COUNTY OF LEHIGH
Department of Administration
Office of Veterans Affairs

Thomas L. Applebach
Director
Viola Hertzog
Assistant Director
Lynn Weimer
Veterans Service Officer

Summary of VA Pension Benefits

VA helps Veterans with wartime service and their families cope with financial challenges by providing supplemental income through Veterans Pension and Survivors Pension benefits.

ELIGIBILITY FOR VA PENSION BENEFITS

Requirements	Service Requirements	Age / Disability	Income and Net Worth
Veterans	• Discharged from service under other than dishonorable conditions • Served 90 days or more of active duty with at least one day during a period of war[1]	• Age 65 or older, OR • Permanently and totally disabled (not due to own personal misconduct), OR • Patient in a nursing home receiving skilled nursing care, OR • Receiving Social Security disability benefits	• Countable family income is below the amount set by Congress • Unreimbursed medical expenses may reduce countable income • Net worth is not excessive
Un-remarried Surviving Spouses	Spouse must have met all Veteran Service Requirements listed above	N/A	

[1] *Veterans who entered active duty after September 7, 1980 must also serve at least 24 months of active duty service. If the total length of service is less than 24 months, the Veteran must have completed his or her entire tour of active duty.*

AID AND ATTENDANCE AND HOUSEBOUND

Veterans or surviving spouses who are eligible for VA pension and are housebound or require the aid and attendance of another person may be eligible for an additional monetary payment.

Aid and Attendance (A&A). An increased monthly pension amount paid if you meet one of the following conditions:

- You require help in performing daily functions, which may include bathing, eating, or dressing
- You are bedridden
- You are a patient in a nursing home
- Your eyesight is limited to a corrected 5/200 visual acuity or less in both eyes; or concentric
- contraction of the visual field to 5 degrees or less

Housebound. An increased monthly pension amount paid if you are substantially confined to your immediate premises because of a permanent disability.

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

INCOME AND NET WORTH LIMITATIONS

If eligible, your pension benefit is the difference between your "countable" income and the annual pension limit set by Congress. VA generally pays this difference in 12 equal monthly payments.

Countable income. Includes income from most sources as well as from any eligible dependents. It generally includes earnings, disability and retirement payments, interest and dividend payments from annuities, and net income from farming or a business. Some expenses, such as unreimbursed medical expenses, may reduce your countable income.

Net worth. Includes assets such as bank accounts, stocks, bonds, mutual funds, annuities, and any property other than your residence and a reasonable lot area. You should report all of your net worth. VA will determine whether your assets are of a sufficiently large amount that you could live off of them for a reasonable period of time.

Yearly Income. Your yearly family income must be less than the amount set by Congress to qualify for the Veterans or Survivors' Pension benefit.

Entitlement to a VA Pension or VA Pension with Aid & Attendance is determined by financial need based on combined income and assets which may not exceed **$130,773** after deducting qualifying, non-reimbursed medical expenses such as health care premiums and the cost of nursing home care, qualified senior living/personal care, or in-home care services.

After deducting qualifying unreimbursed medical expenses, Countable Income cannot exceed…		
	Pension Only	**With Aid & Attendance**
Veteran Only	**$13,931**	**$23,238**
Un-Remarried Surviving Spouse	**$9,344**	**$14,934**
Veteran & Spouse	**$18,243**	**$27,549**

Frequently Asked Questions (FAQs)

What qualifies as a wartime period?

Under current law, VA recognizes the following war periods:

- World War I (April 6, 1917—November 11, 1918)
- World War II (December 7, 1941—December 31, 1946)
- Korean conflict (June 27, 1950—January 31, 1955)
- Vietnam era (November 1, 1955—May 7, 1975 for Veterans who served in the Republic of Vietnam during that period; otherwise August 5, 1964—May 7, 1975)
- Gulf War (August 2, 1990—through a future date to be set by law or Presidential Proclamation)

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

If I am already receiving monthly payments for a service-connected disability, can I also receive a VA pension?
You cannot receive a VA non-service-connected pension and service-connected disability compensation at the same time. However, if you apply for a pension benefit and are awarded payments, VA will pay you whichever benefit is greater.

Can I reapply for pension benefits if I do not initially qualify?
Yes, you may reapply at any time if your countable income is below the yearly limit (which may occur after deducting unreimbursed medical expenses from the 12 month period after VA received your claim), or if you were denied because you were not rated as permanently and totally disabled but your disabilities have become worse.

APPLYING FOR A VA PENSION WITH AID & ATTENDANCE

Prior to scheduling an appointment to apply for this benefit you must collect all required documentation and complete the worksheets and forms as explained in Sections I, II, and III below. Failure to bring all necessary documentation and forms to your appointment may necessitate return trips to our office and will delay submission of the application. Please note: Do not send us any documents prior to your appointment unless explicitly asked to do so.

Required Documents:

VETERAN'S MILITARY DISCHARGE (DD-214 OR REPORT OF SEPARATION) SHOWING 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 one is on file. If unavailable, visit www.archives.gov to order a copy.

COPIES OF MARRIAGE LICENSES, DIVORCE DECREES, AND DEATH CERTIFICATES (AS APPLICABLE). If there are prior marriages for the veteran or spouse, proof is required that the marriage was terminated via a divorce decree or death certificate.

SECTION I – VA FORM 21P-0969 (Income and Asset Statement Worksheet)

This form is a worksheet. Fully complete all applicable sections of the form and provide documentation as appropriate. Documentation includes, but is not limited to:

- **VERIFICATION OF ALL INCOME:** This includes current statements from employers (wage slips), Social Security (annual statement), pension(s), interest (1099INT), dividends (1099DIV), and all other income sources. All sources of income, even if it is direct deposit, need a statement of the source.
- **VERIFICATION OF ALL ASSETS AND ASSET TRANSFERS:** Included in assets is the current net worth of all bank deposits and accounts, IRA's, Keogh Plans, stocks, bonds, mutual funds, CD's, real property (not including current home/primary residence).

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

- **VERIFICATION OF UNREIMBURSED MEDICAL EXPENSES:** In addition to care costs, this includes health insurance premiums (i.e., Medicare Part B & D, Capital Blue Cross, Aetna) and prescriptions.

SECTION II – VA FORM 21-2680 (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance)

This form must be fully completed and signed by a qualified physician

SECTION III – Provider Statement(s)

The appropriate VA form and Care Expense worksheet must be completed and signed by an authorized official. If the claimant is receiving Medicaid, appropriate documentation is also required. In addition:

- Assisted Living, Adult Day Care, or a similar facility must also submit a current statement with an itemization of the fees the claimant pays and a breakdown of the care received.
- In-Home Attendant Providers must submit current statements showing the fees the claimant pays and also provide a current breakdown of the time the attendant spends assisting the veteran or disabled person with health care services, ADLs, and IADLs.

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

Please Note:

- **You must schedule an appointment by calling (610) 782-3295. Walk-ins are not accepted.**
- **Appointments generally last 60 to 90 minutes.**
- **Please have all of the above documentation in-hand before 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 March 4, 2021)

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

SECTION I

INCOME & ASSET STATEMENT

WORKSHEET

(VA FORM 21P-0969)

Note: You must include documentation of all income and assets reported. For example, income from a pension must include an IRS Form 1099 or a statement from the payer. Asset transfers (Section IX) require documentation of the transfer.

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, 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 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.

SECTION II

Examination for Housebound Status or Permanent Need for Regular Aid and Attendance

(VA FORM 21-2680)

Note: This form must be fully completed and signed by a qualified physician.

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 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. 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.

SECTION III

Care Provider ADL Assessment

This statement must be fully completed and signed by an authorized official for claimants living in an Assisted Living, Adult Day Care, or a Similar Facility. If the claimant is receiving Medicaid, appropriate documentation is also required.

Care Provider Statement(s)

The appropriate worksheet must be fully completed and signed by an authorized official. If the claimant is receiving Medicaid, appropriate documentation is also required.

- **VA FORM 21P-0969 – Page 12**

  Worksheet For An Assisted Living,
  Adult Day Care, or a Similar Facility PLUS the ADL Assessment as noted above

- **VA FORM 21P-0969, Page 13**

  Worksheet for In-Home Attendant Expenses

- **VA Form 21-0779**

  Request For Nursing Home Information in Connection With Claim for Aid and Attendance

CARE PROVIDER ADL ASSESSMENT

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

Date: _____

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

Patient's Name (Last, First, MI): _____ SS#_____
(If other than Veteran)

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

The patient's care status is: ☐ Personal Care Home ☐ Other: _____

Name of facility or care provider: _____

Contact person: _____

Address of facility or care provider: _____

_____

Phone: _____ Email: _____

Staffed 24 hours per day with caregivers? ☐ Yes ☐ No

Date entered facility or services began: _____

Total monthly charge for patient $_____ per month **(Attach copy of invoice)**

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

Section 2. The care provider(s) listed above offers the following specific services:

(ADL = Activity of Daily Living, IADL = Instrumental Activities of Daily Living)

	YES	NO		YES	NO
Provides help with dressing (ADL)			Preparing meals (IADL)		
Provides help with getting out of bed (ADL)			Provides room and board (IADL)		
Provides help with bathing or personal hygiene (ADL)			Transportation (IADL)		
Provides help with ambulating (ADL)			Supervising or providing reminders for medication (IADL)		
Provides help with toileting (ADL)			Monitor/room checks		
Provides help with incontinence (ADL)			Provides supervision to prevent person from harming himself		
Provides help with feeding (ADL)			Provides medical alert systems		
Provides help with prosthetic adjustments (ADL)			Provides strategies to prevent wandering		
Provides close supervision to prevent injury, wandering, or falls (ADL)			Provides social activities and/or social stimulation		
Does housework and laundry (IADL)			Transportation		

Section 3. Facility Administrator or Care Provider Signatures

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

_____ _____
Name Title

_____ _____
Signature Date

(Updated December 2019)

VETERAN'S SOCIAL SECURITY NUMBER | | | – | | – | | | | |

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)?

◯ YES ◯ NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)
(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)

VETERAN'S SOCIAL SECURITY NUMBER | | | – | | – | | | | |

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)

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

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

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

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

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* — —

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

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

6. SOCIAL SECURITY NUMBER — —

7. VA FILE NUMBER *(If applicable)*

8. DATE OF BIRTH *(MM/DD/YYYY)* — —

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

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

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

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

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

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

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

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

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

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

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

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

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

18. NURSING HOME OFFICIAL'S TITLE

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

Enter International Phone Number *(If applicable)*

SECTION V - CERTIFICATION AND SIGNATURE

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

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

21. DATE SIGNED *(MM/DD/YYYY)* — —

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