFICATION INFORMATION	SECTION V: OTHER MEDICAL EXPENSES
SECTION II: CLAIMANT'S CONTACT INFORMATION	SECTION VI: MILEAGE
SECTION III: REPORTING PERIOD	SECTION VII: CERTIFICATION AND SIGNATURE
SECTION IV: IN-HOME CARE AND CARE FACILITY EXPENSES	SECTION VIII: WITNESS TO SIGNATURE

This form contains the following addendums and worksheets that may be required to support your application:

Addendum:

- A: In-Home Care or Care Facility Expenses
- B: Other Medical Expenses Continued
- C: Mileage Traveled for Medical Purposes Using Privately Owned Vehicle

Worksheet:

- Residential Care, Adult Daycare, or a Similar Facility
- In-Home Attendant Expenses

IMPORTANT INFORMATION

- All medical expenses must be reported on VA Form 21P-8416, *Medical Expense Report*. This form contains optional addendums that you may submit to supplement this form without the need to submit multiple copies of VA Form 21P-8416. You may submit as many copies of each addendum as you need. If you leave the questions on the addendum blank, VA will assume you are not submitting any additional medical expenses beyond the pages received.
- Do not include any expenses for which you were or will be reimbursed. If you receive reimbursement after you have filed this claim, promptly notify VA by submitting a completed VA Form 21-4138, *Statement in Support of Claim*, or by contacting our call center at 1-800-827-1000.
- VA can deduct allowable expenses paid by either you, your spouse (for veterans) or other relative that is a constructive member of the household.
NOTE: Constructive member means the expenses can be for a spouse in a nursing home, a child away at school, or a similar situation. The expenses were incurred on behalf of the claimant or a relative of the claimant (not necessarily a dependent for VA purposes) who is a member or constructive member of the claimant's household.
- If you are unsure whether VA can deduct a payment for a particular expense, furnish a complete description including the purpose of the payment. VA will inform you if an expense cannot be deducted.
- If you are claiming vitamins, food supplements and/or herbal remedies, VA may allow these expense deductions on a limited basis (per household member and calendar year). If the deductions are over the limit per household member, VA requires evidence from a healthcare provider instructing the claimant or other dependent member of the household to purchase vitamins, food supplements and/or herbal remedies. Please ensure these expenses are listed separately per household member.

IMPORTANT INFORMATION (Continued)

- **DO NOT** submit receipts for medical expenses you paid. VA may require you to verify the amounts you paid in some circumstances. Therefore, please keep all receipts or other documentation of payments for at least 3 years after receiving a decision on your medical expense claim. If you are unable to provide documentation of your claimed medical expenses when VA asks you to do so, your benefits may be retroactively reduced or discontinued.
- Submitting a new VA Form 21P-8416 without reporting a previously counted continuing medical expense may result in removal of the medical expense from the date of receipt of the form.
- If reporting expenses for a nursing home facility, please also submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*. **Important** - This only applies if your care facility is found under the "Nursing homes including rehab services" section of the following website address:
<https://www.medicare.gov/care-compare>.
- If you are claiming expenses for an in-home care provider or for assisted living or similar care, each care provider should complete the applicable worksheet for VA to determine whether all or some of your payments to the provider or facility are deductible. The applicable worksheets are:
 - o Residential Care, Adult Daycare, or a Similar Facility - **OR** -
 - o In-Home Attendant Expenses

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)

You may wish to contact an accredited Veterans Service Officer to assist you with your application. For a list of accredited Veterans service organizations go to <https://www.va.gov/vso/>. You may also contact your state office of Veterans Affairs at <https://www.va.gov/statedva.htm>, should you need further assistance with the application process. To assign a VSO as your power of attorney for the claims process, please submit a VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents

Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veteran Affairs, go to: <https://www.va.gov/ogc/apps/accreditation/index.asp>. To assign a private attorney or claims agent as your power of attorney for the claims process, please submit VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims

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

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

RESPONDENT BURDEN: We need this information to determine whether medical expenses you paid may be used to reduce the amount of income we count in determining eligibility to benefits (38 U.S.C. 1503). Title 38, United States Code, 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 Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

MEDICAL EXPENSE REPORT

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

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

FIRST: _____ MI: _____ LAST: _____

1B. VETERAN'S SOCIAL SECURITY NUMBER

1C. VA FILE NUMBER (If applicable)

SECTION II: CLAIMANT'S CONTACT INFORMATION

2A. NAME OF CLAIMANT (First, Middle Initial, Last - if different from veteran)

FIRST: _____ MI: _____ LAST: _____

2B. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code, and Country)

No. and Street _____ Apt./Unit Number _____

City _____ State/Province _____ Country _____ Zip Code/Postal Code _____

2C. PRIMARY TELEPHONE NUMBER (Include Area Code)

_____-_____-_____-_____-_____-_____- International Telephone Number (If applicable) _____

2D. CLAIMANT'S EMAIL ADDRESS (Optional)

SECTION III: REPORTING PERIOD

This form is designed to provide VA with your medical expenses paid during a specific date range to determine or adjust your benefits. If you are submitting an initial application, please only report medical expenses paid on or after your effective date. Your effective date is typically the earliest of the following dates:

- Date VA receives your initial application
- Date VA receives your VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*
- Date of the veteran's death (for Survivors Pension, if within one year of the veteran's death)

If you are already in receipt of pension benefits, report medical expenses you paid on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX). If you are responding to a letter that identifies a specific date range, please report medical expenses you paid during the requested period(s).

NOTE: Submit separate VA Form 21P-8416's if reporting information for additional date ranges beyond a 1-year period.

3. THE INFORMATION SHOWN BELOW REPRESENTS MEDICAL EXPENSES PAID DURING THE FOLLOWING DATE RANGE:

Report amounts paid between the dates _____ and _____ - OR- DATE RECEIVED BY VA (For initial applications only)

SECTION IV: IN-HOME CARE AND CARE FACILITY EXPENSES

IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on pages 9 and 10, in addition to completion of this section. If you are reporting a nursing home found under the "Nursing homes including rehab services" section of the <https://www.medicare.gov/care-compare> website, you must submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*, instead of a worksheet.

4A (1). WHOSE EXPENSES WERE PAID?

VETERAN SPOUSE CHILD (Specify) OTHER (Specify)

Specify Name of Child or Other: _____

4A. (3) PROVIDER START AND END DATE (MM/DD/YYYY)

START: ____/____/____

NOTE: If care is ongoing leave end date blank.

END: ____/____/____

4A (2). NAME OF PROVIDER

4A (4). AMOUNT PAID MONTHLY

\$ ____ , ____ . ____

4A (5). IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW

Payment Rate (Per Hour) \$ ____ .00 Average Hours Worked (Per Week) ____

4B (1). WHOSE EXPENSES WERE PAID?

VETERAN SPOUSE CHILD (Specify) OTHER (Specify)

Specify Name of Child or Other: _____

4B. (3) PROVIDER START AND END DATE (MM/DD/YYYY)

START: ____/____/____

NOTE: If care is ongoing leave end date blank.

END: ____/____/____

4B (2). NAME OF PROVIDER

4B (4). AMOUNT PAID MONTHLY

\$ ____ , ____ . ____

4B (5). IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW

Payment Rate (Per Hour) \$ ____ .00 Average Hours Worked (Per Week) ____

NOTE: If you have additional in-home care or care facility expenses, complete Addendum A: In-Home Care or Care Facility Expenses on page 6.

SECTION V: OTHER MEDICAL EXPENSES

DO NOT report your monthly recurring expenses on multiple lines; rather, report recurring expenses on one line. For recurring expenses include the specific dates the recurring expense started and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. If a recurring expense has already terminated, please treat the expense as non-recurring. Non-recurring expenses must be reported individually on separate lines. Prescription medications are generally not considered recurring.

NOTE: A new VA Form 21P-8416 submitted without reporting a previously counted continuing medical expense may result in removal of the medical expense from the date of receipt of the form.

5A (1). WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

5A (2). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	5A (3). FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	5A (4). PAYMENT AMOUNT \$ <input type="text"/> , <input type="text"/> . <input type="text"/>
--	---	---

5A (5). PAID TO (Name of provider, insurance company, etc.) <input type="text"/>	5A (6). PURPOSE (Insurance premium, medical supplies, etc.) <input type="text"/>
---	---

5B (1). WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

5B (2). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	5B (3). FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	5B (4). PAYMENT AMOUNT \$ <input type="text"/> , <input type="text"/> . <input type="text"/>
--	---	---

5B (5). PAID TO (Name of provider, insurance company, etc.) <input type="text"/>	5B (6). PURPOSE (Insurance premium, medical supplies, etc.) <input type="text"/>
---	---

5C (1). WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

5C (2). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	5C (3). FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	5C (4). PAYMENT AMOUNT \$ <input type="text"/> , <input type="text"/> . <input type="text"/>
--	---	---

5C (5). PAID TO (Name of provider, insurance company, etc.) <input type="text"/>	5C (6). PURPOSE (Insurance premium, medical supplies, etc.) <input type="text"/>
---	---

5D (1). WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

5D (2). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	5D (3). FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	5D (4). PAYMENT AMOUNT \$ <input type="text"/> , <input type="text"/> . <input type="text"/>
--	---	---

5D (5). PAID TO (Name of provider, insurance company, etc.) <input type="text"/>	5D (6). PURPOSE (Insurance premium, medical supplies, etc.) <input type="text"/>
---	---

5E (1). WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

5E (2). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	5E (3). FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	5E (4). PAYMENT AMOUNT \$ <input type="text"/> , <input type="text"/> . <input type="text"/>
--	---	---

5E (5). PAID TO (Name of provider, insurance company, etc.) <input type="text"/>	5E (6). PURPOSE (Insurance premium, medical supplies, etc.) <input type="text"/>
---	---

5F (1). WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

5F (2). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	5F (3). FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	5F (4). PAYMENT AMOUNT \$ <input type="text"/> , <input type="text"/> . <input type="text"/>
--	---	---

5F (5). PAID TO (Name of provider, insurance company, etc.) <input type="text"/>	5F (6). PURPOSE (Insurance premium, medical supplies, etc.) <input type="text"/>
---	---

5G (1). WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

5G (2). DATE COSTS PAID (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	5G (3). FREQUENCY <input type="checkbox"/> MONTHLY <input type="checkbox"/> ANNUALLY	5G (4). PAYMENT AMOUNT \$ <input type="text"/> , <input type="text"/> . <input type="text"/>
--	---	---

5G (5). PAID TO (Name of provider, insurance company, etc.) <input type="text"/>	5G (6). PURPOSE (Insurance premium, medical supplies, etc.) <input type="text"/>
---	---

NOTE: If you have additional medical expenses to report, complete Addendum B: Other Medical Expenses on page 7.

SECTION VI: MILEAGE

Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in Section III of this form.

6A. (1). WHO NEEDED TO TRAVEL? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____	6A. (3). TOTAL MILES TRAVELED [][][][]	6A. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year [][] / [][] / [][][][]
6A. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6A. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$ [][][] , [][][] . [][]
6B. (1). WHO NEEDED TO TRAVEL? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____	6B. (3). TOTAL MILES TRAVELED [][][][]	6B. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year [][] / [][] / [][][][]
6B. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6B. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$ [][][] , [][][] . [][]
6C. (1). WHO NEEDED TO TRAVEL? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____	6C. (3). TOTAL MILES TRAVELED [][][][]	6C. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year [][] / [][] / [][][][]
6C. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6C. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$ [][][] , [][][] . [][]
6D. (1). WHO NEEDED TO TRAVEL? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____	6D. (3). TOTAL MILES TRAVELED [][][][]	6D. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year [][] / [][] / [][][][]
6D. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6D. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$ [][][] , [][][] . [][]

NOTE: If you have additional mileage reimbursement to report, complete Addendum C: Mileage for Privately Owned Vehicle Travel for Medical Purposes on page 8.

SECTION VII: CERTIFICATION AND SIGNATURE

CERTIFICATION: I have not and will not receive reimbursement for these expenses. I certify the information contained on this form and the attached addendums is a true representation of expenses I have paid.

7A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE _____	7B. DATE SIGNED (MM/DD/YYYY) [][] / [][] / [][][][]
--	--

SECTION VIII: WITNESS TO SIGNATURE (Two witness signatures are required if claimant signed 7A with an "X")

8A. PRINTED NAME OF FIRST WITNESS (NOTE: Only to be used if claimant signed in 7A using an "X") _____	8B. SIGNATURE OF FIRST WITNESS (NOTE: Only to be used if claimant signed in 7A using an "X") _____
8C. MAILING ADDRESS OF FIRST WITNESS No. and Street _____ Apt./Unit Number _____ City _____ State/Province _____ Country _____ Zip Code/Postal Code _____	
8D. PRINTED NAME OF SECOND WITNESS (NOTE: Only to be used if claimant signed in 7A using an "X") _____	8E. SIGNATURE OF SECOND WITNESS (NOTE: Only to be used if claimant signed in 7A using an "X") _____
8F. MAILING ADDRESS OF SECOND WITNESS No. and Street _____ Apt./Unit Number _____ City _____ State/Province _____ Country _____ Zip Code/Postal Code _____	

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 payment to which you are not entitled.

ADDENDUM A: IN-HOME CARE OR CARE FACILITY EXPENSES

If you are not claiming expenses related to a care facility or from an in-home care provider, completion of Addendum A is not required.

IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on pages 9 and 10, in addition to completion of this section. If you are reporting a nursing home, you must submit VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance.

1A. WHOSE EXPENSES WERE PAID? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____		1C. PROVIDER START AND END DATE (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> NOTE: If care is ongoing leave end date blank. END: <input type="text"/> / <input type="text"/> / <input type="text"/>	
1B. NAME OF PROVIDER		1E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	
1D. AMOUNT PAID MONTHLY \$ <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/>		2C. PROVIDER START AND END DATE (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> NOTE: If care is ongoing leave end date blank. END: <input type="text"/> / <input type="text"/> / <input type="text"/>	
2A. WHOSE EXPENSES WERE PAID? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____		2E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	
2B. NAME OF PROVIDER		3C. PROVIDER START AND END DATE (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> NOTE: If care is ongoing leave end date blank. END: <input type="text"/> / <input type="text"/> / <input type="text"/>	
2D. AMOUNT PAID MONTHLY \$ <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/>		3E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	
3A. WHOSE EXPENSES WERE PAID? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____		4C. PROVIDER START AND END DATE (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> NOTE: If care is ongoing leave end date blank. END: <input type="text"/> / <input type="text"/> / <input type="text"/>	
3B. NAME OF PROVIDER		4E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	
3D. AMOUNT PAID MONTHLY \$ <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/>		5C. PROVIDER START AND END DATE (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> NOTE: If care is ongoing leave end date blank. END: <input type="text"/> / <input type="text"/> / <input type="text"/>	
4A. WHOSE EXPENSES WERE PAID? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____		5E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	
4B. NAME OF PROVIDER		6C. PROVIDER START AND END DATE (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> NOTE: If care is ongoing leave end date blank. END: <input type="text"/> / <input type="text"/> / <input type="text"/>	
4D. AMOUNT PAID MONTHLY \$ <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/>		6E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	
5A. WHOSE EXPENSES WERE PAID? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____		6D. AMOUNT PAID MONTHLY \$ <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/>	
5B. NAME OF PROVIDER		6E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	
5D. AMOUNT PAID MONTHLY \$ <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/>		6C. PROVIDER START AND END DATE (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> NOTE: If care is ongoing leave end date blank. END: <input type="text"/> / <input type="text"/> / <input type="text"/>	
6A. WHOSE EXPENSES WERE PAID? <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify) Specify Name of Child or Other: _____		6E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	
6B. NAME OF PROVIDER		6D. AMOUNT PAID MONTHLY \$ <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/>	
6D. AMOUNT PAID MONTHLY \$ <input type="text"/> , <input type="text"/> <input type="text"/> . <input type="text"/>		6E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Average Hours Worked (Per Week) <input type="text"/>	

ADDENDUM B: OTHER MEDICAL EXPENSES

If you are not claiming additional expenses, completion of Addendum B is not required.

Please report your monthly recurring expenses that are not reported in other sections on one line, including the specific dates the recurring expense started, and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. Prescription medications are generally not considered recurring. If a recurring expense has already stopped, please treat the expense as non-recurring and report a total amount paid during the designated time period.

NOTE: A new VA Form 21P-8416 submitted without reporting a previously counted continuing medical expense may result in removal of the medical expense from the date of receipt of the form.

1A. WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

1B. DATE COSTS PAID (MM/DD/YYYY) / /
1C. FREQUENCY MONTHLY ANNUALLY NOT RECURRING
1D. PAYMENT AMOUNT \$, .

1E. PAID TO (Name of provider, insurance company, etc.)
1F. PURPOSE (Insurance premium, medical supplies, etc.)

2A. WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

2B. DATE COSTS PAID (MM/DD/YYYY) / /
2C. FREQUENCY MONTHLY ANNUALLY NOT RECURRING
2D. PAYMENT AMOUNT \$, .

2E. PAID TO (Name of provider, insurance company, etc.)
2F. PURPOSE (Insurance premium, medical supplies, etc.)

3A. WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

3B. DATE COSTS PAID (MM/DD/YYYY) / /
3C. FREQUENCY MONTHLY ANNUALLY NOT RECURRING
3D. PAYMENT AMOUNT \$, .

3E. PAID TO (Name of provider, insurance company, etc.)
3F. PURPOSE (Insurance premium, medical supplies, etc.)

4A. WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

4B. DATE COSTS PAID (MM/DD/YYYY) / /
4C. FREQUENCY MONTHLY ANNUALLY NOT RECURRING
4D. PAYMENT AMOUNT \$, .

4E. PAID TO (Name of provider, insurance company, etc.)
4F. PURPOSE (Insurance premium, medical supplies, etc.)

5A. WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

5B. DATE COSTS PAID (MM/DD/YYYY) / /
5C. FREQUENCY MONTHLY ANNUALLY NOT RECURRING
5D. PAYMENT AMOUNT \$, .

5E. PAID TO (Name of provider, insurance company, etc.)
5F. PURPOSE (Insurance premium, medical supplies, etc.)

6A. WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

6B. DATE COSTS PAID (MM/DD/YYYY) / /
6C. FREQUENCY MONTHLY ANNUALLY NOT RECURRING
6D. PAYMENT AMOUNT \$, .

6E. PAID TO (Name of provider, insurance company, etc.)
6F. PURPOSE (Insurance premium, medical supplies, etc.)

7A. WHOSE EXPENSES WERE PAID?
 VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other: _____

7B. DATE COSTS PAID (MM/DD/YYYY) / /
7C. FREQUENCY MONTHLY ANNUALLY NOT RECURRING
7D. PAYMENT AMOUNT \$, .

7E. PAID TO (Name of provider, insurance company, etc.)
7F. PURPOSE (Insurance premium, medical supplies, etc.)

ADDENDUM C: MILEAGE FOR PRIVATELY OWNED VEHICLE TRAVEL FOR MEDICAL PURPOSES

Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in Section III of VA Form 21P-8416, *Medical Expense Report* submitted with this addendum.

<p>1A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)</p> <p><input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify)</p> <p>Specify Name of Child or Other: _____</p>	<p>1C. TOTAL MILES TRAVELED</p> <p align="center">[][][][][][]</p>	<p>1D. DATE TRAVELED (MM/DD/YYYY)</p> <p align="center">Month Day Year</p> <p align="center">[][] / [][] / [][][][]</p>
<p>1B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)</p>		<p>1E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)</p> <p>\$ [][][] . [][][] [][][]</p>
<p>2A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)</p> <p><input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify)</p> <p>Specify Name of Child or Other: _____</p>	<p>2C. TOTAL MILES TRAVELED</p> <p align="center">[][][][][][]</p>	<p>2D. DATE TRAVELED (MM/DD/YYYY)</p> <p align="center">Month Day Year</p> <p align="center">[][] / [][] / [][][][]</p>
<p>2B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)</p>		<p>2E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)</p> <p>\$ [][][] . [][][] [][][]</p>
<p>3A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)</p> <p><input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify)</p> <p>Specify Name of Child or Other: _____</p>	<p>3C. TOTAL MILES TRAVELED</p> <p align="center">[][][][][][]</p>	<p>3D. DATE TRAVELED (MM/DD/YYYY)</p> <p align="center">Month Day Year</p> <p align="center">[][] / [][] / [][][][]</p>
<p>3B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)</p>		<p>3E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)</p> <p>\$ [][][] . [][][] [][][]</p>
<p>4A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)</p> <p><input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify)</p> <p>Specify Name of Child or Other: _____</p>	<p>4C. TOTAL MILES TRAVELED</p> <p align="center">[][][][][][]</p>	<p>4D. DATE TRAVELED (MM/DD/YYYY)</p> <p align="center">Month Day Year</p> <p align="center">[][] / [][] / [][][][]</p>
<p>4B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)</p>		<p>4E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)</p> <p>\$ [][][] . [][][] [][][]</p>
<p>5A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)</p> <p><input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify)</p> <p>Specify Name of Child or Other: _____</p>	<p>5C. TOTAL MILES TRAVELED</p> <p align="center">[][][][][][]</p>	<p>5D. DATE TRAVELED (MM/DD/YYYY)</p> <p align="center">Month Day Year</p> <p align="center">[][] / [][] / [][][][]</p>
<p>5B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)</p>		<p>5E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)</p> <p>\$ [][][] . [][][] [][][]</p>
<p>6A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)</p> <p><input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify)</p> <p>Specify Name of Child or Other: _____</p>	<p>6C. TOTAL MILES TRAVELED</p> <p align="center">[][][][][][]</p>	<p>6D. DATE TRAVELED (MM/DD/YYYY)</p> <p align="center">Month Day Year</p> <p align="center">[][] / [][] / [][][][]</p>
<p>6B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)</p>		<p>6E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)</p> <p>\$ [][][] . [][][] [][][]</p>
<p>7A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)</p> <p><input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify)</p> <p>Specify Name of Child or Other: _____</p>	<p>7C. TOTAL MILES TRAVELED</p> <p align="center">[][][][][][]</p>	<p>7D. DATE TRAVELED (MM/DD/YYYY)</p> <p align="center">Month Day Year</p> <p align="center">[][] / [][] / [][][][]</p>
<p>7B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)</p>		<p>7E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)</p> <p>\$ [][][] . [][][] [][][]</p>
<p>8A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)</p> <p><input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (Specify) <input type="checkbox"/> OTHER (Specify)</p> <p>Specify Name of Child or Other: _____</p>	<p>8C. TOTAL MILES TRAVELED</p> <p align="center">[][][][][][]</p>	<p>8D. DATE TRAVELED (MM/DD/YYYY)</p> <p align="center">Month Day Year</p> <p align="center">[][] / [][] / [][][][]</p>
<p>8B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)</p>		<p>8E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)</p> <p>\$ [][][] . [][][] [][][]</p>

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

--	--

2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

--	--

3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

--

4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

--

5. WHAT IS THE FACILITY TELEPHONE NUMBER?

International Phone Number (If applicable)

[]	[]	-	[]	[]	-	[]	[]	[]
-----	-----	---	-----	-----	---	-----	-----	-----

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

--

Apt./Unit Number

[]	[]	[]	[]	[]
-----	-----	-----	-----	-----

City

[]	[]	[]	[]	[]	[]	[]	[]	[]	[]
-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

State/Province

[]	[]
-----	-----

Country

[]	[]
-----	-----

ZIP Code

[]	[]	[]	[]	[]	[]
-----	-----	-----	-----	-----	-----

-

[]	[]	[]	[]
-----	-----	-----	-----

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

--

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

- A. EATING
 B. BATHING/SHOWERING
 C. TRANSFERRING IN OR OUT OF BED OR CHAIR
 D. DRESSING
 E. USING THE TOILET
 F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT BELOW PLEASE CHECK THE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

- THE STATE OR COUNTRY REQUIRES THIS FACILITY TO BE LICENSED
 THE FACILITY IS LICENSED
 THE FACILITY IS RESIDENTIAL
 THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH. (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

- YES
 NO, Care is being provided by a third-party provider.
 NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY (MM/DD/YYYY)

[]	[]	/	[]	[]	/	[]	[]	[]	[]
-----	-----	---	-----	-----	---	-----	-----	-----	-----

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.)

[]	[]	/	[]	[]	/	[]	[]	[]	[]	[]	[]	[]	[]
-----	-----	---	-----	-----	---	-----	-----	-----	-----	-----	-----	-----	-----

 INDEFINITE

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

\$ [] [] [] [] [] [] [] [] [] PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)

--

15. DATE SIGNED (MM/DD/YYYY)

[]	[]	/	[]	[]	/	[]	[]	[]	[]
-----	-----	---	-----	-----	---	-----	-----	-----	-----

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

--	--	--	--

2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency Administrator, Provider)

--	--	--	--

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)

YES NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

YES NO (If "NO," skip to question 7)

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

--	--	--	--

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

--	--	--	--	--	--	--

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

--	--	--	--

Apt./Unit Number

--	--

 City

--	--	--	--

State/Province

--

 Country

--

 ZIP Code

--	--

 -

--	--

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.

- A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR
 D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

- A. SHOPPING B. FOOD PREPARATION C. NON-MEDICAL TRANSPORTATION
 D. LAUNDERING E. USING TELEPHONE F. MANAGING FINANCES
 G. HOUSEKEEPING H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

YES NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. (MM/DD/YYYY)

--	--	--	--	--	--	--

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

--	--	--	--	--	--	--

 INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

\$

--

 PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

--

 HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)

--	--	--	--	--	--	--



INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

This form should be used to report or verify income and/or net worth. Changes to income and net worth over multiple years must be reported on a separate VA Form 21P-0969 for each year. Changes to dependents and medical expenses may impact your benefits. Submit the following forms if you need to update dependent or medical expense information.

- To update dependents, submit VA Form 21-686c, *Application Request to Add and/or Remove Dependents*.
- To update medical expenses, submit VA Form 21P-8416, *Medical Expense Report*.

INFORMATION FOR CLAIMANTS

NOTE: The term assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of your or your dependents' primary residence including the residential lot area, not to exceed 2 acres); less the amount of mortgages or other (specify) encumbrances specific to the mortgages or encumbered property. Personal property means the value of personal effects that are in excess of being suitable consistent with a reasonable mode of life. There is a space on your initial application form to provide the value of the portion of your primary residence that exceeds 2 acres.

If you are a **Veteran**, you must report assets for:

- Yourself
- Your spouse (**unless** you live apart, **and** you are estranged, **and** you do not contribute to your spouse's support)
- Your child or children (**unless** you do not have custody,* **and** you do not contribute to your child's or children's support)

If you are a **Surviving Spouse**, you must report income and assets for:

- Yourself
- Your child or children (**unless** you do not have custody,* **and** you do not contribute to your child's or children's support)

If you are a **Surviving Child** or the **Custodian of a Surviving Child**, you must report income and assets for:

- Yourself and/or the surviving child
- Child's custodian (unless the child's custodian is an institution)
- Custodian's spouse

If you are a **Parent**, you must report income for:

- Yourself
- Your spouse (even if your spouse is the veteran's other parent. If your spouse is the veteran's other parent, you should file separate claims.)

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

** Parents' D.I.C. claimants do **not** need to report or provide documentation of their assets.

THIS FORM IS COMPRISED OF 14 SECTIONS. BE SURE TO ANSWER THE QUESTION(S) IN EACH SECTION AS REQUIRED.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION
SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS
SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS
SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS
SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES

SECTION VII: ASSET TRANSFERS
SECTION VIII: TRUSTS
SECTION IX: ANNUITIES
SECTION X: ASSETS PREVIOUSLY NOT REPORTED
SECTION XI: DISCONTINUED OR IRREGULAR INCOME
SECTION XII: WAIVER OF RECEIPT INCOME
SECTION XIII: CERTIFICATION AND SIGNATURE
SECTION XIV: WITNESS TO SIGNATURE

INSTRUCTIONS FOR INDIVIDUAL SECTIONS

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS

This section is for reporting all income not attached to a physical asset, financial account or other type of net worth. Income generated from assets will be captured in other sections of this form. Examples of income not associated with accounts or assets may include:

- Pensions
- Military Retirement
- Private Retirement
- Social Security Income
- Civil Service Retirement
- Black Lung Benefits
- Railroad Retirement Benefits
- Wages
- Unemployment Benefits

NOTE: If submitting this form with an initial application, do not report income(s) previously reported on your application (VA Form 21P-527EZ or VA Form 21P-534EZ.)

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS

This section is for reporting assets not related to property that generates income. Examples of income and net worth associated with accounts may include:

- Savings Bonds
- Stocks and Dividends
- Annuities
- Interest Earning Accounts (Checking, Savings, etc)
- Individual Retirement Account (IRA) Distributions (Including RMDs)
- Pension Plans with Cash Value (Employee, SEP, etc)

SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS

This section is for reporting physical assets that generate income. These assets may be partially owned by third parties. Only report the portion of the asset that you own. When reporting the asset value of your portion of the property within this section, you may subtract from the reported value any mortgage or other encumbrance that you still owe for each, if applicable. Examples of current income and net worth associated with owned assets may include:

- Rental Property
- Farm Earnings
- Business Earnings

Additional documentation may be required for each of the following income sources:

- Property assets may require submission of a statement showing the fair market value (not an evaluation for property taxes, as appraisal from a licensed appraiser, realtor or an established online estimation tool is preferred).
- If you are in receipt of income from a:
 - Farm - You must submit VA Form 21P-4165, *Pension Claim Questionnaire for Farm Income*.
 - Business or a rental property - You must submit VA Form 21P-4185, *Report of Income from Property or Business*.

SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES

This section is for reporting income generated from royalties and other owned assets. For these types of assets, you may submit any documentation you have demonstrating the self-ability, value and income of the asset. Examples of income generated from royalties and other properties include:

- Intellectual Property Royalties (i.e., Acting, Written Works, Invention)
- Mineral Royalties
- Other Land Use

SECTION VII: ASSETS TRANSFERS

This section is for clarifying the specific details of any applicable asset transfers. If income is received from the sale of a asset, in addition to reporting the details of the transfer in this section, ensure the remaining proceeds (if any) are reported as part of your assets within the other appropriate sections of this form.

- Sold - Exchange of property ownership for monetary benefit
- Gave Away - Exchange of property ownership without benefit
- Traded - Exchange of property ownership for alternative property
- Conveyed - Exchange of property ownership through a legal process

NOTE: A transfer for less than fair market value means you disposed of an asset for less than the asset was worth.

SECTION VIII: TRUSTS

This section is for reporting aspects of trusts to include possible income(s), value and controlling interest. Trusts may be countable as an asset and may generate income depending on the terms of the trust. If you have more than one trust to report, submit the information on a separate VA Form 21P-0969 or provide the information on VA Form 21-4138 for each additional trust established. Provide the following additional evidence for each trust:

- Initial contract from your financial institution establishing the trust
- Schedule of Assets must be included
- Current statement showing surrender value and monthly payments

SECTION IX: ANNUITIES

This section is for reporting annuity benefits. If additional space is needed due to ownership of multiple annuities, submit VA Form 21-4138, *Statement in Support of Claim*, with the information requested in this section for each additional annuity. You may need to submit the following evidence for each annuity:

- Initial contract from your financial institution establishing the trust
- Current statement showing surrender value and monthly payments

SECTION X: ASSETS PREVIOUSLY NOT REPORTED

This section is for reporting any assets that have not been reported previously. For proceeds from asset transfers identified in Section VI, only include assets that you still have access to (not spent). Examples of assets that may not have been reported previously include:

- Non-Interest-Bearing Accounts
- Collectible Valuables
- Real Estate
- Cash

SECTION XI: DISCONTINUED OR IRREGULAR INCOME

This section is for reporting all discontinued or irregular income received during the period reported in question 2E. If this form is submitted with your initial claim, submit information pertaining to the previous calendar years. You may need to submit copies of closed account documents, or current statements showing non-receipt of income such as a bank statement with no generated interest. Examples of discontinued or irregular income include:

- Discontinued Wages
- Unemployment Income
- Interest or Dividends from Depleted Accounts
- Lottery or Gambling Winnings

These incomes are typically classified as:

- Recurring - Income that occurred at a regular interval
- One-Time - Income that only occurred once
- Irregular - Income received several times during the reporting period at irregular intervals or irregular amounts

SECTION XII: WAIVER OF RECEIPT OF INCOME

Waived income, or income you are entitled to receive but have chosen not to accept at this time is considered countable income for VA pension purposes. It is unlawful to waive of entitlement of any income to create a need for pension. Examples include:

- Deferred Compensation
- Life Insurance
- Legal Settlements

EXCEPTION: Waiving income from the Social Security Administration done so to get a higher amount of SSA by waiting longer is allowed.

NOTICE

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

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

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

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 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 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.



**INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR
 PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)**

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME (First, Middle Initial (M.I.), Last)		
First:	MI:	Last:
1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VETERAN'S FILE NUMBER (If known)	

**SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
 (If you are the Veteran, skip questions 2A and 2B)**

2A. CLAIMANT'S NAME (First, Middle Initial (M.I.), Last)		
First:	MI:	Last:
2B. CLAIMANT'S SOCIAL SECURITY NUMBER	2C. CLAIMANT'S TELEPHONE NUMBER (If known)	
2D. TYPE OF CLAIMANT (Check only one box)		
<input type="checkbox"/> VETERAN <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> SURVIVING CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> CUSTODIAN OF CHILD BENEFICIARY		

This form is designed to provide VA with your income and net worth during a specific date range to determine your eligibility or adjust your benefits. If you are submitting an initial application, report current information. Your effective date is typically the earliest of the following dates:

- Date VA receives your application
- Date VA receives your intent to file
- Date of Veteran's death (Survivor's Benefits only)

If you are submitting this form as a response to VA correspondence, report your income and net worth information during the date range specified in that correspondence. If you are reporting an income change, report changes from the date the change took effect.

NOTE: Submit a separate VA Form 21P-0969 if reporting income and net worth information for additional date ranges.

2E. THE INFORMATION ON THIS FORM REPRESENTS INCOME AND NET WORTH FOR THE FOLLOWING PERIOD:
THROUGH _____ -OR- <input type="checkbox"/> DATE RECEIVED BY VA (For initial claims only.)

**SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS
 (See instructions on Page 2)**

3A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS FROM SOURCES NOT RELATED TO AN ACCOUNT OR YOUR ASSETS?
<input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, skip to Section IV)

3B. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify): _____	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify): _____	(4). GROSS MONTHLY INCOME \$ <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/> . <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/>
(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	

3C. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify): _____	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify): _____	(4). GROSS MONTHLY INCOME \$ <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/> . <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/>
(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (Continued)

(See instructions on Page 2)

3D.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
	(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):	(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	
3E.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
	(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):	(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	
3F.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
	(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):	(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS

(See instructions on Page 2)

4A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS THAT IS RELATED TO FINANCIAL ACCOUNTS? <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, skip to Section V)		
4B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4C.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4D.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS (Continued)

(See instructions on Page 2)

<p>4E. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):</p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)</p>	<p>(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)</p>	<p>(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>

<p>4F. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):</p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)</p>	<p>(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)</p>	<p>(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>

SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS

(See instructions on Page 2)

5A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS GENERATED BY OWNED PROPERTY OR OTHER PHYSICAL ASSETS?
 YES NO (If NO, skip to Section VI)

<p>5B. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)</p>	<p>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185</p>	

<p>5C. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other only)</p>	<p>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185</p>	

<p>5D. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other only)</p>	<p>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185</p>	

SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES

(See instructions on Page 2)

6A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES?

YES NO (If NO, skip to Section VII)

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	
(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET <input type="checkbox"/> BENEFITS FROM INTELLECTUAL PROPERTY <input type="checkbox"/> EXTRACTION OF MINERALS/LUMBER <input type="checkbox"/> USE OF LAND <input type="checkbox"/> OTHER (Specify):		
(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	(6). CAN THE ASSET BE SOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO
(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET		

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	
(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET <input type="checkbox"/> BENEFITS FROM INTELLECTUAL PROPERTY <input type="checkbox"/> EXTRACTION OF MINERALS/LUMBER <input type="checkbox"/> USE OF LAND <input type="checkbox"/> OTHER (Specify):		
(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	(6). CAN THE ASSET BE SOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO
(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET		

SECTION VII: ASSET TRANSFERS

(See instructions on Page 2)

7A. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ANY ASSETS?

YES NO (If NO, skip to Section VIII)

(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
(2). SPECIFY HOW THE ASSET WAS TRANSFERRED <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify):	(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE? <input type="checkbox"/> YES <input type="checkbox"/> NO
(3). WHAT ASSET WAS TRANSFERRED?	(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED? \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
(4). WHO RECEIVED THE ASSET?	(10). WHAT WAS THE SALE PRICE? (If applicable) \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
(5). RELATIONSHIP TO NEW OWNER	(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION VII: ASSET TRANSFERS (Continued)
(See instructions on Page 2)

<p>7C. (1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) [] [] - [] [] - [] [] [] []</p>
<p>(2). SPECIFY HOW THE ASSET WAS TRANSFERRED <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify):</p>	<p>(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(3). WHAT ASSET WAS TRANSFERRED?</p>	<p>(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED? \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(4). WHO RECEIVED THE ASSET?</p>	<p>(10). WHAT WAS THE SALE PRICE? (If applicable) \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(5). RELATIONSHIP TO NEW OWNER</p>	<p>(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

<p>7D. (1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) [] [] - [] [] - [] [] [] []</p>
<p>(2). SPECIFY HOW THE ASSET WAS TRANSFERRED <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify):</p>	<p>(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(3). WHAT ASSET WAS TRANSFERRED?</p>	<p>(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED? \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(4). WHO RECEIVED THE ASSET?</p>	<p>(10). WHAT WAS THE SALE PRICE? (If applicable) \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(5). RELATIONSHIP TO NEW OWNER</p>	<p>(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

SECTION VIII: TRUSTS
(See instructions on Page 2)

8A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED A TRUST OR DO YOU OR YOUR DEPENDENTS HAVE ACCESS TO A TRUST? (If you have more than one trust to report, submit the information on a separate VA Form 21P-0969 or provide the information on VA Form 21-4138 for each trust established.)
 YES NO (If NO, skip to Section IX)

<p>8B. DATE TRUST ESTABLISHED (MM/DD/YYYY) [] [] - [] [] - [] [] [] []</p>	<p>8C. SPECIFY MARKET VALUE OF ALL ASSETS WITHIN THE TRUST AT TIME OF ESTABLISHMENT \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>	<p>8D. SPECIFY TYPE OF TRUST ESTABLISHED <input type="checkbox"/> REVOCABLE <input type="checkbox"/> IRREVOCABLE <input type="checkbox"/> BURIAL TRUST</p>
<p>8E. HAVE YOU ADDED FUNDS TO THE TRUST AFTER IT WAS ESTABLISHED? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8F. WHEN DID YOU ADD FUNDS? (MM/DD/YYYY) (If more than one date, submit a VA Form 21-4138 with all dates and amounts) [] [] - [] [] - [] [] [] []</p>	<p>8G. HOW MUCH DID YOU ADD? \$ [] [] [] , [] [] [] [] . [] []</p>
<p>8H. ARE YOU RECEIVING INCOME FROM THE TRUST? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8I. HOW MUCH DO YOU RECEIVE ANNUALLY? \$ [] [] [] , [] [] [] [] . [] []</p>	
<p>8J. IS THE TRUST BEING USED TO PAY FOR OR TO REIMBURSE SOMEONE ELSE FOR YOUR MEDICAL EXPENSES? (Such as a guardian, family member or other service provider) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8K. HOW MUCH IS BEING REIMBURSED MONTHLY? \$ [] [] [] , [] [] [] [] . [] []</p>	
<p>8L. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8M. DO YOU HAVE ANY ADDITIONAL AUTHORITY OR CONTROL OF THE TRUST? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

SECTION IX: ANNUITIES
(See instructions on Page 2)

9A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED AN ANNUITY? (If you have more than one annuity to report, submit the information below on a separate VA Form 21P-0969, or provide the below information on VA Form 21-4138 for each annuity established.)

YES NO (If NO, skip to Section X)

9B. SPECIFY DATE ANNUITY WAS ESTABLISHED (MM/DD/YYYY)

□□ - □□ - □□□□

9C. SPECIFY MARKET VALUE OF ASSET AT TIME OF ANNUITY PURCHASE

\$ □□.□□□□.□□□□.□□

9D. HAVE YOU ADDED FUNDS TO THE ANNUITY IN THE CURRENT OR PRIOR THREE YEARS?

YES NO

9E. WHEN DID YOU ADD FUNDS? (MM/DD/YYYY)

□□ - □□ - □□□□

9F. HOW MUCH DID YOU ADD?

\$ □□.□□□□.□□□□.□□

9G. IS THE ANNUITY REVOCABLE OR IRREVOCABLE?

REVOCABLE IRREVOCABLE

9H. DO YOU RECEIVE INCOME FROM THE ANNUITY?

YES NO

9I. IF YES IN 9H, PROVIDE ANNUAL AMOUNT RECEIVED (If NO, skip to 9J)

\$ □□.□□□□.□□□□.□□

9J. CAN THE ANNUITY BE LIQUIDATED?

YES NO

9K. IF YES IN 9J, PROVIDE THE SURRENDER VALUE (If NO, skip to Section X)

\$ □□.□□□□.□□□□.□□

SECTION X: ASSETS PREVIOUSLY NOT REPORTED
(See instructions on Page 2)

10A. DO YOU OR YOUR DEPENDENTS HAVE ASSETS NOT ALREADY REPORTED?

YES NO (If NO, skip to Section XI)

10B.	(1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ □□.□□□□.□□□□.□□
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10C.	(1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ □□.□□□□.□□□□.□□
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10D.	(1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ □□.□□□□.□□□□.□□
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10E.	(1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ □□.□□□□.□□□□.□□
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)

SECTION XI: DISCONTINUED OR IRREGULAR INCOME

(See instructions on Page 2)

11A. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME THAT HAS STOPPED OR IS NO LONGER BEING RECEIVED WITHIN:
THE REPORTING PERIOD (From question 2E)? - OR - LAST FULL CALENDAR YEAR (For initial claim)?

YES NO (If NO, skip to Section XII)

11B. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(5). SPECIFY FREQUENCY OF INCOME RECEIVED <input type="checkbox"/> RECURRING <input type="checkbox"/> IRREGULAR <input type="checkbox"/> ONE TIME PAYMENT
(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(6). DATE INCOME LAST PAID (MM/DD/YYYY) [] [] - [] [] - [] [] [] []
(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS? \$ [] [] [] , [] [] [] . [] []
(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)	

11C. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(5). SPECIFY FREQUENCY OF INCOME RECEIVED <input type="checkbox"/> RECURRING <input type="checkbox"/> IRREGULAR <input type="checkbox"/> ONE TIME PAYMENT
(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(6). DATE INCOME LAST RECEIVED (MM/DD/YYYY) [] [] - [] [] - [] [] [] []
(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS? \$ [] [] [] , [] [] [] . [] []
(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)	

SECTION XII: WAIVER OF RECEIPT OF INCOME

(See instructions on Page 2)

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

YES NO (If NO, skip to Section XIII Certification and Signature)

12B. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE? \$ [] [] [] , [] [] [] . [] []
(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY) [] [] - [] [] - [] [] [] [] <input type="checkbox"/> This income will not resume
(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(6). WAIVED GROSS MONTHLY INCOME \$ [] [] [] , [] [] [] . [] []

12C. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE? \$ [] [] [] , [] [] [] . [] []
(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY) [] [] - [] [] - [] [] [] [] <input type="checkbox"/> This income will not resume
(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(6). WAIVED GROSS MONTHLY INCOME \$ [] [] [] , [] [] [] . [] []

SECTION XIII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on the form are true and correct to the best of my knowledge and belief. **I UNDERSTAND THAT** without consent, the Department of Veterans Affairs (VA) may disclose information that I provide to entities under a published "routine use." Under such a routine use, the VA may disclose information to third party entities that participate in VA claims processing and are authorized to assist the VA in administering benefits; to other federal agencies under computer matching programs, such as those with the Internal Revenue Service, Social Security Administration, Selective Service System, Department of Homeland Security, Department of Justice; and to members of Congress if they are assisting to help with Veteran's benefit questions.

13A. SIGNATURE	13B. DATE SIGNED (MM/DD/YYYY) [] [] - [] [] - [] [] [] []
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SECTION XIV: WITNESS TO SIGNATURE

(Two witness signatures are required if the claimant signed item 13A with an "X")

14A. SIGNATURE OF FIRST WITNESS (If claimant signed above using an "X")

14B. PRINTED NAME OF FIRST WITNESS

FIRST: MI: LAST:

14C. ADDRESS OF FIRST WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code -

14D. SIGNATURE OF SECOND WITNESS (If claimant signed above using an "X")

14E. PRINTED NAME OF SECOND WITNESS

FIRST: MI: LAST:

14F. ADDRESS OF SECOND WITNESS

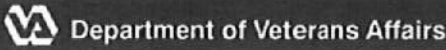
No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code -

Where to Send Correspondence - After completing the form, mail to:
Department of Veterans Affairs
Pension Intake Center
P.O. Box 5365
Janesville, WI 53547-5365

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.



VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 4. Use this form to determine eligibility for aid and attendance or housebound benefits. For more information, you can contact us online through Ask VA: <https://ask.va.gov/>. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms.

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 check box to help expedite processing of the form.

1. VETERAN/BENEFICIARY'S NAME (First, Middle Initial, Last)	
<input type="text"/>	
2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)
<input type="text"/>	<input type="text"/>
4. VETERAN'S SERVICE NUMBER (If applicable)	5. DATE OF BIRTH (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION

6. CLAIMANT'S NAME (First, Middle Initial, Last)		
<input type="text"/>		
7. CLAIMANT'S SOCIAL SECURITY NUMBER	8. RELATIONSHIP OF CLAIMANT TO VETERAN	9. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)
<input type="text"/>	<input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	<input type="text"/>
10. MAILING ADDRESS (Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)		
No. & Street <input type="text"/>		
Apt./Unit Number <input type="text"/>	City <input type="text"/>	
State/Province <input type="text"/>	Country <input type="text"/>	ZIP Code/Postal Code <input type="text"/>

11. TELEPHONE NUMBER (Optional) (Include Area Code)
<input type="text"/> - <input type="text"/> - <input type="text"/> Enter International Phone Number (If applicable) <input type="text"/>

12. EMAIL ADDRESS (Optional) <input type="checkbox"/> I agree to receive electronic correspondence from VA in regards to my claim.
<input type="text"/>
<input type="text"/>

SECTION III: CLAIM INFORMATION

13. SELECT ONE OF THE FOLLOWING BENEFITS (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 or Dependency Indemnity Compensation (DIC). 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 them from the hazards of their daily environment, or are housebound (substantially confined to their 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.

				-					-				
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SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

14A. IS THE CLAIMANT HOSPITALIZED?

YES (If "YES," complete Items 14B, 14C & 14D)
 NO (If "NO," skip to Section V)

14B. DATE ADMITTED (MM/DD/YYYY)

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

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.

15A. VETERAN/CLAIMANT'S SIGNATURE (Required)

15B. DATE SIGNED (MM/DD/YYYY)

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

**SECTION VI: EXAMINATION INFORMATION
 (IMPORTANT: Remainder of form MUST be filled out by Examiner)**

NOTE: Examiner must be a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.

16. DATE OF EXAMINATION (MM/DD/YYYY)

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veteran/claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. Please provide as much description as needed for each question as this will assist VA to determine if the disease(s) or injury(ies) listed may lead to physical or mental impairment, loss of coordination or enfeeblement that require assistance with daily living. 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 they ambulate, where they go, and what they are able to do during a typical day.

17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR EACH CONDITION (Diagnosis needs to equate to the level of assistance described in Items 26 through 37) (Describe below)

18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)

A.		D.	
B.		E.	
C.		F.	

19A. AGE

--	--	--

19B. WEIGHT

ACTUAL LBS.

--	--	--

ESTIMATED LBS.

--	--	--

19C. HEIGHT

FEET

--	--

INCHES

--	--

20. NUTRITION

21. GAIT

22. BLOOD PRESSURE

--	--	--

23. PULSE RATE

--	--	--

24. RESPIRATORY RATE

--	--	--

25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

26. IF THE PATIENT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

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

27. DOES THE PATIENT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> BATHING/SHOWERING | <input type="checkbox"/> TENDING TO HYGIENE NEEDS | <input type="checkbox"/> ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below) |
| <input type="checkbox"/> EATING OR SELF-FEEDING | <input type="checkbox"/> TRANSFERRING IN OR OUT OF BED/CHAIR | |
| <input type="checkbox"/> DRESSING | <input type="checkbox"/> TOILETING | |
| <input type="checkbox"/> AMBULATING WITHIN THE HOME OR LIVING AREA | <input type="checkbox"/> MEDICATION MANAGEMENT | |

28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)

- YES
 NO

28B. CORRECTED VISION

LEFT EYE	RIGHT EYE
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

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

- YES
 NO

30. IN YOUR JUDGMENT, DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYMENTS, OR ARE THEY ABLE TO DIRECT SOMEONE TO DO SO?

- YES
 NO

(If "NO," provide the disability(ies) that prevent them from performing this function and any rationale to support your conclusion in the space provided)

31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE

33. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. (NOTE: If indicated, comment specifically on weight bearing, balance and propulsion of each lower extremity)

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

VETERAN'S SOCIAL SECURITY NUMBER --

35. DESCRIBE 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 PATIENT'S ABILITY TO PERFORM SELF-CARE, OR IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA

36. HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES (to include the level of assistance required) IS THE PATIENT ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES (Describe)

37. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION?

YES (If "YES," check the applicable box or specify distance) 1 BLOCK 5 OR 6 BLOCKS 1 MILE OTHER (Specify distance) _____
 NO

SECTION VII: EXAMINER'S SIGNATURE

38. PRINTED NAME OF EXAMINER

39. TITLE OF EXAMINER

40. SIGNATURE OF EXAMINER (REQUIRED)

41. DATE SIGNED (MM/DD/YYYY)

--

SECTION VIII: EXAMINER'S INFORMATION

42. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER OF EXAMINER

43. NAME OF MEDICAL FACILITY

44. ADDRESS OF MEDICAL FACILITY (Number and street or rural route, city, state, ZIP Code and Country)

45. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)

-- Enter International Phone Number (If applicable)

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.

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

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet website 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.



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 on page 2. VA uses this form to determine eligibility for pension and aid and attendance benefits based on nursing home status. For more information you can contact us online through Ask VA: <https://ask.va.gov>, or call us toll-free at 1-800-827-1000 (TTY: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 checkbox 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.

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 Veteran Readiness 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: VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. 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.

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

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

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

- Status of pending claim or appeal Amount of money owed VA Current benefit and rate
 Request a benefit payment letter Payment history Change of address or direct deposit
 Other (Specify below):

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

- One time only Ongoing until written notice is given to VA to terminate
 From the date of signing below until (Specify Date (MM/DD/YYYY)): - -

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

A. SECURITY QUESTION	B. ANSWER
<input type="checkbox"/> The city and state your mother was born in	<input type="text"/>
<input type="checkbox"/> The name of the high school you attended	<input type="text"/>
<input type="checkbox"/> Your first pet's name	<input type="text"/>
<input type="checkbox"/> Your favorite teacher's name	<input type="text"/>
<input type="checkbox"/> Your father's middle name	<input type="text"/>

SECTION IV - DECLARATION OF INTENT

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

15. CLAIMANT/BENEFICIARY SIGNATURE (REQUIRED)

16. DATE SIGNED (MM/DD/YYYY)

- -

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

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