COUNTY OF LEHIGH
Department of Administration
Office of Veterans Affairs

Lehigh County Government Center
17 South Seventh Street
Allentown, PA 18101-2401
Phone: 610-782-3295
Fax: 610-820-2026

APPLYING FOR A VA PENSION WITH AID & ATTENDANCE

Please read this entire check list. You must collect all required documentation prior to scheduling an appointment. Failure to bring all necessary documentation may necessitate return trips to our office.

Entitlement to a VA pension is determined by financial need based on your income and assets. This benefit is based on total income after deducting non-reimbursed medical expenses such as assisted living facilities, nursing homes, and personal care.

After deducting unreimbursed medical expenses, your income cannot exceed…		
	Pension Only	**With Aid & Attendance**
Veteran alone	**$12,868.00**	**$21,466.00**
Surviving spouse	**$8,630.00**	**$13,794.00**
Veteran & spouse	**$16,851.00**	**$25,448.00**
Your assets cannot exceed $80,000. Assets do not include the veteran's (or surviving spouse's home).		
The above income limits are current as of December 1, 2014		

Documentation needed to apply:

VETERAN'S MILITARY DISCHARGE (DD-214 OR REPORT OF SEPARATION) SHOWING WARTIME SERVICE. Call our office if you are unclear regarding dates of wartime service. We cannot accept a discharge certificate. If the DD-214 or Report of Separation is lost, contact the Lehigh County Recorder of Deeds at 610-782-3162 to find out if it is on file and to obtain a certified copy. If unavailable, visit www.archives.gov to obtain a copy.

COPIES OF ALL MARRIAGE LICENSES, DIVORCE DECREES, AND DEATH CERTIFICATES, AS APPLICABLE. If there are any prior marriages for the veteran or spouse, then we need proof that the marriage has been terminated via divorce decree or death certificate.

A FULLY COMPLETED VA FORM 21-2680 (ATTACHED) OR A LETTER SIGNED BY THE PHYSICIAN If the doctor provides a letter, there must be sufficient detail as to the patient's diagnosis and prognosis including competency. The letter must be on the physician's letterhead and signed by the doctor. A prescription pad is not an acceptable letter.

A FULLY COMPLETED CARE EXPENSE STATEMENT (ATTACHED) or a letter from the assisted living facility, personal care provider or nursing home. This letter must include the individual's name, the date entered the facility (or into contract with care provider), cost per day or month, the amount already paid as of the date of the letter and the date paid. Documentation of expenses (i.e. bills received and bills paid) must be provided.

VERIFICATION OF ALL INCOME. This includes current statements from employers (wage slips), Social Security (annual statement), pension(s), dividends (1099INT), interest (1099DIV), and all other income sources. Proof of all income, even if it is direct deposit, need a statement for source.

VERIFICATION OF ALL ASSETS. Current bank statements for all checking & savings accounts. Included in assets is the current net worth of all IRA's, Keogh Plans, stocks, bonds, mutual funds, CD's and real property (not including current home) and any other assets.

UNREIMBURSED MEDICAL EXPENSES. In addition to care costs, this includes health care premiums (i.e., Capital Blue Cross, Aetna) and prescriptions.

MISCELLANEOUS ITEMS. Bank Account and Routing Number for direct deposit, Social Security numbers for spouse and dependents, birth certificates for dependent children, and powers of attorney.

Please call our office at (610) 782-3295 to schedule an appointment to apply for pension benefits. Please have all financial information available prior to making the appointment. Office hours are 8 a.m. to 4 p.m., Monday thru Friday. No appointments will be made after 2 p.m. due to the length of time required to complete an application.

(Updated January 22, 2015)

COUNTY OF LEHIGH
Department of Administration
Office of Veterans Affairs

Lehigh County Government Center
17 South Seventh Street,
Allentown, Pennsylvania 18101-2401
Phone: 610-782-3295
Fax: 610-820-2026

CARE EXPENSE STATEMENT

Section 1. General Information (To be completed by the facility administrator or in-home care provider)

Date: _____

Veteran's Name (Last, First, MI): _____

Veteran's Social Security Number: _____

Patient's Name (Last, First, MI): _____

Patient's Social Security Number: _____

Patient is: ☐ Veteran ☐ Spouse ☐ Surviving Spouse ☐ Other: _____

The patient's care status is:
☐ Personal Care Facility ☐ Nursing Home ☐ In-Home ☐ Other: _____

Name of facility or in-home care provider: _____

Contact person: _____

Address of facility or care provider: _____

_____

Phone: _____ Email: _____

Date entered facility or in-home care began: _____

Total monthly charge for patient $_____ per month

Total paid to provider by claimant in year 20__ $_____

Has the patient applied for Medicaid? ☐ Yes ☐ No

Date applied for Medicaid: _____ Date Medicaid began: _____

Is part of the patient's cost covered by Medicaid, Medicare, or insurance? ☐ Yes ☐ No

What is the source of the payment? _____

What is the monthly amount covered by this source? $_____ per month

When did coverage begin? _____

What is the monthly amount the veteran or patient pays from his/her own funds, which is not reimbursed by of the above listed sources? (If the patient is receiving Medicaid, what amount does Medicaid take from the patient?) $_____ per month

If the patient is receiving Medicaid, attach a copy of the SDS-512 Medicaid form.

Section 2. In-Home Care Information
(This section to be completed only if the patient is being provided residential in-home care)

Do you provide any medical or nursing services for the patient ☐ Yes ☐ No

Are you a licensed health professional? ☐ Yes ☐ No

If Yes, provide your license number: _____

**To allow medical expenses for in-home caregivers, VA regulations require you to submit specific documentation of expenses. Documentation includes at a minimum, one or more of the following:*

- *A receipt bill*
- *Statement on the providers letterhead*
- *Computer summary*
- *Ledger*
- *Bank statement*

The evidence submitted must include:

- *The amount paid*
- *The date payment was made*
- *The purpose of the payment*
- *The name of the person to or for whom the service was provided*
- *Identification of the provider to whom payment was made*

Section 3. We provide the following specific services to this patient:

	YES	NO		YES	NO
Provides help with dressing and/or getting out of bed			Provides meals because care recipient above is physically or mentally incapable of preparing his own meals		
Provides help with bathing			Provides homemaker services		
Provides help with ambulating			Transportation		
Provides help with toileting			Provides staff for skilled medical care		
Provides help with incontinence			Provides training for family caregivers		
Provides medical or monitoring alert equipment			Provides supervision to prevent person from harming himself		
Provides 24/7 emergency response staff			Provides supervision to prevent person from harming others		
Provides help with feeding			Provides supervision to prevent wandering		
Provides off-premise home care services			Provides restraint or direction if care recipient is uncooperative		
Provides supervision and properly structured living arrangements for a protected environment			Provides qualified personnel for administering medications or provides supervision and reminders for medications		

Section 4. Facility or Care Provider Administrator Signature

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

_____ _____

Name Title

_____ _____

Signature Date

Revised 1/30/2015

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

Department of Veterans Affairs

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

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

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

6. DATE OF EXAMINATION	7. HOME ADDRESS

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

NOTE: EXAMINER PLEASE READ CAREFULLY

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

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

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

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

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

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

14. NUTRITION	15. GAIT

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

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

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

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

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

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

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

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

☐ YES
☐ NO

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

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

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

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

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