Dear Friend:

It has been a pleasure working with you. You should now have all of the necessary forms to file a claim for VA Pension. If awarded, your claim for a **Surviving Spouse** pays a tax-free monthly amount of **$1,149.00** for life. This benefit is awarded solely by the Department of Veterans Affairs.

Each month we have the privilege of serving over 2,000 senior veterans and families across the U.S. with our 24/7 service which we do not charge. Yet, we encourage each family to consider paying it forward by helping us support other families, just like yours, with a **donation of just $21.00**. To do so, simply click the donate button on our home page with your gift.

How did we pick $21.00? As you know, the highest honor given any military or foreign dignitary is the twenty-one gun salute. Additionally, the Sentinel takes 21 steps during their "walk" at the Tomb of the Unknowns. On the 21st step, they turn and face the Tomb for 21 seconds. They turn to face the mat, mentally count out another 21 seconds and step off another 21 steps. They have done this 24/7, rain or shine since 1948.

We are **grateful** for your gift and your support. **Our charity is grateful for those that have served and those that continue to serve.** We may be reached anytime at: seniorvetllc@gmail.com.

Respectfully,

David F. Bolser
CEO/Founder

What's Included

- Coaching Tips
- Other Documents Needed
- Checklist (VA Forms and helpful hints)
- VA Form 21-534EZ (5 pages)
- VA Form 21-2680 (2 pages)
- VA Form 21-0779 (1 page)
- VA Form 21-4142 (1 page)
- Claimant Unreimbursed Medical Expenses (2 pages)
- VA Form 21-4138 (1 page)
- Pension Management Centers (1 page)
- Sample-Template Letter (3 pages)
- Too Much Money Worksheet (1 page)
- Claimant Unreimbursed Medical Expenses (Family Care Provider-Example-2 pages)
- Claimant Unreimbursed Medical Expenses (Facility Information-Example-2 pages)

Surviving Spouse
VA Form 21-534 EZ

Coaching Tips:

1. The ***claimant*** is the person receiving the benefit. The ***veteran*** is the person that has earned the benefit through his/her service. They ***may*** be the same person.
2. Please note **Other Documents** that ***must*** be included in this application.
3. Do not leave any space blank, even if it does not apply to you. Answer with a N/A or O.
4. VA form numbers are listed in the lower left hand corner of the form, i.e. 21-2680 etc.
5. Use the ***veteran's SS# in place of the VA File Number***. You will be assigned a VA File Number later. Make copies.
6. It can take the VA up to 8 months to award this claim. They will pay the claimant ***retro*** to the time they receive the application.
7. Contact us at seniorvetllc@gmail.com if you have questions. We are available 24/7, seven days a week.
8. Yes, the forms are lengthy and redundant. A ***fine glass of wine*** will take off the rough edges. Cheers!

Other Documents Needed:

1. An ***original*** or ***certified*** copy of the veteran's discharge papers often called ***DD 214's*** or ***Separation Papers***. This document proves the length of service and the dates of service to the VA. The VA is very good at returning your originals. If you do not have these documents, they can be ordered from our site under ***Ordering Military Documents.***
2. A copy of the **Marriage Certificate**.
3. A copy of the **Death Certificate**

Checklist

_____VA Form 21-534 EZ

- Page 7, Section IV-Dependent Children. Generally this will not apply to the claimant. Mark with N/A.
- Page 8, we crossed off as this would not apply to anyone.
- Page 9, Section VII –Net Worth. Refer to the **"Too Much Money"** worksheet that is included in this application.
- Page 9 Section X-Medical, Last Illness, Burial. There is no need to list every expense. However, list the monthly recurring expenses for the claimant which is taken from the ***Claimant Unreimbursed Medical Expenses*** sheet.
- Page 10 Section XI-Direct Deposit. Use whatever bank account you desire for the monthly deposits.
- Signatures are very important. Make sure the claimant signs wherever applicable.

_____VA Form 21-2680

- This form is for the claimant's physician. It does ***not*** need to be a VA doctor. It should be the physician that knows him/her best. You ***may*** need to provide some input on questions 25, 26 and 27. Have the physician be specific on what type of care is needed. (Question 25)

_____VA Form 21-0779

- This form ***seldom*** applies to the claimant. If it does not simply draw a line through it or make with "N/A"

_____VA Form 21-4142

- Simply a medical records release form. The VA seldom utilizes it, but it must be included.

_____Claimant Unreimbursed Medical Expenses

- This is a ***very*** important form. Please see the examples we have included for both In-Home Care Information and Other Care Facility Information.
- Receipts are ***not*** required.

_____VA Form 21-4138

- We have filled ***most*** of this out for you. Again, make sure signatures are included.

_____Pension Management Centers

- This is where you will send your completed application. Please ***make sure you keep copies***.

_____Sample-Template Letter

- If there is such a thing as a silver bullet, this is it. We elected our officials. **Ask them to help!** Use this template-letter 60-90 days **after** your application has been sent to the VA.

OMB Control No. 2900-0004
Respondent Burden: 25 minutes
Expiration Date: 1/31/2015

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

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

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

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

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

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

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

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

14A. WHAT IS YOUR ADDRESS?	14B. YOUR TELEPHONE NUMBER(S) (Include Area Code)
Street address, rural route, or P.O. Box Apt. number	DAYTIME ( )
	EVENING ( )
City State ZIP Code Country	CELL PHONE ( )

15A. YOUR PREFERRED E-MAIL ADDRESS (If applicable)	15B. YOUR ALTERNATE E-MAIL ADDRESS (If applicable)

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

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

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

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

17A. DID THE VETERAN SERVE UNDER ANOTHER NAME?	17B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:
☐ YES ☐ NO (If "Yes," complete Item 17B) (If "No," skip to Item 18A)	

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

18D. DID THE VETERAN SERVE IN A COMBAT ZONE SINCE 9-11-2001?	18E. PLACE OF LAST SEPARATION
☐ YES ☐ NO	

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

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

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

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

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

TELL US ABOUT THE VETERAN'S MARRIAGES

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

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

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

TELL US ABOUT YOUR MARRIAGES

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

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

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

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

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

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

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

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

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

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

*(Skip to Section V if you are **NOT** claiming benefits for a child(ren) of the veteran)*

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

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

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

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

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

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

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

☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED

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

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

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

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

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

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

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

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

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

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

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

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

35. WHAT BENEFIT ARE YOU CLAIMING?

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

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

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

SECTION VII: NET WORTH *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

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

37. **NET WORTH** (DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")

Report total net worth for your household. Identify the ***specific*** owner for each net worth source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your net worth and the child's net worth, if any.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	$		REAL PROPERTY *(Not your home, vehicle, furniture, or clothing)*	$	
INTEREST-BEARING BANK ACCOUNTS	$		OTHER PROPERTY *(Provide source)*	$	
IRA'S, KEOGH PLANS, ETC.	$		OTHER PROPERTY *(Provide source)*	$	
STOCKS, BONDS, MUTUAL FUNDS, ETC.	$		OTHER *(Provide source)*	$	

SECTION VIII: GROSS MONTHLY INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

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

38. **GROSS MONTHLY INCOME** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report total monthly income for your household. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your income and the child's income, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	$		SERVICE RETIREMENT/ SURVIVOR BENEFIT PLAN (SBP) ANNUITY	$	
SOCIAL SECURITY	$		SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE	$	
U.S. CIVIL SERVICE	$		OTHER *(Provide source)*	$	
U.S. RAILROAD RETIREMENT	$		OTHER *(Provide source)*	$	
BLACK LUNG BENEFITS	$		OTHER *(Provide source)*	$	

SECTION IX: EXPECTED INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

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

39. **EXPECTED INCOME - NEXT 12 MONTHS** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report expected total household income for the 12 month period following the veteran's death. If the claim is filed more than one year after the veteran died, report the expected total household income for the 12 month period from the date you sign this application. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report ***your expected income*** and the ***child's expected income***, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
TOTAL DIVIDENDS AND INTEREST	$		OTHER INCOME EXPECTED *(Provide source)*	$	

SECTION X: MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

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

40. MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of any continuing family medical expenses such as the monthly Medicare deduction or nursing home costs you pay. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the veteran's or his/her child's last illness and burial and the veteran's just debts. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Do not include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim.

AMOUNT PAID BY YOU	DATE PAID (mm/dd/yyyy)	PURPOSE (Medicare deduction, nursing home costs, burial expenses, etc.)	PAID TO (Name of nursing home, hospital, funeral home, etc.)	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.)
$				
$				
$				
$				
$				

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. Please attach a voided personal check or deposit slip or provide the information requested below in Items 41, 42, and 43 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

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

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

Account No.: _____ Account No.: _____

42. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	43. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

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 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 44, 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.

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

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

45A. CLAIMANT'S SIGNATURE **(REQUIRED)**	45B. DATE SIGNED

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

46A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	46B. PRINTED NAME AND ADDRESS OF WITNESS
47A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	**47B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0721
Respondent Burden: 30 minutes

Department of Veterans Affairs

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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT *(If other than veteran)*	3. RELATIONSHIP OF CLAIMANT TO VETERAN

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER

6. DATE OF EXAMINATION	7. HOME ADDRESS

8A. IS CLAIMANT HOSPITALIZED?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*		

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person.

The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable.

Findings should be recorded to show whether the claimant is blind or bedridden.

Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

11A. AGE	11B. SEX	12. WEIGHT	13. HEIGHT
		ACTUAL: LBS. ESTIMATED: LBS.	FEET: INCHES:

14. NUTRITION	15. GAIT

16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

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

From 9 PM To 9 AM: From 9 AM To 9 PM:

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

☐ YES ☐ NO

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

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

☐ YES ☐ NO

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

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

☐ YES ☐ NO

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

☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*

☐ YES ☐ NO

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

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

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

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

34. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? *(If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)*

☐ YES
☐ NO

(If "YES," give distance)(Check applicable box or specify distance) ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 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 of the SSN 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 page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. 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

Department of Veterans Affairs

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

VA DATE STAMP
(Do Not Write In This Space)

INSTRUCTIONS: For free help in completing this form, call VA toll-free at 1-800-827-1000. (Hearing Impaired TDD line 1-800-829-4833.)

Section I - IDENTIFICATION INFORMATION

1A. NAME OF NURSING HOME	1B. ADDRESS OF NURSING HOME

2. ADDRESS OF VA REGIONAL OFFICE

3. FIRST NAME - MIDDLE INITIAL- LAST NAME OF CLAIMANT

4. SOCIAL SECURITY NUMBER	5. VA FILE NUMBER

SECTION II - NURSING HOME INFORMATION *(To be completed by a Nursing Home Official)*

6. DATE ADMITTED TO NURSING HOME *(Month, Day, Year)*	7. DATE MEDICAID BEGAN *(Month, Day, Year)*

8. AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET

$

9. 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

10. NURSING HOME OFFICIAL'S NAME *(First & Last) (Please print)*

11. NURSING HOME OFFICIAL'S TITLE *(Please print)*	12. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)*

13A. SIGNATURE OF NURSING HOME OFFICIAL	13B. DATE SIGNED

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0001
Respondent Burden: 5 minutes
Expiration Date: 8/31/2017

Department of Veterans Affairs

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

NOTE - PLEASE READ THE ENTIRE FORM *(both pages)* BEFORE SIGNING IN ITEM 11 BELOW.

SECTION I - RECORDS TO BE RELEASED TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of: ***All* my medical records; including information related to my ability to perform tasks of daily living. This includes specific permission to release:**

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including,* but not limited to:
   a. Psychological, psychiatric, or other mental impairment(s) excluding "psychotherapy notes" as defined in 45 C.F.R. §164.501,
   b. Drug abuse, alcoholism, or other substance abuse,
   c. Sickle cell anemia,
   d. Records which may indicate the presence of a communicable or non-communicable disease; and tests for or records of HIV/AIDS,
   e. Gene-related impairments (including genetic test results).
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months *after* the date this authorization is signed in Item 11, as well as past information.

YOU SHOULD NOT COMPLETE THIS FORM UNLESS YOU WANT THE VA TO OBTAIN PRIVATE TREATMENT RECORDS ON YOUR BEHALF. IF YOU HAVE ALREADY PROVIDED THESE RECORDS OR INTEND TO OBTAIN THEM YOURSELF, THERE IS NO NEED TO FILL OUT THIS FORM. DOING SO WILL LENGTHEN YOUR CLAIM PROCESSING TIME.

IMPORTANT - In accordance with 38 C.F.R. §3.159(c), "VA will not pay any fees charged by a custodian to provide records requested."

SECTION II - VETERAN IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME *(Type or print)*	2. DATE OF BIRTH *(MM,DD,YYYY)*	3. SOCIAL SECURITY NUMBER/VA FILE NUMBER

SECTION III - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING

4. LAST NAME - FIRST NAME - MIDDLE NAME *(Type or print)*	5. DATE OF BIRTH *(MM,DD,YYYY)*	6. SOCIAL SECURITY NUMBER
7. STREET ADDRESS	**8. CITY, STATE, ZIP CODE**	**9. TELEPHONE NUMBER *(Include Area Code)***

SECTION IV - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

- **ALL** medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities,
- Social workers/rehabilitation counselors,
- Consulting examiners used by VA,
- Employers, insurance companies, workers' compensation programs, and
- Others who may know about my condition (family, neighbors, friends, public officials).

SECTION V - AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO VA AND SIGNATURE

10. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE *(If this space is left blank, there is no limitation to records)*:

TO WHOM: The Department of Veterans Affairs (VA).
PURPOSE: Determining my eligibility for benefits, and whether I can manage such benefits.
EXPIRES: This authorization is good for 12 months from the date shown in Item 12.

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above in Section I.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties (See page 2 for details).
- I may write to VA and my source(s) to revoke this authorization at any time (See page 2 for details).
- VA will give me a copy of this form, if I ask; I may also ask the source(s) to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed. See Patient Acknowledgement on Page 2.**

11. SIGNATURE OF PERSON AUTHORIZING DISCLOSURE *(Required)*	12. DATE SIGNED *(MM,DD,YYYY) (Required)*
13. PRINTED NAME OF PERSON SIGNING *(First, Middle Initial, Last)*	**14. TELEPHONE NUMBER *(Include Area Code)***

15. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, city, State, and ZIP code. All court appointments must include docket number, county, and State)*

NOTE: This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical and other information under P.L. 104-191 ("HIPAA"); 45 C.F.R. parts 160 and 164; 42 U.S.C. §290dd-2; 42 C.F.R. part 2, and State Law.

Claimant Unreimbursed Medical Expenses

General Information

Veteran's Name _____

Veteran's SS # _____

Claimant's Name _____

Claimant's SS# _____

The claimant is currently receiving:

☐ In Home Care

☐ Nursing Home Care

☐ Other Care Facility (Assisted Living, Memory Care, Group Home, Adult Day Care)

Monthly amount claimant pays from his/her own funds which is NOT reimbursed by any other source: $_____

***VA Form 21-2680 "Examination For Housebound Status Or Permanent Need For Regular Aid and Attendance"** is included in this application.

Name of facility OR care provider: _____

Phone # of facility OR care provider: _____

Address of facility OR care provider:

City & State: _____

Zip Code: _____

Date that care began: _____

Will the claimant need this care indefinitely? ☐ Yes ☐ No

In-Home Care Information (Completed by care provider)

Does the care provider provide medical OR nursing services for the claimant?
(i.e. Medication management, assisting with dressing, bathing, etc.)

☐ Yes ☐ No

Briefly describe the services you provide:

Is the care-giver a licensed health professional? (RN,LVN,LPN)

☐ Yes ☐ No

If Yes, provide your license number: _____

Other Care Facility Information:

Type of facility: ☐ Assisted Living ☐ Memory Care ☐ Adult Day Care
☐ Group Home ☐ Other

Do you provide medical OR nursing services for the claimant? ☐ Yes ☐ No
(I.e. Medication management, assisting with dressing, bathing, transportation, help with finances, or meal preparation)

Briefly describe the services you provide:

Are these services provided by a licensed health professional (RN, LVN, LPN)?
☐ Yes ☐ No

Nursing Home Information (Completed by administrator)

Is your facility licensed by the State? ☐ Yes ☐ No

Is the patient in your facility because of a physical or mental disability?
☐ Yes ☐ No

Do you provide either skilled or intermediate level nursing care to the patient?
☐ Yes ☐ No

What was the admitting diagnosis? _____

Signatures: (To be completed by administrator/care-provider and claimant)

I/We certify that the above statements are true and correct to the best of my knowledge and belief.

_____ _____
Signature of facility administrator OR care provider Date

I certify that the above statements are true and correct to the best of my knowledge and belief.
I am paying $_____ per month for my care from my own funds.

_____ _____
Signature of Claimant Date

OMB Control No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA Programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. 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 obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO. C/CSS -

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

1. The veteran has served 90 days of consecutive service at least one day of which was during a period of war. (Please find attached service douments)
2. The claimant requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment.
3. The claimant submits VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance as well as a completed VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance.
4. The claimant has included a signed Unreimbursed Medical Expense Report detailing out-of-pocket expenses for medical care.
5. The claimant,believing that all documents to process this claim have been included, wishes to have this claim processed under the Fully Developed Claim or FDC process.

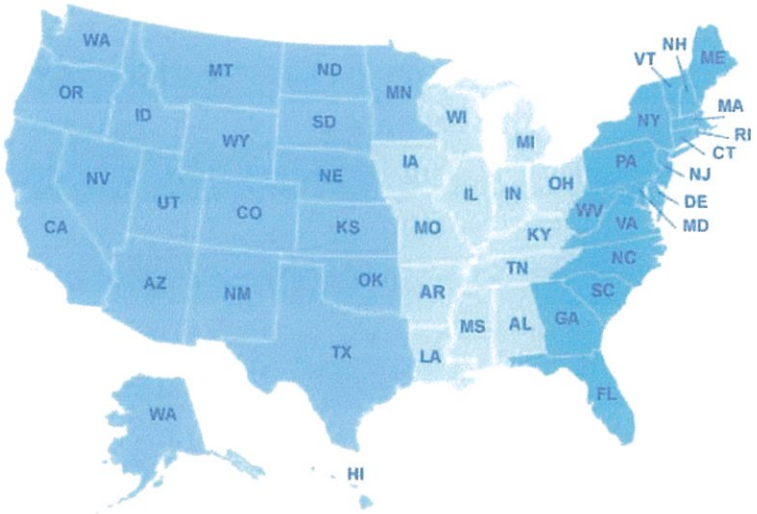
I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE	DATE SIGNED	
ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

Pension Management Centers

Use the map below to find the Pension Management Center that serves your state.



Philadelphia VA Regional Office
PO Box 8079
Philadelphia, PA 19101

Service Area: Connecticut, Delaware, Florida, Georgia, Maine , Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Vermont, Virginia, West Virginia

Milwaukee VA Pension Center
PO Box 342000
Milwaukee WI 53234-9907

Service Area: Alabama, Missouri, Arkansas, Illinois, Iowa, Indiana, Kentucky, Louisiana, Michigan, Mississippi, Ohio, Tennessee, Wisconsin

St. Paul VA Regional Office
Pension Management Center (335/21P)
PO BOX 11000
St. Paul, MN 55111-0000

Service Area: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Kansas, Minnesota, Montana, Nebraska, North Dakota, New Mexico, Nevada, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming

(Sample-Template Letter)

*Send this letter 60-90 days **after** you have submitted your claim to the VA.

(Date)

(Congressman/Senator)
(Use state of claimant)
(Address)
(RE: SS# or VA Claim # of Claimant)

Dear (Name)

I am the (daughter, son, etc.) of (claimant's name). I have been assisting my (mother, father etc) with the VA's "Non-Service Connected Disability Claim" sometimes referred to as "Aid and Attendance." It has been over (# of days) since this claim was submitted and I have yet to hear anything from the Department of Veterans Affairs.

My (mother, father etc.) is (#) years old and needs daily assistance with basic activities of daily living. This VA benefit has been earned through the service of (veteran's name and relationship). Additionally, my (mother, father etc.) is forced to pay out-of-pocket for (his/her) long-term care medical costs. This VA benefit would be a *huge financial relief* not only for (her/him) but to our family.

(her/his) savings will soon be depleted. I am asking for **your help** in getting (name of claimant) this benefit so that (he/she) may be able to live the final years of (his/her) life ***without*** the financial hardship that (he/she) is currently experiencing.

Again, my (mother, father's, etc.) name is (name) and (his/her) (SS# or VA Claim #) is (number) This VA claim was sent to the VA Pension Center at (Use VA Pension Center that was used)

Could you please find it in your heart to help one of our senior (veterans or widows) with this VA benefit that could change (her/his) life? Thank you for looking out for those that have served our great country.

Respectfully,

(All of your contact information)

Addresses of VA Pension Centers

Department of Veterans Affairs
Milwaukee Pension Management Ctr.
PO Box 342000
Milwaukee, WI
53234-9907
Attn: VA Pension Manager

Department of Veterans Affairs
Philadelphia Regional Office
5000 Wissahickon Ave.
Philadelphia, PA
19101
Attn: VA Pension Manager

Department of Veterans Affairs
Bishop Henry Whipple Federal Building
P.O. Box 1000
St. Paul, MN
55111-0000
Attn: VA Pension Manager

*Here are some "coaching" tips:

- These are guides. Use whatever language you prefer, but embellish shamelessly!
- Don't delay and be aggressive. Keep copies of everything and **make your representative work for you.**
- Our e-mail address is: seniorvetllc@gmail.com. My personal cell is: 719-505-2385.
- We can coach, but **you** have to execute.

Too Much Money?

The VA will ask you to disclose your net assets on your application. Net assets include:

- Cash/Non-Interest Bearing Bank Accounts, Interest-Bearing Bank Accounts, IRA's, Keogh Plans, Stocks, Bonds, Mutual Funds, CD's and Annuities.
- The claimant's residence, autos, and personal belongings are **excluded.**

Too Much $ to File?

There is no **objective** number; however, below is the VA's definition of "too much."

"The VA will determine whether your assets are of a sufficiently large amount that you could live off them for a reasonable period of time." **–Department of Veterans Affairs.**

Our Coaching Tip

- Contact your Financial Planner/Accountant and show them the VA application page that addresses income/net assets.
- Tell them your loved one's assets need to be ***safe and liquid. (Most claimants prefer not to have their assets in their name. Check with your financial advisor)***
- Currently, there is **no** look-back period for the VA.
- Do this **before** you complete your claim application.
- Senior Veterans, Inc. will **not** give financial, tax or legal advice.

Example: Family Care Provider

Claimant Unreimbursed Medical Expenses

General Information

Veteran's Name: John Q. Brown

Veteran's SS #: 111-11-1111

Claimant's Name: Mary V. Brown

Claimant's SS#: 111-11-1111

The claimant is currently receiving:

- [X] In Home Care
- [ ] Nursing Home Care
- [ ] Other Care Facility (Assisted Living, Memory Care, Group Home, Adult Day Care)

Monthly amount claimant pays from his/her own funds which is NOT reimbursed by any other source: $ 3,000.00

[X] VA Form 21-2680 "Examination For Housebound Status Or Permanent Need For Regular Aid and Attendance" is included in this application.

Name of facility OR care provider: Veronica Brown

Phone # of facility OR care provider: (719) 000-0000

Address of facility OR care provider:

City & State: 123 Main St Colo. Springs, Co

Zip Code: 80906

Date that care began: April 1, 2015

Will the claimant need this care indefinitely? [X] Yes [ ] No

In-Home Care Information (Completed by care provider)

Does the care provider provide medical OR nursing services for the claimant?
(i.e. Medication management, assisting with dressing, bathing, etc.)

[X] Yes [ ] No

Briefly describe the services you provide:

Financial mgmt., med. management, transportation, meal prep.

Is the care-giver a licensed health professional? (RN,LVN,LPN)

[ ] Yes [X] No

If Yes, provide your license number: N/A

Other Care Facility Information:

Type of facility: ☐ Assisted Living ☐ Memory Care ☐ Adult Day Care ☐ Group Home ☐ Other

Do you provide medical OR nursing services for the claimant? ☐ Yes ☐ No
(i.e. Medication management, assisting with dressing, bathing, transportation, help with finances, or meal preparation)

Briefly describe the services you provide:

N/A

Are these services provided by a licensed health professional (RN, LVN, LPN)?
☐ Yes ☐ No

Nursing Home Information (Completed by administrator)

Is your facility licensed by the State? ☐ Yes ☐ No

Is the patient in your facility because of a physical or mental disability?
☐ Yes ☐ No

Do you provide either skilled or intermediate level nursing care to the patient?
☐ Yes ☐ No

What was the admitting diagnosis? N/A

Signatures: (To be completed by administrator/care-provider and claimant)

I/We certify that the above statements are true and correct to the best of my knowledge and belief.

Veronica Brown — Signature of facility administrator OR care provider

4-5-2015 — Date

I certify that the above statements are true and correct to the best of my knowledge and belief.
I am paying $ 3,000.00 per month for my care from my own funds.

Mary V. Brown — Signature of Claimant

4-5-2015 — Date

Example: Facility Provider

Claimant Unreimbursed Medical Expenses

General Information

Veteran's Name: John Q. Brown

Veteran's SS #: 111-11-1111

Claimant's Name: John Q. Brown

Claimant's SS#: 111-11-1111

The claimant is currently receiving:

- [ ] In Home Care
- [ ] Nursing Home Care
- [x] Other Care Facility (Assisted Living, Memory Care, Group Home, Adult Day Care)

Monthly amount claimant pays from his/her own funds which is NOT reimbursed by any other source: $ 4,000.00

*VA Form 21-2680 "Examination For Housebound Status Or Permanent Need For Regular Aid and Attendance" is included in this application.

Name of facility OR care provider: ABC Assisted Living

Phone # of facility OR care provider: (719) 000-0000

Address of facility OR care provider:

City & State: 123 Main, Colo. Springs, Co

Zip Code: 80906

Date that care began: 4-1-2015

Will the claimant need this care indefinitely? [x] Yes [ ] No

In-Home Care Information (Completed by care provider)

Does the care provider provide medical OR nursing services for the claimant?
(i.e. Medication management, assisting with dressing, bathing, etc.)

[ ] Yes [ ] No

Briefly describe the services you provide:

N/A

Is the care-giver a licensed health professional? (RN,LVN,LPN)

[ ] Yes [ ] No

If Yes, provide your license number: _____

Other Care Facility Information:

Type of facility: [X] Assisted Living [ ] Memory Care [ ] Adult Day Care
[ ] Group Home [ ] Other

Do you provide medical OR nursing services for the claimant? [X] Yes [ ] No
(i.e. Medication management, assisting with dressing, bathing, transportation, help with finances, or meal preparation)

Briefly describe the services you provide:
Med. management, hygiene, meal prep., transportation

Are these services provided by a licensed health professional (RN, LVN, LPN)?
[X] Yes [ ] No

Nursing Home Information (Completed by administrator)

Is your facility licensed by the State? [X] Yes [ ] No

Is the patient in your facility because of a physical or mental disability?
[X] Yes [ ] No

Do you provide either skilled or intermediate level nursing care to the patient?
[ ] Yes [X] No

What was the admitting diagnosis? Dementia

Signatures: (To be completed by administrator/care-provider and claimant)

I/We certify that the above statements are true and correct to the best of my knowledge and belief.

Susan B. Jones, Director — 4-5-2015
Signature of facility administrator OR care provider — Date

I certify that the above statements are true and correct to the best of my knowledge and belief.
I am paying $ 4,000.00 per month for my care from my own funds.

John Q. Brown — 4-5-2015
Signature of Claimant — Date