Department of Veterans Affairs

GENERAL INSTRUCTIONS
FOR INCOME, ASSET AND EMPLOYMENT STATEMENT

NOTE: Read these instructions very carefully, detach, and keep for your reference.

Frequently Asked Questions

How can I contact VA if I have a question?

If you have questions about this form, how to complete it, or about benefits, contact your nearest VA regional office. You can find the address of the nearest VA regional office on the Internet at https://www.va.gov/directory. For additional information or questions contact us online through Ask VA: https://www.va.gov/contact-us or call us toll-free at 1-800-827-1000 (TTY: 711).

When do I use VA Form 21P-527?

Use VA Form 21P-527 to apply for veterans pension if you ***have*** previously filed a claim for compensation and/or veterans pension. For expeditious processing under the Fully Developed Claim process use VA Form 21P-527EZ, *Application for Veterans Pension*. VA forms are available at www.va.gov/vaforms.

What is veterans pension and how does VA decide what I will and will not receive?

You should apply for veterans pension benefits if ***all*** of the following are true:

- Your income and assets do not exceed certain limits. Visit our website at www.benefits.va.gov/pension/rates.asp for the maximum yearly income we allow.
- You are 65 or older or permanently and totally disabled. Your disabilities do not have to be related to your military service.
- You served on active duty with at least one day during a period of war. Visit our website at www.benefits.va.gov/pension/vetpen.asp for more specific information.

VA pays veterans pension based on income and asset amounts for the veteran and his/her dependents. VA must include all sources of income that Federal law specifies. You can find out what the current income limitations and rates of benefits are by contacting your nearest VA office.

You must provide information about the Social Security benefits you and your dependents receive. Report the gross amount you and your dependents receive monthly before deductions are taken out. If you have a copy of your most recent Social Security award letter, please include a copy of the letter with your application.

You must tell us if you or your dependents receive or received income from sources other than Social Security. Please also report if you or your dependents own your primary residence and the value of your assets and your dependents' assets. Your assets **do** include your spouse's assets. Although your assets ***do not*** include your child's assets, you must tell us if your child has significant assets.

Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the 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. You must tell us if you or your dependents have transferred assets in the past three calendar years.

IMPORTANT: If you or your dependents receive or received income in addition to Social Security benefits ***or*** you or your dependents have significant assets or have transferred assets, we will require you to complete VA Form 21P-0969, *Income and Asset Statement,* in addition to this application.

VA may pay benefits from the date of receipt of your application unless severe disability prevented you from filing a claim for a period of at least 30 days. If you want this claim considered for retroactive payment, indicate so in Item 36, "Remarks," and identify the specific disability which prevented you from filing.

What is special monthly pension?

Special monthly pension is an increased amount paid to individuals who, due to mental or physical disability, require the aid of another person to perform activities of daily living, are a patient in a nursing home, have severe visual problems, or are substantially confined to his or her home. If you wish to apply for this benefit, check "Yes" in Item 22A.

What medical evidence should I submit?

If you are you are a veteran who is claiming pension and you are age 65 or older, or determined to be disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application unless you are claiming special monthly pension. Otherwise, provide only those medical records that are related to the disabilities that prevent you from working.

If you wish to claim special monthly pension and are not in a nursing home, please 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 the application is signed by a physician, physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialist (CNS). If you are a patient in a nursing home, please attach a completed VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*, signed by an official of the nursing home showing the date you were admitted to the nursing home, the level of care you receive, and whether Medicaid covers all or part of your nursing home costs.

If you want help getting medical records related to this claim, you may complete VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA). By signing VA Form 21-4142, you authorize any doctors, hospitals, or caregivers that have treated you to release information about your treatment to VA. You do not need to complete this form for any treatment you received at a VA facility. If you need a copy of the VA Form 21-4142 or VA Form 21-0779, you may contact VA as shown on page 1 in "How can I contact VA if I have a question?" or download the forms from the VA web site www.va.gov/vaforms.

What do I do when I have completed my application?

When you have completed this application, mail it to the Pension Intake Center listed below. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and everything that you submit to VA before mailing it.

MAIL: Department of Veterans Affairs
Pension Intake Center
P.O. Box 5365
Janesville, WI 53547-5365

How can I assign someone to act as my representative?

You may wish to contact an accredited veterans service officer (VSO) to assist you with your application. For a list of accredited veterans service organizations go to https://www.va.gov/vso/. You may also contact your state office of veterans affairs at https://www.va.gov/statedva.htm, should you need further assistance with the application process.

Depending on the type of representative you want to designate, please submit one of the following forms:

- VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative ***or***
- VA Form 21-22A, Appointment of Individual as Claimant's Representative

You may download these forms at: www.va.gov/vaforms. If you have already designated a representative, no further action is required on your part.

IMPORTANT: If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on VA recognized marriages is available at **https://www.va.gov/opa/marriage/**.

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.

PRIVACY ACT INFORMATION: 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 Veteran Readiness 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 response 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 1 hour 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. 2900-0002
Respondent Burden: 1 hour
Expiration Date: 08/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden Information and General Instructions carefully before completing this form. Type, print, or write plainly.

PART I - VETERAN'S IDENTIFYING INFORMATION

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. FIRST - MIDDLE INITIAL - LAST NAME OF VETERAN (Type or Print)

2A. VETERAN'S SOCIAL SECURITY NO. – –

2B. VA FILE NUMBER *(If applicable)*

3. 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 –

4A. TELEPHONE NUMBERS *(Include Area Code)*

DAYTIME – – EVENING – – CELL PHONE – –

4B. PREFERRED E-MAIL ADDRESS *(If applicable)*

PART II - MARITAL INFORMATION

NOTE: If married, you should provide a copy of your marriage certificate.

5. WHAT IS YOUR MARITAL STATUS?

☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ NEVER MARRIED

(If you are divorced or widowed skip to Item 14)
(If never married skip to Part III)

6A. DATE YOU WERE YOU MARRIED? *(MM-DD-YYYY)* – –

6B. WHERE DID YOU GET MARRIED? (City, State, or Country)

7. SPOUSE'S NAME (First, middle, last)

8. SPOUSE'S DATE OF BIRTH *(MM-DD-YYYY)* – –

9. SPOUSE'S SOCIAL SECURITY NUMBER – –

10A. IS YOUR SPOUSE ALSO A VETERAN?

☐ YES ☐ NO

(If "Yes," complete Item 10B, if known)

10B. SPOUSE'S VA FILE NUMBER (If any)

11. DO YOU LIVE WITH YOUR SPOUSE?

☐ YES ☐ NO

(If "Yes," skip to Item 14) (If "No," complete Items 12, 13A, & 13B)

PART II - MARITAL INFORMATION (Continued)

12. SPOUSE'S 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 –

13A. IF YOU DO NOT LIVE WITH YOUR SPOUSE PLEASE PROVIDE THE REASON (i.e., illness, work, etc.)

13B. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO SPOUSE'S SUPPORT? $, .00

INFORMATION ABOUT THE VETERAN'S & SPOUSE'S PREVIOUS MARRIAGES

NOTE: Furnish the following information about all of your and your present spouse's previous marriages. If you need additional space please attach VA Form 21-686c, *Declaration of Status of Dependent,* providing the requested information about the marriages.

14. HOW MANY TIMES HAVE YOU BEEN MARRIED?

15A. DATE OF MARRIAGE *(Month, Day, Year)*	15B. PLACE OF MARRIAGE *(City, State, Country)*	15C. NAME OF FORMER SPOUSE *(First, Middle, Last)*	15D. DATE MARRIAGE ENDED *(Month, Day, Year)*	15E. PLACE MARRIAGE ENDED *(City, State or Country)*	15F. REASON MARRIAGE ENDED *(Death, Divorce)*

16. HOW MANY TIMES HAS YOUR CURRENT SPOUSE BEEN MARRIED?

17A. DATE OF MARRIAGE *(Month, Day, Year)*	17B. PLACE OF MARRIAGE *(City, State, Country)*	17C. NAME OF FORMER SPOUSE *(First, Middle, Last)*	17D. DATE MARRIAGE ENDED *(Month, Day, Year)*	17E. PLACE MARRIAGE ENDED *(City, State or Country)*	17F. REASON MARRIAGE ENDED *(Death, Divorce)*

PART III - INFORMATION ABOUT YOUR UNMARRIED DEPENDENT CHILDREN

VA recognizes your biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:
- under age 18, or
- between 18 and 23 and pursuing an approved course of education, or
- of any age if they became seriously disabled and permanently unable to support themselves ***before*** reaching age 18.

"Seriously disabled" means that the child became permanently unable to support himself/herself before reaching age 18.
Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.
If you need additional space, please attach a separate sheet of paper providing the requested information about each child.

Note: You should provide a copy of the public record of birth for each child or a copy of the court record of adoption for each adopted child.

INFORMATION ABOUT THE CHILDREN WHO LIVE WITH YOU

18. DO YOU HAVE ANY DEPENDENT CHILDREN? ☐ YES ☐ NO *(If "No," skip to Part IV)*

19A. NAME OF CHILD *(First, Middle, Last)*	19B. DATE OF BIRTH *(Mo., Day, Yr.)*	19C. PLACE OF BIRTH *(City, State, or Country)*	19D. SOCIAL SECURITY NUMBER	19E. CHECK EACH APPLICABLE CATEGORY					
				BIOLOGICAL	ADOPTED	STEPCHILD	18-23 YRS. OLD AND ATTENDING SCHOOL	SERIOUSLY DISABLED	CHILD PREVIOUSLY MARRIED
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

INFORMATION ABOUT THE CHILDREN WHO *DO NOT* LIVE WITH YOU

20A. NAME OF CHILD *(First, Middle, Last)*	20B. CHILD'S COMPLETE ADDRESS	20C. NAME OF PERSON CHILD LIVES WITH *(If applicable)*	20D. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
			$ .00
			$ .00
			$ .00
			$ .00

PART IV - INFORMATION ABOUT YOUR DISABILITY(IES) AND BACKGROUND

NOTE: If you are a veteran who is claiming pension and you are age 65 or older, or determined disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application unless you are claiming special monthly pension.

21A. WHAT DISABILITY(IES) PREVENT YOU FROM WORKING?	21B. WHEN DID THE DISABILITY(IES) BEGIN? *(Month, Day, Year)*

22A. 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 completed and signed by a Physician, Physician Assistant (PA),Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS.)*

22B. ARE YOU NOW OR HAVE YOU RECENTLY BEEN HOSPITALIZED OR GIVEN OUTPATIENT OR HOME CARE? (Due to the disability(ies) listed in Item 21A)

☐ YES ☐ NO *(If "Yes," complete Items 23A & 23B)*

23A. DATE(S) OF RECENT HOSPITALIZATION OR CARE	23B. NAME AND MAILING ADDRESS OF FACILITY OR DOCTOR

24A. ARE YOU NOW EMPLOYED?
☐ YES ☐ NO *(If "No," complete Item 24B)*

24B. WHEN DID YOU LAST WORK? *(Month, Day, Year)*

24C. WERE YOU SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED?
☐ YES ☐ NO *(If "Yes," complete Items 24D and 24E)*

24D. WHAT KIND OF WORK DID YOU DO?

24E. ARE YOU STILL SELF-EMPLOYED?
☐ YES ☐ NO *(If "Yes," complete Item 24F)*

24F. WHAT KIND OF WORK DO YOU DO NOW?

PART IV - INFORMATION ABOUT YOUR DISABILITY(IES) AND BACKGROUND (Continued)

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

25A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	25B. WHAT WAS YOUR JOB TITLE?	25C. WHEN DID YOUR WORK BEGIN? *(Mo., day, year)*	25D. WHEN DID YOUR WORK END? *(Mo., day, year)*	25E. HOW MANY DAYS WERE MISSED DUE TO DISABILITY?	25F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00

26A. CHECK THE HIGHEST YEAR OF EDUCATION YOU COMPLETED:

Grade school:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

College:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Over 4

26B. LIST THE OTHER TRAINING OR EXPERIENCE YOU HAVE AND ANY CERTIFICATES THAT YOU HOLD:

PART V - NURSING HOME INFORMATION

NOTE: If you are a patient in a nursing home, please 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.

27A. ARE YOU NOW IN A NURSING HOME?

☐ YES ☐ NO *(If "Yes," complete Item 27B)*

27B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?

27C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS, OR HAVE YOU APPLIED AND NOT RECEIVED A DECISION?

☐ YES ☐ NO ☐ APPLIED - HAVE NOT RECEIVED DECISION

27D. ARE YOU RECEIVING SOCIAL SECURITY DISABILITY (SSD) OR SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) OR HAVE YOU APPLIED FOR SSD OR SSI BUT NO DECISION HAS BEEN MADE?

☐ YES ☐ NO ☐ APPLIED - HAVE NOT RECEIVED DECISION

PART VI - INCOME AND ASSETS

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

☐ YES ☐ NO *(If "Yes," complete Items 28A and 28B)*

(If "No," skip to Item 29)

A. SOCIAL SECURITY RECIPIENT	B. GROSS MONTHLY AMOUNT
	$ .00
	$ .00
	$ .00
	$ .00
	$ .00

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

☐ YES ☐ NO (If "No," skip to Item 31A after reading the Important Information below) (If "Yes," complete Items 30A and 30B)

30A. IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS ON, OVER 2 ACRES (87,120 SQ FT)?

☐ YES ☐ NO (If yes, complete 30B and 30C, if no, skip to 31)

30B. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES?

$ .00 Do not include the value of the residence or the first 2 acres)

30C. IS THE LAND OVER 2 ACRES (87,120 SQ FT) LISTED IN 30B MARKETABLE? ☐ 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.

31A. ***OTHER THAN SOCIAL SECURITY***, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME? ☐ YES ☐ NO

31B. ***OTHER THAN SOCIAL SECURITY***, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR? ☐ YES ☐ NO

31C. 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

31D. 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

31E. DID YOU ANSWER "YES" TO **ANY** OF THE ITEMS IN 31A - 31D?

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

PART VII - INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

NOTE: 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 were reimbursed. If more space is needed, attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: If you are claiming expenses for in-home care or an assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on Pages 10 and 11.

32A. AMOUNT YOU PAID	32B. DATE PAID *(Month, year)*	32C. HOURLY RATE/HOURS *(In-home attendant only)*	32D. PURPOSE *(Doctor's fees, hospital charges, attorney fees, etc.)*	32E. PAID TO *(Name of doctor, hospital, pharmacy, etc.)*	32F. PERSON FOR WHOM EXPENSE PAID *(Self, spouse, child)*
$ .00					
$ .00					
$ .00					

PART VII - INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES (Continued)

32A. AMOUNT YOU PAID	32B. DATE PAID *(Month, year)*	32C. HOURLY RATE/HOURS *(In-home attendant only)*	32D. PURPOSE *(Doctor's fees, hospital charges, attorney fees, etc.)*	32E. PAID TO *(Name of doctor, hospital, pharmacy, etc.)*	32F. PERSON FOR WHOM EXPENSE PAID *(Self, spouse, child)*
$ .00					
$ .00					
$ .00					
$ .00					
$ .00					
$ .00					
$ .00					

PART VIII - DIRECT DEPOSIT INFORMATION

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph below and answer Items 33-35.

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. 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.

33. ACCOUNT NUMBER (PLEASE CHECK THE APPROPRIATE BOX AND PROVIDE THE ACCOUNT NUMBER, IF APPLICABLE)

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

ACCOUNT NUMBER

34. NAME OF FINANCIAL INSTITUTION

35. ROUTING OR TRANSIT NUMBER

PART IX - REMARKS

36. REMARKS - USE THIS SPACE FOR ANY ADDITIONAL STATEMENTS THAT YOU WOULD LIKE TO MAKE CONCERNING YOUR APPLICATION

PART IX - REMARKS (Continued)

36. REMARKS - USE THIS SPACE FOR ANY ADDITIONAL STATEMENTS THAT YOU WOULD LIKE TO MAKE CONCERNING YOUR APPLICATION

PART X - CERTIFICATION AND SIGNATURE

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

37A. PRINTED NAME OF CLAIMANT

37B. SIGNATURE OF CLAIMANT

37C. DATE SIGNED (MM-DD-YYYY)

– –

If signature of claimant made by "X" mark, you must have 2 people you know witness as you sign. They must then sign the form and print their names and addresses.

38A. SIGNATURE OF WITNESS

38B. PRINTED NAME AND ADDRESS OF WITNESS

Name:

Address:

39A. SIGNATURE OF WIITNESS

39B. PRINTED NAME AND ADDRESS OF WITNESS

Name:

Address:

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

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," claim all payments to the facility qualify as medical expenses in Items 32A - 32F. 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 22A 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 32A - 32F. 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 32A - 32F 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)

(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 32A - 32F applicable amounts you pay the facility for (1) health care services and 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 32A - 32F. 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 32A - 32F)

(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 32A - 32F. 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)

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 22A 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 32A - 32F 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 32A - 32F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 32A - 32F amounts you pay an in-home attendant for (1) health care services or assistance, (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 32A - 32F applicable amounts you pay an in-house 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 32A - 32F. 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 32A - 32F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 32A - 32F. 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 ☐ HANDLING MEDICATION

☐ HANDLING FINANCES ☐ 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, Signature and Title of Certifying Official) (Date Certified)