COMPLETE VA "AID & ATTENDANCE" APPLICATION

- Please print out the current, updated VA forms required to submit your application for "Aid & Attendance." ***Your application must include the claimant's original or certified discharge papers often known as the DD-214. This can be "certified" by a Notary Public. This discharge paper, one sheet, is the official record the VA uses to determine if the claimant/veteran meets the service eligibility criteria. If you are unable to locate these papers, you can order them on our site, "Ordering Military Records." Allow 4-6 weeks for the VA to get these to you.***
- The application is composed of **five** segments with each segment containing directions. Many of the questions have been pre-filled for your convenience. The VA section numbers are located at the bottom left-hand corners of the application.
- Our charity has been doing this a long time, over 10 years, and we have helped thousands of families throughout the U.S. Additionally, we will provide 24/7 personal assistance for the life of the claim, and you can reach out to us at anytime via email at **seniorvetllc@gmail.com.**
- The clock does not start **until the VA receives your claim.** If the claim is awarded, the claimant will be paid **retro** to the time the VA received it. Therefore, it is critical that you get the claim to them ASAP. Every day you wait means lost income for your loved one.

Finally, on a personal basis, our charity is dependent on donations to continue our mission. There is a "Donate" button on our site where you can donate $10, $20, $50 or more. Every donation is tax deductible and, appreciated. Our services have always been free to the senior veterans and families we serve. It will continue that way, thanks to you.

Godspeed,

David

David Bolser
CEO/Founder

APPLICATION FOR VETERANS PENSION
21P-527EZ

- This is for Single/Married Veterans. Some of the boxes have been filled with a **N/A** and **Yes/No** circles that have been filled. If you need to change any of these, please do so. If you are **not** able to answer some of the questions, simply put **N/A.**
- We answered **No** to questions 17C and 17D on **Page 6.** If you are considering Medicaid or if Medicaid covers you, **there is NO good reason to fill out these forms**. It will not work for you. Email us at seniorvetllc@gmail.com if you would like to discuss this.
- If you answered **Yes** to any of the questions **29A-29D on Page 10**, you would need to fill out form **21P-0969, Income and Asset Statement in Support of Claim**, which we have included.
- On Section **VIII**, **Page 11**, you will need to add the name of the veteran on Line **A**, the name of the provider, either Assisted Living, Adult Daycare or Similar Facility or the name of the In-Home Attendant as well as the Monthly Amount on **Line F**. Please, contact us via email at seniorvetllc@gmail.com and ask us to call you **before** you fill out this page.
- We have included both Worksheets (Page 13 & 14) with your application as we do not know which one applies to you. Many of these steps have been filled for you. If they are different, change them. Also, contact us via email at seniorvetllc@gmail.com to discuss these sheets as they are complicated.

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

Department of Veterans Affairs

APPLICATION FOR VETERANS PENSION

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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 (*First, Middle Initial, Last*)

2. SOCIAL SECURITY NUMBER

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

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

5. VA FILE NUMBER *(If applicable)*

6A. MAILING ADDRESS

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

6B. TELEPHONE NUMBERS *(Include Area Code)*

DAYTIME

EVENING

CELL PHONE

7. PREFERRED E-MAIL ADDRESS *(If applicable)*

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

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

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

10A. DID YOU SERVE UNDER ANOTHER NAME?
○ YES *(If "Yes," complete Item 10B)*
○ NO *(If "No," skip to Item 11A)*

10B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

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

11A. I ENTERED ACTIVE SERVICE ON *(MM-DD-YYYY)*

11B. BRANCH OF SERVICE

○ ARMY ○ NAVY ○ MARINE CORPS ○ AIR FORCE ○ COAST GUARD

11C. RELEASE DATE FROM ACTIVE SERVICE *(MM-DD-YYYY)*

11D. SERVICE NUMBER

N A

11E. PLACE OF LAST SEPARATION

12A. HAVE YOU EVER BEEN A PRISONER OF WAR?

○ YES *(If "Yes," complete Item 12B)*

○ NO *(If "No," skip to Item 13A)*

12B. DATES OF CONFINEMENT ON *(MM-DD-YYYY)*

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?

N A

13B. WHEN DID THE DISABILITY(IES) BEGIN? *(MM-DD-YYYY)*

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?

● 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.))*

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

15A. DATE(S) OF RECENT HOSPITALIZATION OR CARE *(MM-DD-YYYY)*

15B. NAME AND MAILING ADDRESS OF FACILITY OR DOCTOR

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?

○ YES ● NO

16B. WHEN DID YOU LAST WORK? *(MM-DD-YYYY)*

N A

16C. WERE YOU SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED?

○ YES ● NO *(If "Yes," complete Items 16D and 16E)*

16D. WHAT KIND OF WORK DID YOU DO?

N A

16E. ARE YOU STILL SELF-EMPLOYED?

○ YES ● NO

(If "Yes," complete Item 16F)

16F. WHAT KIND OF WORK DO YOU DO NOW?

N A

17A. ARE YOU NOW IN A NURSING HOME?

○ 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.)

17B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?

17C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?

○ YES ● NO *(If "No," complete Item 17D)*

17D. HAVE YOU APPLIED FOR MEDICAID?

○ YES ● NO

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

18A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	N A		
18B. WHAT WAS YOUR JOB TITLE?	N A		
18C. WHEN DID YOUR JOB BEGIN?	N A – –	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	
18D. WHEN DID YOUR JOB END?	N A – –	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?	$, .00

18A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	N A		
18B. WHAT WAS YOUR JOB TITLE?	N A		
18C. WHEN DID YOUR JOB BEGIN?	N A – –	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	
18D. WHEN DID YOUR JOB END?	N A – –	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?	$, .00

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 *(MM-DD-YYYY)* 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 *(MM-DD-YYYY)* AND PLACE MARRIAGE ENDED *(City and State or Country)*	– –

20A. DATE *(MM-DD-YYYY)* 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 *(MM-DD-YYYY)* 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 *(MM-DD-YYYY)* 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 *(MM-DD-YYYY)* AND PLACE MARRIAGE ENDED *(City and State or Country)*	– –

22A. DATE *(MM-DD-YYYY)* 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 *(MM-DD-YYYY)* 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? *(MM-DD-YYYY)* – –	23B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER? – –	23C. IS YOUR SPOUSE ALSO A VETERAN? ○ YES ○ NO *(If "Yes," complete Item 23D)*
23D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER *(If any)*? N A	23E. DO YOU LIVE WITH YOUR SPOUSE? ○ YES ○ NO *(If "Yes," skip to Section VI)* *(If "No," complete Items 23F, 23G and 23H)*	

23F. WHAT IS YOUR SPOUSE'S 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 –

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? $, .00

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)*	N A
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

24A. NAME OF DEPENDENT CHILD *(First, Middle initial, Last)*	N A
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

24A. NAME OF DEPENDENT CHILD *(First, Middle initial, Last)*	N A
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

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)*

N A

25B. CHILD'S COMPLETE ADDRESS *(Number and street or rural route, city or P.O., city, State, ZIP Code and country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code -

25C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable) (First, middle initial, last)*

25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT $, .00

25A. NAME OF DEPENDENT CHILD *(First, middle initial, last)*

N A

25B. CHILD'S COMPLETE ADDRESS *(Number and street or rural route, city or P.O., city, State, ZIP Code and country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code -

25C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable) (First, middle initial, last)*

25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT $, .00

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

25A. NAME OF DEPENDENT CHILD *(First, middle initial, last)*

N A

25B. CHILD'S COMPLETE ADDRESS *(Number and street or rural route, city or P.O., city, State, ZIP Code and country)*

No. & Street

Apt./Unit Number | City

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

25C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable) (First, middle initial, last)*

25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT $, .00

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 *(First, middle initial, last)*	B. GROSS MONTHLY AMOUNT
	$, .00
	$, .00
	$, .00
	$, .00
	$, .00

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?

N A Square feet

28B. COULD ANY PART OF THE LOT BE SOLD *WITHOUT SELLING THE RESIDENCE*?

○ 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

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 10 and 11.

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 *(MM-DD-YYYY)*	E. HOURLY RATE/ HOURS *(In-home Provider Only)*	F. AMOUNT YOU PAY
		Med. Expenses	Monthly	$ N A .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00

SECTION IX: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. 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 the 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.)

( ) YES ( ) NO

Account No.:

( ) I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

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 paid 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")	37A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

36B. PRINTED NAME AND ADDRESS OF WITNESS	37B. PRINTED NAME AND ADDRESS OF WITNESS
Name:	Name:
Address:	Address:

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.

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

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

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

(1) Eating

(2) Bathing/Showering

(3) Dressing

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

(5) Using the toilet

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

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

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

○ YES ○ NO (If "NO," continue to Step 2)

(If "YES," all payments to the facility qualify as medical expenses in Items 30A - 30F. 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 veteran) the disabled person?

○ YES ○ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

◉ YES ○ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amounts you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 30A - 30F. 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 ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 30A - 30F applicable amounts you pay the facility for (1) ***lodging and meals,*** (2) ***health care services or assistance with ADLs provided by a health care provider,*** and (3) ***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 disability)

(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 30A - 30F. 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)?

◉ YES ○ NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 30A - 30F)

(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 30A - 30F. 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 Facility)

and his or her care at this facility

(Name of Facility)

at

(Address of Facility (Line 1))

(Address of Facility (Line 2))

(Name of Person Certifying for the Facility)

(Signature of Person Certifying for the Facility)

(Title of Person Certifying for the Facility)

– – (Date Certified)

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 veteran) the disabled person?

○ YES ○ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

◉ 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 30A - 30F 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 30A - 30F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Item 30A - 30F 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 30A - 30F 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 30A - 30F. 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 30A - 30F.)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 30A - 30F. Payment for assistance with IADLs ***do not*** qualify as a medical expense)

STEP 6. Check all activities below with which 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 ○ TRANSPORTATION 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 of Certifying Official)

_____ (Signature of Certifying Official)

_____ (Title of Certifying Official)

__ __ – __ __ – __ __ __ __ (Date Certified)

INCOME AND ASSET STATEMENT
21P-0969

- If you answered **Yes** to any of the questions **29A-29D** on **Page 10 of 21P-527EZ**, you need to fill out **Form 21P-0969, Income and Asset Statement**.
- Some of this we have filled out for you as we didn't think it would apply to the claimant. If that is different, please change it.
- If the Questions at the top of the pages do not pertain to you, skip them and go on to the next page as per the directions.

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, and 21P-534EZ)

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.

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.

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

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.

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

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 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. 2900-0829
Respondent Burden: 25 minutes
Expiration Date: 12/31/2024

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, and 21P-534EZ)

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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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?
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* AND EXPECTED INCOME 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 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 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 *(MM/DD/YYYY)*	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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 *(MM/DD/YYYY)* 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 OF PERMANENT NEED FOR AID & ATTENDANCE 21-2680

- This is the form for the claimant's Dr. to fill out. It should be the physician that is most familiar with the claimant.
- You may need to assist the physician with answers on this form, especially #30, #31 and #32. Ask the physician to be more specific, instead of just a YES/NO answer.
- Make sure you include the claimant's SS# at the top of the pages.

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)* — X X X

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

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

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 <u>without</u> 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	18C. HEIGHT
	ACTUAL: LBS. ESTIMATED: LBS.	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.

MAILING YOUR APPLICATION

- Be sure to make copies of the application and send the application Certified, Registered or via the USPS 2-3 day delivery. The USPS 2-3 day delivery is around $8.00 very simple to use.
- Do **NOT** Fax these forms, even though you can. Everything in writing!

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			

ASK YOUR SENATOR TO EXPEDITE CLAIM

- You **must** send a letter, using this template, to one of the Senators representing the state the claimant lives in no later than 45 days after you send your claim to the VA. Again, I would use the $8.00 USPS 3-4 day mailer.
- The Washington D.C. address on the template is **correct**. Send it there.
- The VA is **notorious for sitting on these claims for months**. You **do not** have the luxury of time.
- Contact us immediately, 24/7 if you need any help or guidance with this.

(Date)

(Your State Senator)
261 Russell Senate Bldg.
Washington, D.C.
20510

Dear Senator_____:

I am the (daughter, son) of a senior veteran, (claimant's name & SS#) who is also one of your constituents. Over 30 days ago, I submitted a claim for my (father,mother) to the VA. This claim was for the "Non-Service Connected Disability Pension" AKA "Aid and Attendance." The claim was sent to (Use the address where you sent the claim). To date, I have heard nothing from the VA.

This claim can help my (father, mother) pay for (his,her) long-term care as (his/her) health is failing dramatically and, of course, (his,her) life savings are being depleted to pay for(his/her) long-term care. Very soon, (his,her) money will run out.

Surely, in your position, you could inquire about my (father's, mother's) claim and ask the VA to expedite it. My (father,mother) is _____ years old. I fear that the time (he/she) has left is very short. Senator_____, my family needs your help.

Thank you for your time and attention to this matter.

Respectfully,

(Name & Contact Information)