County of Cambria

Department of Veteran Services

200 South Center Street
Ebensburg, PA 15931
PHONE: (814) 472-1590 FAX: (814)472-1423

Dear Survivor of a Deceased Veteran or Service Member,

I am truly sorry for your loss and grateful for your loved one's service and sacrifice for our Country.

Attached is a packet to help you to apply for a **Dependency and Indemnity Compensation (DIC)** from the Department of Veterans Affairs (VA). If you are the survivor of a Veteran who **died from a service-related injury or illness, or** are a surviving spouse, child, or parent of a service member who died **in the line of duty**, you may be eligible for DIC.

The process to get DIC 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 **survivor** of the Veteran/Service Member 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 survivor, 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 DIC. These are the following:

- A VA Form 21P-534EZ (Claim Form) signed by the survivor
- 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 surviving spouse
- The survivor's Direct Deposit Information (found on a check)
- Any details concerning the names of and dates when the Veteran/Service Member received care at a VA and/or military treatment facility.
- Information on any VA Compensation that a deceased Veteran received (date compensation began, % compensation received, compensated conditions/disabilities).
- Diagnoses of any conditions that were related to the Veteran's passing.

Additional forms that may be required:

- **VA Form 21-2680 (Exam)**. The VA uses this form to determine if a claimant should be paid additional compensation for their care (nursing home/in-home care providers). **If you are requesting** a special monthly compensation for **Aid and Attendance, a doctor must complete a 21-2680** for the survivor. 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.
- **VA Form 21-0779 (Nursing Home Information).** - If the survivor 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 Facility** – Page 19 of the VA Form 21P-534EZ. If the survivor 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 20 of the VA Form 21P-534EZ. If the survivor is getting care at home, have the company providing care, or each caregiver, complete this form and sign it.
- **VA Form 21-0845 (Disclosure)** – This 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

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date:7/31/2026

Department of Veterans Affairs

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)*

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)*

11A. CLAIMANT'S DATE OF BIRTH
Month Day Year – –

11B. RELATIONSHIP TO VETERAN

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)*

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV: AUTHORIZATION INFORMATION

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

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

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

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

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

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

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

I, the claimant named in Items 1 *or* 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *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))*
	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ 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.

OMB Control No. 2900-0826
Respondent Burden: 5 minutes
Expiration Date: 02/28/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. This form is used to notify VA of your intent to file for the general benefit(s). For more information, 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 completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable check box to expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER

3. HAVE YOU EVER FILED A VA CLAIM?
☐ YES (If "YES," complete Item 4)
☐ NO

4. VA FILE NUMBER (If applicable)

5. DATE OF BIRTH (MM/DD/YYYY)

6. VETERAN'S SERVICE NUMBER (If applicable)

7. MAILING ADDRESS (If applicable) (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)

Enter International Phone Number (If applicable)

9. E-MAIL ADDRESS (If applicable) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY if the claimant is NOT the veteran)

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

11. SOCIAL SECURITY NUMBER

12. HAVE YOU EVER FILED A VA CLAIM?
☐ YES (If "YES," complete Item 13)
☐ NO

13. VA FILE NUMBER (If applicable)

14. RELATIONSHIP TO VETERAN (Check one)

☐ SPOUSE ☐ CHILD ☐ FIDUCIARY ☐ VETERAN SERVICE OFFICER ☐ ALTERNATE SIGNER

☐ THIRD-PARTY ☐ OTHER (Specify)

15. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)

16. MAILING ADDRESS (If applicable) (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

17. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

18. E-MAIL ADDRESS (If applicable) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

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)	21. DATE SIGNED (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.

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.

OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: 07/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 18. Use this form to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. For additional information or questions contact us online at **https://www.va.gov/contact-us** or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at **www.va.gov/vaforms**. If submitting by mail, send completed form to: **Department of Veterans Affairs, Pension Intake Center, P.O. Box 5365, Janesville, WI 53547-5365.**

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

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

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

1B. VETERAN'S SOCIAL SECURITY NUMBER — – –

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

1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA? ◯ YES ◯ NO (If "YES," provide the file number in Item 1E)

1E. VA FILE NUMBER (If known)

1F. DID THE VETERAN DIE WHILE ON ACTIVE DUTY? ◯ YES ◯ NO

1G. VETERAN'S SERVICE NUMBER

1H. VETERAN'S DATE OF DEATH? (MM/DD/YYYY) / /

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

2A. YOUR NAME (First, Middle Initial, Last)

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)

◯ SURVIVING SPOUSE ◯ CHILD 18-23 IN SCHOOL ◯ CUSTODIAN FILING FOR CHILD UNDER 18 ◯ HELPLESS ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER — – –

2D. YOUR DATE OF BIRTH (MM/DD/YYYY) / /

2E. ARE YOU A VETERAN? ◯ YES ◯ NO

2F. 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

2G. YOUR TELEPHONE NUMBER (Include Area Code) – – Enter International Phone Number (If applicable)

2H. E-MAIL ADDRESS (Optional)

2I. WHAT ARE YOU CLAIMING? (Check all that apply)

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

SECTION III: VETERAN'S SERVICE INFORMATION

(Skip to Section IV if the veteran was receiving VA compensation or pension benefits at the time of their death)

NOTE: Please refer to Instructions page 4, Military Service Verification for more information pertaining to service information and relevant documents.

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME?

◯ YES ◯ NO (If "YES," list other names the veteran served under below)

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)

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

3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

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

3E. PLACE OF LAST SEPARATION

3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard)
○ YES ○ NO (If "NO," skip to Item 3J)

3G. DATE OF ACTIVATION (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code) ☐☐☐ – ☐☐☐ – ☐☐☐☐

3J. WAS THE VETERAN EVER A PRISONER OF WAR?
○ YES ○ NO (If "NO," skip to Section IV)

3K. DATES OF CONFINEMENT (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐
END: ☐☐/☐☐/☐☐☐☐

SECTION IV: MARITAL INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?
○ YES ○ NO (If "YES," provide explanation below)

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF THE VETERAN'S DEATH?
○ YES ○ NO (If "NO," complete Item 4C)

4C. HOW DID YOUR MARRIAGE TO THE VETERAN END?
○ DEATH ○ DIVORCE ○ OTHER (Explain)

4D. DATES OF YOUR MARRIAGE TO THE VETERAN (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐
END: ☐☐/☐☐/☐☐☐☐

4E. PLACE OF MARRIAGE (City/State or Country)

4F. PLACE OF MARRIAGE TERMINATION (City/State or Country)

4G. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.)
○ CEREMONIAL ○ OTHER (Explain):

4H. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?
○ YES ○ NO

4I. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?
○ YES ○ NO

4J. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF THE VETERAN'S DEATH?
○ YES ○ NO (If "YES," skip to Item 4L)

4K. WAS THE SEPARATION DUE TO MARITAL DISCORD, MEDICAL, OR FINANCIAL REASONS?
○ YES ○ NO (If "YES," provide explanation in space provided)
NOTE: Give, the reason, date(s), and duration of the separation
(If the separation was by court order, attach a copy of the order)

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4L. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?
○ YES ○ NO (If "NO," skip to Item 5A)

4M. WHAT ARE THE DATES OF YOUR REMARRIAGE? (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐
END: ☐☐/☐☐/☐☐☐☐

4N. HOW DID YOUR REMARRIAGE END?
○ DEATH ○ DIVORCE ○ DID NOT END ○ OTHER (Explain)

4O. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH?
○ YES ○ NO (If "YES," please submit a VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for each marriage)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION V: MARITAL HISTORY

TELL US ABOUT ANY OTHER MARRIAGES YOU AND/OR THE VETERAN HAD. IF YOU AND THE VETERAN DID NOT HAVE ANY ADDITIONAL MARRIAGES SKIP TO SECTION VI.

VETERAN'S PRIOR MARRIAGES (If none skip to Item 5L)

5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?

○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: __/__/____

END: __/__/____

5D. PLACE OF MARRIAGE (City/State or Country)

5E. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?

○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: __/__/____

END: __/__/____

5I. PLACE OF MARRIAGE (City/State or Country)

5J. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?

○ YES ○ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement In Support of Claim*, as needed to provide the information for additional marital history)

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN (If none skip to Section VI)

5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5M. HOW DID YOUR PREVIOUS MARRIAGE END?

○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: __/__/____

END: __/__/____

5O. PLACE OF MARRIAGE (City/State or Country)

5P. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5R. HOW DID YOUR PREVIOUS MARRIAGE END?

○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: __/__/____

END: __/__/____

5T. PLACE OF MARRIAGE (City/State or Country)

5U. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?

○ YES ○ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement In Support of Claim*, as needed to provide the information for additional marital history)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VI: CHILD OF THE VETERAN INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)
(Skip to Section VII if you are NOT claiming benefits for a child(ren) of the veteran)

NOTE: Please refer to instructions page 2, under "*Special Circumstances*" for what is considered a dependent child. In most circumstances, children over the age of 23 are not considered dependent for VA purposes.

6A. HOW MANY DEPENDENT CHILDREN DO YOU HAVE?

(**NOTE:** Please complete a VA Form 21-686c, *Application Request to Add and/or Remove Dependents*, if you need more space for additional dependents)

6B. CHILD'S NAME (First, Middle Initial, Last)

6C. CHILD'S DATE OF BIRTH (MM/DD/YYYY) ___/___/____

6D. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6E. PLACE OF BIRTH (City/State or Country)

6F. WHAT IS THE CHILD'S STATUS? (Check all that apply)

○ BIOLOGICAL ○ ADOPTED ○ STEPCHILD ○ 18-23 YEARS OLD (in school) ○ SERIOUSLY DISABLED ○ CHILD PREVIOUSLY MARRIED

○ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___,___.00

6G. CHILD'S NAME (First, Middle Initial, Last)

6H. CHILD'S DATE OF BIRTH (MM/DD/YYYY) ___/___/____

6I. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6J. PLACE OF BIRTH (City/State or Country)

6K. WHAT IS THE CHILD'S STATUS? (Check all that apply)

○ BIOLOGICAL ○ ADOPTED ○ STEPCHILD ○ 18-23 YEARS OLD (in school) ○ SERIOUSLY DISABLED ○ CHILD PREVIOUSLY MARRIED

○ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___,___.00

6L. CHILD'S NAME (First, Middle Initial, Last)

6M. CHILD'S DATE OF BIRTH (MM/DD/YYYY) ___/___/____

6N. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6O. PLACE OF BIRTH (City/State or Country)

6P. WHAT IS THE CHILD'S STATUS? (Check all that apply)

○ BIOLOGICAL ○ ADOPTED ○ STEPCHILD ○ 18-23 YEARS OLD (in school) ○ SERIOUSLY DISABLED ○ CHILD PREVIOUSLY MARRIED

○ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___,___.00

6Q. DO YOUR CHILDREN WHO DO NOT LIVE WITH YOU (If listed above) RESIDE AT THE SAME ADDRESS?

○ YES ○ NO (If "YES," please complete Item 6R) (If "NO," please complete a VA Form 21-4138, *Statement in Support of Claim*, with the following information. Name of person the child is currently living with, and the full address where the child resides)

6R. PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHILD(RENS) CUSTODIAN BELOW:

Custodian's Name (First, Middle Initial, Last)

Custodian's 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 ___ – ____

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VII: DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Skip to Section VIII if you are NOT claiming DIC)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

○ DIC ○ DIC under 38 U.S.C. 1151 (**Note:** DIC under 38 U.S.C. 1151 is a rare benefit. Please refer to Instructions page 5 for guidance on 38 U.S.C 1151) ○ DIC due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 (PACT Act) (**Note:** Please refer to Instructions page 6 for guidance on PACT Act)

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: __/__/____ END: __/__/____
	START: __/__/____ END: __/__/____
	START: __/__/____ END: __/__/____

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

○ YES ○ NO (If "YES," please complete a 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/CRNP), or Clinical Nurse Specialist (CNS))

8B. ARE YOU NOW IN A NURSING HOME?

○ YES ○ NO (If "YES," complete VA Form 21-0779, *Request for Nursing Home Information In Connection with Claim for Aid and Attendance.* For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC") (If "NO," skip to Item 9A)

SECTION IX: INCOME AND ASSETS
(Skip to Section X if you are NOT claiming survivors pension benefits)

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.

IMPORTANT:

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

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

○ YES ○ NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC)*)

(If "No," provide an estimate of the total value of your assets below)

$ ___,___.__

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 a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC)*)

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

○ YES ○ NO (If "NO," skip to Item 9G)

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

○ YES ○ NO (If "NO," skip to Item 9H)

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

$ ___,___,___.__

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

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

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

○ YES ○ NO (If "YES," please submit a VA Form 21P-0969, and ONLY report your Social Security income in Item 9I)

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

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

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION IX: INCOME AND ASSETS (CONTINUED)
(Skip to Section X if you are not claiming survivors pension benefits)

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' DIC*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

NO.	(1) WHO IS THE INCOME RECIPIENT?	(2) WHAT IS THE TYPE/SOURCE OF INCOME?	(3) WHAT IS THE CURRENT GROSS MONTHLY INCOME?
9I	○ SURVIVING SPOUSE ○ CHILD (Provide name below)	○ SOCIAL SECURITY ○ PENSION/RETIREMENT ○ CIVIL SERVICE ○ INTEREST/DIVIDENDS ○ OTHER (Specify Source i.e., Inheritance, etc.)	$ ___,___.___
9J	○ SURVIVING SPOUSE ○ CHILD (Provide name below)	○ SOCIAL SECURITY ○ PENSION/RETIREMENT ○ CIVIL SERVICE ○ INTEREST/DIVIDENDS ○ OTHER (Specify Source i.e., Inheritance, etc.)	$ ___,___.___
9K	○ SURVIVING SPOUSE ○ CHILD (Provide name below)	○ SOCIAL SECURITY ○ PENSION/RETIREMENT ○ CIVIL SERVICE ○ INTEREST/DIVIDENDS ○ OTHER (Specify Source i.e., Inheritance, etc.)	$ ___,___.___
9L	○ SURVIVING SPOUSE ○ CHILD (Provide name below)	○ SOCIAL SECURITY ○ PENSION/RETIREMENT ○ CIVIL SERVICE ○ INTEREST/DIVIDENDS ○ OTHER (Specify Source i.e., Inheritance, etc.)	$ ___,___.___

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid.

Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child, educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

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

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

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10B (1). WHOSE EXPENSES WERE PAID?	10B (2). NAME OF PROVIDER AND TYPE OF CARE	10B (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
○ SURVIVING SPOUSE ○ OTHER (Specify below)	CHECK ONE: ○ CARE FACILITY ○ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $ ___.00 Hours Worked (Per Week) ___

10B (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10B (5). PAYMENT FREQUENCY	10B (6). AMOUNT YOU PAY (Based on frequency selected in Item 10B (5))
START: __/__/____ END: __/__/____ ○ NO END DATE	○ MONTHLY ○ ANNUALLY	$ ___,___.___

VETERAN'S SOCIAL SECURITY NUMBER ___ - ___ - ____

IN-HOME CARE OR CARE FACILITY (Continued)

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10C (1). WHOSE EXPENSES WERE PAID?
- ○ SURVIVING SPOUSE
- ○ OTHER (Specify below)

10C (2). NAME OF PROVIDER AND TYPE OF CARE

CHECK ONE:
○ CARE FACILITY ○ IN-HOME CARE ATTENDENT

10C (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Payment Rate (Per Hour) $ ___ .00
Hours Worked (Per Week) ___

10C (4). PROVIDER START AND END DATE (MM/DD/YYYY)
START: __/__/____
END: __/__/____
○ NO END DATE

10C (5). PAYMENT FREQUENCY
○ MONTHLY ○ ANNUALLY

10C (6). AMOUNT YOU PAY (Based on frequency selected in Item 10C (5))
$ ___,___.__

10D (1). WHOSE EXPENSES WERE PAID?
- ○ SURVIVING SPOUSE
- ○ OTHER (Specify below)

10D (2). NAME OF PROVIDER AND TYPE OF CARE

CHECK ONE:
○ CARE FACILITY ○ IN-HOME CARE ATTENDENT

10D (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Payment Rate (Per Hour) $ ___ .00
Hours Worked (Per Week) ___

10D (4). PROVIDER START AND END DATE (MM/DD/YYYY)
START: __/__/____
END: __/__/____
○ NO END DATE

10D (5). PAYMENT FREQUENCY
○ MONTHLY ○ ANNUALLY

10D (6). AMOUNT YOU PAY (Based on frequency selected in Item 10D (5))
$ ___,___.__

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E (1). WHOSE EXPENSES WERE PAID? (Check one)
- ○ SURVIVING SPOUSE
- ○ CHILD (Specify below)

10E (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10E (3). DATE COSTS INCURRED (MM/DD/YYYY)
__/__/____

10E (4). PAYMENT FREQUENCY
○ MONTHLY ○ ANNUALLY
○ ONE-TIME

10E (5). AMOUNT YOU PAY (Based on frequency selected in Item 10E (4))
$ ___,___.__

10F (1). WHOSE EXPENSES WERE PAID? (Check one)
- ○ SURVIVING SPOUSE
- ○ CHILD (Specify below)

10F (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10F (3). DATE COSTS INCURRED (MM/DD/YYYY)
__/__/____

10F (4). PAYMENT FREQUENCY
○ MONTHLY ○ ANNUALLY
○ ONE-TIME

10F (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4))
$ ___,___.__

10G (1). WHOSE EXPENSES WERE PAID? (Check one)
- ○ SURVIVING SPOUSE
- ○ CHILD (Specify below)

10G (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10G (3). DATE COSTS INCURRED (MM/DD/YYYY)
__/__/____

10G (4). PAYMENT FREQUENCY
○ MONTHLY ○ ANNUALLY
○ ONE-TIME

10G (5). AMOUNT YOU PAY (Based on frequency selected in Item 10G (4))
$ ___,___.__

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES (Continued)

10H (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10H (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10H (3). DATE COSTS INCURRED (MM/DD/YYYY) __/__/____

10H (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10H (5). AMOUNT YOU PAY (Based on frequency selected in Item 10H (4)) $ ___,___.__

10I (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10I (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10I (3). DATE COSTS INCURRED (MM/DD/YYYY) __/__/____

10I (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10I (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4)) $ ___,___.__

10J (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10J (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10J (3). DATE COSTS INCURRED (MM/DD/YYYY) __/__/____

10J (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10J (5). AMOUNT YOU PAY (Based on frequency selected in Item 10J (4)) $ ___,___.__

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. 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 Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

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

11B. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

11C. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

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

Account No.:

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

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

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

I certify I have enclosed all 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.

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

VETERAN'S SOCIAL SECURITY NUMBER [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE) (Continued)

12B. CLAIMANT'S SIGNATURE OR MARK WITH AN "X" IF UNABLE TO SIGN (REQUIRED)	12C. DATE SIGNED (MM/DD/YYYY) [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

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

13A. SIGNATURE OF WITNESS (Sign in INK) (NOTE: Only sign if claimant signed in Item 12B using an "X")	13B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:
13C. SIGNATURE OF WITNESS (Sign in INK) (NOTE: Only sign if claimant signed in Item 12B using an "X")	13D. PRINTED NAME AND ADDRESS OF 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) [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and 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, verification of identity and status, and personnel administration. Your response is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 40 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WORKSHEET FOR 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 WESITE 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)

/ /

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 02/28/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

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)

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER (If applicable)

4. VETERAN'S SERVICE NUMBER (If applicable)

5. DATE OF BIRTH (MM/DD/YYYY)

SECTION II: CLAIMAINT'S IDENTIFICATION INFORMATION

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

7. CLAIMANT'S SOCIAL SECURITY NUMBER

8. RELATIONSHIP OF CLAIMANT TO VETERAN

☐ SELF ☐ PARENT
☐ SPOUSE ☐ CHILD

9. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)

10. 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

11. TELEPHONE NUMBER (Optional) (Include Area Code)

Enter International Phone Number (If applicable)

12. EMAIL ADDRESS (Optional) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

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.

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

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	19C. HEIGHT
☐☐☐	ACTUAL LBS. ☐☐☐ ESTIMATED LBS. ☐☐☐	FEET ☐ INCHES ☐☐

20. NUTRITION	21. GAIT

22. BLOOD PRESSURE	23. PULSE RATE	24. RESPIRATORY RATE	25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?
☐☐☐	☐☐☐	☐☐☐	

VETERAN'S SOCIAL SECURITY NUMBER [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

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)

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

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

- ☐ YES
- ☐ NO

28B. CORRECTED VISION

LEFT EYE	RIGHT EYE
[ ][ ][ ]	[ ][ ][ ]

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.

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

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

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

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

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER — 3. VA FILE NUMBER — 4. DATE OF BIRTH *(MM/DD/YYYY)*

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

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

6. SOCIAL SECURITY NUMBER — 7. VA FILE NUMBER *(If applicable)* — 8. DATE OF BIRTH *(MM/DD/YYYY)*

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

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

No. & Street

Apt./Unit Number — City

State/Province — Country — ZIP Code/Postal Code

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

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

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

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

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

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

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

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

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

○ SKILLED NURSING CARE ○ INTERMEDIATE NURSING CARE

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

18. NURSING HOME OFFICIAL'S TITLE

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

Enter International Phone Number *(If applicable)*

SECTION V - CERTIFICATION AND SIGNATURE

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

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

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

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

OMB Approved No. 2900-0736
Respondent Burden: 5 minutes
Expiration Date: 04/30/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs (VA) permission to release your personal beneficiary or claim information to a third party. This form *may not be executed* by any beneficiary recognized as incompetent for VA purposes, nor can VA *accept* this form from any beneficiary recognized as incompetent for VA purposes.

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 expedite processing the form.

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

2. VETERAN'S SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER *(If known)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* — —

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

SECTION II - BENEFICIARY/CLAIMANT'S IDENTIFICATION INFORMATION

6. NAME OF BENEFICIARY/CLAIMANT WHO IS *NOT* THE VETERAN *(First, Middle Initial, Last)*

7. ADDRESS OF BENEFICIARY/CLAIMANT *(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)* — —

Enter International Phone Number *(If applicable)*

9. EMAIL ADDRESS *(Optional)* ( ) I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III - CONTACT INFORMATION

10. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION SPECIFIED BELOW TO ONE PERSON *OR* ONE ORGANIZATION LISTED BELOW. PROVIDE THE NAME AND ADDRESS OF THE PERSON YOU HAVE CHOSEN TO RECEIVE INFORMATION FROM VA IN ITEMS 10A AND 10B *OR* PROVIDE THE NAME AND ADDRESS OF THE ORGANIZATION YOU HAVE CHOSEN AND THE NAME OF THE ORGANIZATION'S REPRESENTATIVE IN ITEMS 10C AND 10D.

A. NAME OF PERSON *(First, Middle Initial, Last Name)*

B. ADDRESS OF PERSON

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

NOTE: An organization may have more than one representative. Include the first and last name of any additional representatives.

C. NAME OF ORGANIZATION *(Include name of representative(s))*

VETERAN'S SSN ___ – ___ – ____

D. ADDRESS OF ORGANIZATION

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code –

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", FILL ALL THAT APPLY

◯ Status of pending claim or appeal ◯ Amount of money owed VA ◯ Other (Specify below)

◯ Current benefit and rate ◯ Request a benefit payment letter

◯ Payment history ◯ Change of address or direct deposit

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

◯ One time only ◯ From the date of signing below until ___ – ___ – ____
(Specify date - MM, DD, YYYY)

◯ Ongoing until written notice is given to VA to terminate

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
◯ The city and state your mother was born in	
◯ The name of the high school you attended	
◯ Your first pet's name	
◯ Your favorite teacher's name	
◯ Your father's middle name	

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. VETERAN 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.