ADDITIONAL DOCUMENTS YOU **MUST** SUBMIT WITH YOUR CLAIM APPLICATION

1. A copy of the veteran's **Discharge Papers/Separation Papers.** These are sometimes called DD 214's. The VA requires these as proof of service during the Wartime Periods. **Do whatever you can to find this document**. If all else fails and you must order these documents from the VA, you can do so by returning to our site, www.seniorvet.org and clicking on the Ordering Military Records tab.
2. Married veterans and surviving spouses must submit a copy of the **Marriage Certificate.**
3. A surviving spouse must submit a copy of the **Death Certificate.**

IMPORTANT NOTES

1. If the VA awards your claim, they will pay the claimant **retro to the date at which the Pension Center received your application.** Every day delayed is money lost for your loved one. Be tenacious.
2. This is our charity's mission, and we have helped thousands of families across the country since November 2011. We will never speculate on the success or failure of your claim; however, just over 98% of applicants who follow our "coaching" advice and adhere to the "game plan" have their claims awarded. That is up to the VA, not us. The most important factor in determining success is **you!**
3. We have promised you that we will provide advice and/or support for the **life of your claim.** We work 24/7. E-mail us **any time** you wish at seniorvetllc@gmail.com. Sometimes you just need to vent as this is an extremely stressful time for you and your family. Remember that we **will not** offer any financial, legal or tax advice. We are not licensed to do that. Consult your trusted professionals if you need to seek help.
4. **Everything you need to submit your application is included in this packet**. There are **5 distinct sections, each with their own sheet of directions.** Keep everything in order, plan your work and work your plan.

Pearls of Wisdom

1. **Adult beverages help.** We're not kidding, this application is long, boring, frustrating and repetitive. Your job is to protect your parents, just like they have protected all of us. You are the "straw that stirs the drink." We don't know what your outcome will be, but we do know the outcome if you don't try. This means so much for your loved ones and your family. We are always here at seniorvetllc@gmail.com. Who knows, maybe we'll drink together!
2. We are the coaches. We've put together the game plan, we've got years of experience and we know what works. We will call the plays, but **you must execute those plays.** Together we're a **winning** combination, great coaching and even better execution!
3. Use the SS# in place of the VA File Number, which is asked on almost every form. You will be assigned a VA File Number from the VA **after** they receive your claim.
4. Don't over-analyze the questions, just answer them to the best of your ability. A VA claim **has never been denied** because there was a mistake or missing information on the application. They will let you know, and you can fix it.
5. You have up to 1 year to dispute any decision from the VA. Chances are we will hear from you if there has been a decision that you dispute.
6. Let us know how you're doing, let us know what we need to do to improve, tell us what is confusing or enlightening. We have millions of senior veterans and widows to help and most of them have never heard of this wonderful benefit.
7. Finally, we know that this is one of the most stressful times of your life. Your parents are needing more and more help and they are draining their savings. It is a terrible strain on your family. You will protect them, just like the millions of men and women who have protected and continue to protect the country **we all love.**

Godspeed

seniorvetllc@gmail.com

APPLICATION FOR VETERANS PENSION

1. This is the "guts" of the application package and will include pages 5-9 listed at the lower right-hand corners of the pages.
2. Note that we have completed many questions with an "X" or a N/A. These were obvious responses and specific responses related to your application.
3. Remember that the claimant is the beneficiary, the one receiving the benefit, and the veteran is the one who served. They could be the same.
4. Use the veteran's SS# in place of the VA File Number. You will be assigned a VA File Number **after** the VA receives your application.
5. Use the mailing address, phone number and e-mail address for the person, adult child, completing the application and **not** the claimant. You want all correspondence to go to the person completing the application.
6. Don't be too concerned for questions that ask for something you don't know or can't be specific about, like question 28A under Section VII. Use either an N/A or the SWAG approach (Sophisticated Wild-Assed Guess).
7. You should be answering "Yes" to Question 30 under Section VIII. Also, under the table that states, "See Attached Worksheet" those worksheets are provided for you in a different section, however, put in the monthly amount under F, AMOUNT YOU PAY. This will become obvious when you complete the "In-Home Attendant" or "Facility" worksheets. They are included in this application.
8. Use a bank account where you want the money electronically deposited. If you are completing this application and you manage the claimant's finances, it should be controlled by you or simply set up a separate account.
9. Make sure the claimant signs wherever applicable and you follow the procedure in case they are unable to sign. You can **not** sign as a POA or Fiduciary. The VA does not recognize a POA. If the signature is barely legible, that still works. Use it.
10. Lots of stuff isn't it, but you're following the game plan. Great coaching and even better execution! **Time for a glass of wine!**

OMB Control No. 2900-0002
Respondent Burden: 25 minutes
Expiration Date: 10/31/2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 9 before completing the form.

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

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

4. HAVE YOU EVER FILED A CLAIM WITH VA?	5. VA FILE NUMBER
☐ YES ☐ NO (If "Yes," provide your file number in Item 5)	

6A. MAILING ADDRESS	6B. TELEPHONE NUMBERS (Include Area Code)
Street address, rural route, or P.O. Box Apt. number	DAYTIME ( )
	EVENING ( )
City State ZIP Code Country	CELL PHONE ( )

7A. PREFERRED E-MAIL ADDRESS (If applicable)	7B. ALTERNATE E-MAIL ADDRESS (If applicable)

8. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING?

A. DISABILITY(IES)	B. DATE DISABILITY(IES) BEGAN
N/A	N/A

9. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

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

SECTION II: VETERAN'S SERVICE INFORMATION *(MUST COMPLETE)*

10A. DID YOU SERVE UNDER ANOTHER NAME?	10B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER
☐ YES (If "Yes," complete Item 10B) ☐ NO (If "No," skip to Item 11A)	

11A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	11B. BRANCH OF SERVICE	11C. RELEASE DATE FROM ACTIVE SERVICE

11D. SERVICE NUMBER	11E. PLACE OF LAST SEPARATION

12A. HAVE YOU EVER BEEN A PRISONER OF WAR?	12B. DATES OF CONFINEMENT ON (MM,DD,YYYY)
☐ YES ☐ NO (If "Yes," complete Item 12B) (If "No," skip to Item 13A)	From: To:

SECTION III: VETERAN'S DISABILITY(IES) AND BACKGROUND *(MUST COMPLETE)*

NOTE: You do not have to submit medical evidence or list disabilities if you are age 65 or older, unless you are housebound, or require the regular assistance of another person.

13A. WHAT DISABILITY(IES) PREVENT YOU FROM WORKING?	13B. WHEN DID THE DISABILITY(IES) BEGIN? (MM, DD, YYYY)
N/A	N/A

14A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?	14B. ARE YOU NOW OR HAVE YOU RECENTLY BEEN HOSPITALIZED OR GIVEN OUTPATIENT OR HOME CARE DUE TO THE DISABILITY(IES) LISTED IN ITEM 13A?
☒ YES ☐ NO (If "Yes," complete and attach with this application, VA Form 21-2680, *Exam for Housebound Status or Permanent Need for Regular Aid and Attendance.* Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS.))	☐ YES ☐ NO

15A. DATE(S) OF RECENT HOSPITALIZATION OR CARE	15B. NAME AND MAILING ADDRESS OF FACILITY OR DOCTOR

SECTION III: VETERAN'S DISABILITY(IES) AND BACKGROUND *(MUST COMPLETE)* CONTINUED

NOTE: In the table below, tell us about all of your employment, including self-employment, for one year before you became disabled to the present.

16A. ARE YOU NOW EMPLOYED?	16B. WHEN DID YOU LAST WORK? (MM,DD,YYYY)	16C. WERE YOU SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED?
☐ YES ☒ NO	N/A	☐ YES ☐ NO (If "Yes," complete Items 16D and 16E)

16D. WHAT KIND OF WORK DID YOU DO?	16E. ARE YOU STILL SELF-EMPLOYED?	16F. WHAT KIND OF WORK DO YOU DO NOW?
	☐ YES ☐ NO (If "Yes," complete Item 16F)	

17A. ARE YOU NOW IN A NURSING HOME?	17B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?
☐ YES ☐ NO (If "Yes," complete Items 17B and 17C and submit a statement from an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.)	

17C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?	17D. HAVE YOU APPLIED FOR MEDICAID?
☐ YES ☒ NO (If "No," complete Item 17D)	☐ YES ☐ NO

18A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	18B. WHAT WAS YOUR JOB TITLE?	18C. WHEN DID YOUR JOB BEGIN?	18D. WHEN DID YOUR JOB END?	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
N/A					$
					$

SECTION IV: MARITAL STATUS *(MUST COMPLETE)*

19A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED (Skip to Section VI if never married)

TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

19B. HOW MANY TIMES HAVE ***YOU*** BEEN MARRIED (Including current marriage)?

20A. DATE (Month, Day, Year) AND PLACE OF MARRIAGE (City and State or Country)	20B. TO WHOM MARRIED (First, Middle, Last Name)	20C. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, or Other)	20D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)	20E. DATE (Month, Day, Year) AND PLACE MARRIAGE ENDED (City and State or Country)

20F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 20C, PLEASE EXPLAIN:

SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)*

Note - Skip to Section VI if not currently married.

TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

21. HOW MANY TIMES HAS ***YOUR SPOUSE*** BEEN MARRIED (Including current marriage)?

22A. DATE (Month, Day, Year) AND PLACE OF MARRIAGE (City and State or Country)	22B. TO WHOM MARRIED (First, Middle, Last Name)	22C. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, or Other)	22D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)	22E. DATE (Month, Day, Year) AND PLACE MARRIAGE ENDED (City and State or Country)

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

23A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (Month, Day, Year)	23B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?	23C. IS YOUR SPOUSE ALSO A VETERAN?	23D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (If any)?
		☐ YES ☐ NO (If "Yes," complete Item 23D)	

SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)* CONTINUED

23E. DO YOU LIVE WITH YOUR SPOUSE?	23F. WHAT IS YOUR SPOUSE'S ADDRESS? (Number and street or rural route, city or P.O., State, ZIP Code and country)
☐ YES ☐ NO (If "Yes," skip to Section VI) (If "No," complete Items 23F, 23G and 23H)	
23G. TELL US THE REASON YOU ARE NOT LIVING WITH YOUR SPOUSE (i.e.; illness, work, etc.)	23H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? $

SECTION VI: DEPENDENT CHILDREN *(COMPLETE IF YOU HAVE DEPENDENT CHILDREN)*

Note - Skip to Section VII if you have no dependent children.

24A. NAME OF DEPENDENT CHILD (First, Middle initial, Last)	24B. DATE AND PLACE OF BIRTH (City and State or Country)	24C. SOCIAL SECURITY NUMBER	*(Check all that apply)*						
			24D. BIOLOGICAL	24E. ADOPTED	24F. STEPCHILD	24G. 18-23 YEARS OLD (in school)	24H. SERIOUSLY DISABLED	24I. CHILD MARRIED	24J. CHILD PREVIOUSLY MARRIED
N/A			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

Note - In Items 25A through 25D, tell us about the children listed in Item 24A who ***do not*** live with you.

25A. NAME OF DEPENDENT CHILD (First, middle initial, last)	25B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	25C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
N/A			$
			$
			$

SECTION VII: QUESTIONS REGARDING INCOME AND ASSETS *(If you need more space, attach a separate sheet.)*

26. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

☐ YES ☐ NO (If "Yes," complete Items A and B) (If "No," skip to Item 27)

A. SOCIAL SECURITY RECIPIENT	B. GROSS MONTHLY AMOUNT
	$
	$
	$
	$
	$

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

☐ YES ☐ NO (If "Yes," complete Items 28A and 28B) (If "No," skip to Item 29A)

28A. WHAT IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS?	28B. COULD ANY PART OF THE LOT BE SOLD *WITHOUT SELLING THE RESIDENCE*?
_____ Square feet	☐ YES ☒ NO (If "Yes," also complete VA Form 21P-0969, *Income and Asset Statement*)

IMPORTANT: VA matches income information reported with Federal tax information. Report all income you and your dependents receive on the appropriate sections of this form and VA Form 21P-0969, *Income and Asset Statement*, if appropriate.

29A. ***OTHER THAN SOCIAL SECURITY***, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?

☐ YES ☐ NO

29B. ***OTHER THAN SOCIAL SECURITY***, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?

☐ YES ☐ NO

29C. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN $10,000 IN ASSETS? (**Note:** Assets are all the money and property you or your dependents own. Assets do ***not*** include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation).

☐ YES ☐ NO

29D. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving them away, selling them, purchasing an annuity, or using them to establish a trust.)

☐ YES ☐ NO

SECTION VII: QUESTIONS REGARDING INCOME AND ASSETS (If you need more space, attach a separate sheet) CONTINUED

29E. DID YOU ANSWER "YES" TO **ANY** OF THE ITEMS IN 29A - 29D?

☐ YES ☐ NO (If "Yes," you ***must*** also complete VA Form 21P-0969, *Income and Asset Statement*)

SECTION VIII: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself, dependents you are under obligation to support, 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 at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you or your dependents were/will be reimbursed. Please make sure to complete all 6 criteria below (if applicable). If more space is needed, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

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 11 and 12.

30. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?

☐ YES ☐ NO (If "No," skip to Section IX)

A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	B. PAID TO (Name of Provider, Insurance company, Nursing home, etc.)	C. PURPOSE (Medicare premiums, Nursing Home,etc.)	D. DATE PAID (Month, Day, Year)	E. HOURLY RATE/ HOURS (In-home Provider Only)	F. AMOUNT YOU PAY
See Attached Worksheet		Medical Expenses		$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

SECTION IX: 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 31, 32, and 33 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.

31. 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.:_____

32. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	33. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION X: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

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

I certify I have received the notice attached to this application titled *Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected Pension Benefits.*

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 34, indicating that I 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.

34. 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 rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

35A. VETERAN'S SIGNATURE (**REQUIRED**)	35B. DATE SIGNED

SECTION XI: WITNESSES TO SIGNATURE *(MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 35A WITH AN "X")*

36A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	36B. PRINTED NAME AND ADDRESS OF WITNESS
37A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	**37B. PRINTED NAME AND ADDRESS OF WITNESS**

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

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

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

1. This is a complete financial disclosure for the claimant. This was voted into law in October 2018 and it can be completed rather quickly. It includes pages 1-11 listed at the lower right-hand corners.
2. Many of these pages won't apply, such as Unemployment Income on Page 3. If this is the case, simply enter a "N/A" on the first box and draw a diagonal line through the page and move to the next page. However, since the average claimant's age is 87 and **if** your loved one is **still** drawing Unemployment Income, let us know what water they're drinking!
3. Remember that Senior Veteran's, Inc., **can not and will not** offer any financial, tax or legal advice. You might need to consult a trusted professional for some of your responses, however, this is rare.
4. The VA is the only party that will adjudicate this claim and they will decide to award your claim based, in part, on a **subjective** look at the claimant's finances. The claimant's residence, autos and personal belongings are excluded.

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Attachment to VA Forms 21P-527, 21P-527EZ, 21P-534, 21P-534EZ, and 21-526)

IMPORTANT: This is ***not*** a stand-alone form. Only complete this attachment if you are directed to do so when you complete ***one*** of the following:

(1) Section VI on VA Form 21P-527 or Section VIII on VA Form 21P-527EZ.

(2) Section VII on VA Form 21P-534 or Section VIII on VA Form 21P-534EZ.

(3) Section VIII on VA Form 21-526.

VETERAN/CLAIMANT PERSONAL INFORMATION		
1. VETERAN'S NAME (Last, First, Middle)	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S FILE NUMBER (If known)
4. CLAIMANT'S NAME (Last, First, Middle)	5. CLAIMANT'S SOCIAL SECURITY NUMBER	6. CLAIMANT'S TELEPHONE NUMBER

7. TYPE OF CLAIMANT (Check only one box)

☐ VETERAN ☐ SURVIVING SPOUSE ☐ SURVIVING CHILD ☐ PARENT

IMPORTANT INFORMATION FOR CLAIMANTS

NOTE - The term **"assets"** means the fair market value of all property that an individual owns, including all real and personal property(excluding the value of your or your dependent's primary residence including the residential lot area, not to exceed 2 acres) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

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

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

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

- yourself
- any child of the veteran who is in your custody*

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

- child
- child's custodian (unless the child's custodian is an institution)
- custodian's spouse

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

- yourself
- your spouse (even if your spouse is the veteran's other parent. If your spouse is the veteran's other parent, you must ***both*** file claims)

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

** Parent's DIC claimants do ***not*** need to ***report*** or ***provide*** documentation of their assets.

NOTICE

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

OMB Control No. 2900-0829
Respondent Burden: 25 minutes
Expiration Date: 10/31/2021

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

(Attachment to VA Forms 21P- 527, 21P-527EZ, 21P-534, 21P-534EZ, and 21-526)

SECTION I: RETIREMENT INCOME AND DISTRIBUTIONS (If additional space is needed attach a separate sheet)

1. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS INCLUDING, BUT NOT LIMITED TO, DISTRIBUTIONS FROM A RETIREMENT PLAN, SUCH AS:
   - Military Retirement
   - Civil Service Retirement
   - IRA
   - SEP
   - Qualified Plans
   - Pensions
   - Annuities
   - Black Lung

☐ YES ☐ NO (If "No," skip to Section II)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHO IS THE INCOME PAYER? (Name of business, financial institution, etc.)	C. WHAT IS YOUR CURRENT AND/OR EXPECTED INCOME? (Provide documentation of current income and expected income changes)	D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME? (Provide documentation of assets)
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	

SECTION II - UNEMPLOYMENT INCOME *(If additional space is needed attach a separate sheet)*

2. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE UNEMPLOYMENT INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section III)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED UNEMPLOYMENT INCOME? (Provide documentation of current income and expected income changes)	
	CURRENT MONTHLY GROSS INCOME	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$
	CURRENT MONTHLY GROSS INCOME	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$
	CURRENT MONTHLY GROSS INCOME	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$
	CURRENT MONTHLY GROSS INCOME	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$

SECTION III - SAVINGS BONDS *(If additional space is needed attach a separate sheet)*

3. DO YOU OR YOUR DEPENDENTS OWN A SAVINGS BOND OR RECEIVE OR EXPECT TO RECEIVE INTEREST FROM A SAVINGS BOND WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section IV)

A. WHO OWNS THE SAVINGS BOND? (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED ANNUAL INCOME (interest earned)? (Attach a copy of the savings bond)		C. WHAT IS THE CURRENT FACE VALUE OF THE SAVINGS BOND?
	WHAT IS THE GROSS ANNUAL INCOME?	$	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO	
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$	
	WHAT IS THE GROSS ANNUAL INCOME?	$	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO	
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$	
	WHAT IS THE GROSS ANNUAL INCOME?	$	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO	
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$	
	WHAT IS THE GROSS ANNUAL INCOME?	$	$
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?	☐ YES ☐ NO	
	DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT	$	

SECTION IV - RENTAL PROPERTY, FARM OR BUSINESS INCOME *(If additional space is needed attach a separate sheet)*

4. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INCOME FROM RENTAL PROPERTY, FARM OR BUSINESS WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section V)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT IS YOUR OR YOUR DEPENEDENTS CURRENT OR EXPECTED INCOME FROM THIS SOURCE? (Provide documentation of current income and expected income changes)	C. WHAT KIND OF INCOME IS THIS? (Check applicable box)	D. WHAT IS THE VALUE OF YOUR PORTION OF THE PROPERTY, FARM, OR BUSINESS? (**Note:** Subtract the amount of Mortgages or other encumbrances specific to the property. Provide available documentation)
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	

SECTION V - INTEREST, ROYALTIES, AND DIVIDENDS *(If additional space is needed attach a separate sheet)*

5. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INTEREST, DIVIDENDS, OR ROYALTIES WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section VI)

IMPORTANT: Do *not* report income you have already reported in Section III (Savings Bonds) or Section IV (Rental Property, Farm or Business Income).

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	**B. WHO IS THE INCOME PAYER?** (Name of business, financial institution, etc.)	**C. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED INCOME?** (Provide documentation of current income and expected income changes)	**D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME?** (Provide documentation of assets)
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT $	

SECTION VI - WAGES - INCLUDING SELF-EMPLOYMENT *(If additional space is needed attach a separate sheet)*

6. ARE YOU OR YOUR DEPENDENTS RECEIVING WAGES OR EXPECTING TO RECEIVE WAGES WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If "No," skip to Section VII)

A. WAGE RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT ARE YOUR OR YOUR DEPENDENTS CURRENT WAGES AND/OR EXPECTED WAGES? (Provide documentation of current wages and expected wage changes)
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT $
	CURRENT MONTHLY GROSS WAGE $
	DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAGE WILL CHANGE AND EXPECTED WAGE AMOUNT $

SECTION VII - DISCONTINUED INCOME IN THE PRIOR TAX YEAR *(If additional space is needed attach a separate sheet)*

7. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME *LAST YEAR* THAT IS NO LONGER BEING RECEIVED OR WAS A ONE-TIME PAYMENT?

☐ YES ☐ NO (If "No," skip to Section VIII)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHO WAS THE INCOME PAYER? (Name of business, financial institution, etc.)	C. WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?	D. WHEN DID THE INCOME STOP? (MM,DD,YYYY)
		$	
		$	
		$	
		$	

NOTE: **Parent's DIC Claimants Only** - You ***do not*** have to complete Sections VIII thru XI. Return to the application form. Your certification, signature and date on the application form applies to this attachment.

Pension Claimants - Continue to complete the attachment.

SECTION VIII - ASSETS PREVIOUSLY NOT REPORTED *(If additional space is needed attach a separate sheet)*

8. DO YOU OR YOUR DEPENDENTS HAVE ASSETS ***NOT*** ALREADY REPORTED, SUCH AS NON-INTEREST-BEARING ACCOUNTS, CASH, STOCKS, BONDS, OR REAL ESTATE?

☐ YES ☐ NO (If "No," skip to Section IX)

A. ASSET OWNER (Veteran, Spouse, Child, Parent, Custodial, etc.)	B. WHAT IS THE CURRENT CASH VALUE OF THE ASSET? (Provide a bank or other official statement showing the current value. Do not report assets you have already reported in Sections I through VII)	C. AMOUNT OWED ON THE ASSET OR AMOUNT MORTGAGED OR OTHERWISE ENCUMBERED? (Provide documentation of mortgages or other encumbrances)
	$	$
	$	$
	$	$
	$	$

SECTION IX - ASSET TRANSFERS *(If additional space is needed attach a separate sheet)*

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

☐ YES ☐ NO (If "No," skip to Section X)

A. WHO OWNED THE ASSET? (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER (Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? ☐ Yes ☐ No Was an asset reported to the IRS sold? ☐ Yes ☐ No What was the original purchase price?_____ What was the sale price?_____ What date was the asset sold? (MM,DD,YYYY)_____ What was the gain (capital gain, etc.)?_____
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? ☐ Yes ☐ No Was an asset reported to the IRS sold? ☐ Yes ☐ No What was the original purchase price?_____ What was the sale price?_____ What date was the asset sold? (MM,DD,YYYY)_____ What was the gain (capital gain, etc.)?_____

SECTION IX: ASSET TRANSFERS *(Continued)*

A. WHO OWNED THE ASSET? (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER (Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? ☐ Yes ☐ No Was an asset that was reported to the IRS sold? ☐ Yes ☐ No What was the original purchase price?_____ What was the sale price?_____ What date was the asset sold? (MM,DD,YYYY)_____ What was the gain (capital gain, etc.)?_____
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? ☐ Yes ☐ No Was an asset that was reported to the IRS sold? ☐ Yes ☐ No What was the original purchase price?_____ What was the sale price?_____ What date was the asset sold? (MM,DD,YYYY)_____ What was the gain (capital gain, etc.)?_____

SECTION X: ANNUITIES AND TRUSTS (Attach a separate sheet if more than one annuity or trust is involved)

10A. IN THE CURRENT YEAR OR THE PRIOR THREE TAX YEARS, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS TO A TRUST OR PURCHASE AN ANNUITY?
☐ Yes ☐ No (If "No," skip to Section XI)

10B. WHAT WAS THE MARKET VALUE OF THE ASSET AT THE TIME OF TRANSFER OR ANNUITY PURCHASE? $

10C. WHAT WAS THE DATE THE ASSET WAS TRANSFERRED? (MM,DD,YYYY)

10D. DID YOU PURCHASE AN ANNUITY WITH THE ASSETS?	10E. PROVIDE DATE OF PURCHASE	10F. PROVIDE NAME OF PERSON THE ASSET WAS PURCHASED FROM (First-Middle-Last)
☐ Yes ☐ No (If "Yes," complete Items 10E through 10G)		

10G. PROVIDE TYPE OF ANNUITY PURCHASED *(Give details and attach documentation)*

10H. WERE THE ASSETS USED TO ESTABLISH A TRUST?	10I. PROVIDE TAX NUMBER	10J. PROVIDE DETAILS AND ATTACH DOCUMENTATION
☐ Yes ☐ No (If "Yes," complete Items 10I through 10J)		

10K. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?
☐ Yes ☐ No

SECTION XI - WAIVER OF RECEIPT OF INCOME *(If additional space is needed attach a separate sheet)*

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

☐ YES ☐ NO (If "NO," skip this section. This attachment is complete. Return to the application. Your certification, signature and date on the application form applies to this attachment)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	**B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED WAIVED INCOME?** (Provide documentation of income and expected income changes)
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT $

THIS *ATTACHMENT FORM* IS COMPLETE. RETURN TO THE *APPLICATION FORM*. YOUR CERTIFICATION, SIGNATURE AND DATE ON THE APPLICATION FORM APPLIES TO THIS ATTACHMENT.

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

1. This is for the claimant's physician and it can be any physician, preferably the one that knows them best. This segment will include pages 1-3 at the bottom right corner.
2. You should fill in Section I & II to include your own mailing address, telephone number and e-mail address as before. The physician will complete the rest.
3. Encourage the physician to add comments other than a standard "Yes" or "No" especially on questions 30, 31 & 32. The physician may not know any of this. For example, the claimant may not require "nursing home care" on question 30, but the claimant needs regular care from an in-home attendant, which is most likely yourself.
4. Do **not** wait for the claimant's next appointment, get this completed promptly. Every day this application is not in the hands of the VA costs your loved one.
5. **Only** the physician should sign this form, not a PA, LPN or other professional.

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

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1. VETERAN/BENEFICARY NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER ___ - ___ - ____

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM/DD/YYYY)* Month ___ Day ___ Year ____

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

6. GENDER ☐ MALE ☐ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*

8. PREFERRED E-MAIL ADDRESS *(Optional)*

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

SECTION II: CLAIM INFORMATION

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

11. CLAIMANT'S SOCIAL SECURITY NUMBER ___ - ___ - ____

12. RELATIONSHIP OF CLAIMANT TO VETERAN

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

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

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

SECTION III: INFORMATION OF EXAMINATION

14. DATE OF EXAMINATION

15. HOME ADDRESS

16A. IS CLAIMANT HOSPITALIZED?

☐ YES ☐ NO *(If "Yes," complete Items 16B and 16C)*

16B. DATE ADMITTED

16C. NAME AND ADDRESS OF HOSPITAL

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

NOTE: EXAMINER PLEASE READ CAREFULLY

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

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

18A. AGE	18B. WEIGHT ACTUAL: LBS. ESTIMATED: LBS.	18C. HEIGHT FEET: INCHES:

19. NUTRITION	20. GAIT

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

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

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

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

☐ YES ☐ NO

27. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

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

☐ YES ☐ NO

29A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	29B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

☐ YES ☐ NO

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ - ☐☐ - ☐☐☐☐

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

34. 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)*

35. 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.

36. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

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

40A. PRINTED NAME OF EXAMINING PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED

41A. NAME AND ADDRESS OF MEDICAL FACILITY	41B. 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 and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

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

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES
WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE OR A SIMILAR FACILITY

1. **These two forms are crucial.** The In-Home Attendant form will be #13 at the bottom right hand corner and the Assisted-Living form will be #12. Each sheet has a non-descript Expense Form sheet that goes with it. Since we don't know which one applies to your loved one, **we've included both**. Toss the one that **doesn't** apply and do not send it with the application.
2. The WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR A SIMILAR FACILITY, is self-explanatory and is completed by an administrator of the AL or other senior community. The claimant must sign this along with administrator.
3. The WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is completed by the adult attendant, generally a family member but **not** a spouse. **Be sure to check every ADL that applies in Step 6, even if you've done them once.** Do the same for the IADL'S.
4. A good rule of thumb is that the claimant pays the In-Home Attendant about 80% of their gross monthly income. There are no receipts required nor back receipts or invoices of any kind. What happened in the past is the past. The VA only wants to see what the claimant is paying **from this point forward.** The VA doesn't care how this "looks" in terms of making ends meet. It's a number, and they subtract the monthly care expenses dollar for dollar from the claimant's income.
5. The claimant must be paying for their care, wherever it is delivered, from their own funds. If this can't be shown, the claim will be denied 100% of the time. Again, this is self-reported, and no receipts are required. **What the In-Home Attendant or Facility does with the money they are paid from the claimant is up to them.** That is your call, think about it.
6. This is the most difficult "piece" of this entire application. We have promised to help you for the **life of your claim**. If you feel a need to contact us anytime please e-mail us at seniorvetllc@gmail.com. We return every e-mail or call within 24 hours.

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: Only complete this worksheet if you are claiming expenses for in-home care.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) *Dressing*

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.

Follow the steps below to determine whether or not:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care

STEP 1. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

☒ YES ☐ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Item 37?

☒ YES ☐ NO (If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

☒ YES ☐ NO (If "YES," payments to this in-home attendant ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 45A thru 45F amounts you pay an in-home attendant for: (1) health-care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs, and (3) custodial care. Skip to Step 6)

(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

☒ YES ☐ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," the attendant ***must be a health care provider.*** Only report payments to the in-home attendant for ***health care services or assistance with ADLs*** provided by the health care provider as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs do not qualify as medical expenses. Skip to Step 6)

STEP 5. Is the ***primary responsibility*** of the in-home attendant to provide the disabled person with health care or custodial care?

☒ YES ☐ NO (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 45A thru 45F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs ***do not*** qualify as medical expenses)

STEP 6. Check all activities below that the attendant assists the veteran or disabled person with:

ADLs: ☐ EATING ☐ BATHING/SHOWERING ☐ DRESSING ☐ TRANSFERRING ☐ USING THE TOILET

IADLs: ☐ SHOPPING ☐ FOOD PREPARATION ☐ HOUSEKEEPING ☐ LAUNDERING ☐ MANAGING FINANCES ☐ HANDLING MEDICATIONS ☐ USING THE TELEPHONE ☐ TRANSPORTANTION FOR NON-MEDICAL PURPOSES

STEP 7. In-Home Attendant Certification: Please submit a current breakdown of the time the attendant spends assisting the veteran or disabled person with health care services, ADLs and IADLs.

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment pertaining to _____ (Name of Person Requiring Care) and his or her care from _____ (Name of Attendant).

_____ (Name, Signature and Title of Certifying Official) _____ (Date Certified)

IN-HOME ATTENDANT EXPENSES

I certify that _____ currently pays
(Name of claimant)

_____

(Name of Attendant and complete address)

a monthly fee of $_____ for the care delivered by

_____ .

(Attendant)

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR A SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

(If "NO," continue to Step 2)

☐ YES ☐ NO (If "YES," ***all*** payments to the facility qualify as medical expenses in Items 45A thru 45F. You are finished completing this worksheet)

STEP 2. Do ***all*** of the following apply to the facility?
- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with caregivers.

☒ YES ☐ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

☒ YES ☐ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension or special monthly DIC in Item 37?

☒ YES ☐ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the ***primary reason*** you live in the facility (or attend day care in the facility)?

☒ YES ☐ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension or special monthly DIC. Please report the amount you pay the facility for lodging and meals separate from the amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** as medical expenses in Items 45A thru 45F. Skip to Step 8)
(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay the facility for: (1) ***health care services or assistance with ADLs provided by a health care provider***; and (2) ***custodial care***. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

☒ YES ☐ NO (If "YES," ***you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services*** or custodial care that the facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disabilty)
(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

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

(If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)

☒ YES ☐ NO (If "NO," ***only*** claim payments you pay the facility for assistance with ***health care and/or assistance with custodial care*** as medical expenses in Items 45A thru 45F. Payment to this facility for meals and lodging ***do not*** qualify)

STEP 8. Facility Certification: Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received.

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to _____ (Name of person staying at your facility) and his or her care at this facility _____ (Name and address of facility).

_____ (Name, Signature and Title of Person Certifying for the Facility) _____ (Date Certified)

FACILITY CERTIFICATION

I certify that _____ currently pays
(Name of claimant/resident)

_____
(Facility and complete address)

a monthly fee of $_____ for the care delivered by

_____ .
(Facility Name)

WHERE TO MAIL YOUR APPLICATION
EXPEDITING YOUR CLAIM

1. These are the addresses where you **mail** your completed application. We recommend that you keep 2 copies of everything and that you send this either certified or registered. Send this **only** to the address listed. Do not send to any local or regional VA office. It might never get to one of the Pension Centers.
2. The sample letter to your U.S. Senator is the silver-bullet in expediting your claim. You don't have 8-12 months to wait on the VA. Your loved one deserves an answer, now. Most likely a staffer will handle this, so put some teeth into this. We sign their paychecks. Your loved one earned this, never forget that.

Godspeed

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Milwaukee Pension Center
P.O. Box 5192
Janesville, WI 53547-5192
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Alabama	Arkansas	Illinois	Indiana
Kentucky	Louisiana	Michigan	Mississippi
Missouri	Ohio	Tennessee	Wisconsin

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: Philadelphia Pension Center
P.O. Box 5206
Janesville, WI 53547-5206
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Connecticut	Delaware	Florida	Georgia
Maine	Maryland	Massachusetts	New Hampshire
New Jersey	New York	North Carolina	Pennsylvania
Rhode Island	South Carolina	Vermont	Virginia
West Virginia	District of Columbia	Puerto Rico	Canada
Countries outside of North, Central or South America			

Mail your form to:
Department of Veterans Affairs
Claims Intake Center
Attn: St. Paul Pension Center
P.O. Box 5365
Janesville, WI 53547-5365
Or fax your form to:
Toll Free: (844) 655-1604

This Pension Center Serves The Following:			
Alaska	Arizona	California	Colorado
Hawaii	Idaho	Iowa	Kansas
Minnesota	Montana	Nebraska	Nevada
New Mexico	North Dakota	Oklahoma	Oregon
South Dakota	Texas	Utah	Washington
Wyoming	Mexico	Central America	South America
Caribbean			

IMPORTANT:

No later than 30 days after you submit your claim to the VA, you **must** send this letter to one of the U.S. Senators from the state in which the claimant resides. Send this to the Washington D.C. office and not the local, state office. This is just a sample and you can change anything you wish but send it. **This works.**

(Date)

(Senator & Address)
(Re: Name & SS# of Claimant)

Dear (Senator's Name)

I am the (daughter, son) of (claimant's name and SS#). Over 30 days ago, I submitted a claim for "Aid and Attendance" also called the "Non-Service-Connected Disability Pension" to the VA Pension Center at (use the VA Pension Ctr's address where you sent your claim). I have heard **nothing** from the VA, however, my (mother, fathers) health declines daily. Senator (name) my (father, mother) earned this VA benefit through (his, her) service to our country.

My (mother, father) is (#) years old. The medical expenses for my (mother, father) are extremely high and very soon my (father's, mother's) savings will be depleted. However, the VA benefit we have applied for could reduce this financial stress considerably, but only if the VA acts soon, very soon.

Surely, Senator (name) you can find it in your heart to help my (mother, father). Will you help expedite this VA claim for my (#) year old (father, mother)? I am grateful for your support of our seniors and for **all** the men and women who protect the country **we all love.**

Respectfully,

(Your name and all contact information, including e-mail)