HAYWOOD COUNTY VETERANS SERVICE OFFICE
221 MORGAN STREET
BROWNSVILLE, TN 38012

731-772-1440 or FAX 731-772-4931

TIPTON COUNTY VETERANS SERVICE OFFICE
1286 MUNFORD AVE
MUNFORD TN 38058

901-476-2456 or FAX 901-837-9141

HAYWOODTNCSO@YAHOO.COM

WIDOW'S PENSION WITH NEED OF A&A. WITH AN IN HOME SITTER

Please bring **ALL ITEMS THAT PERTAIN TO YOUR CLAIM** with you on your appointment date
(CALL FOR APPOINTMENT)
(NOTE: All correspondence via phone or in person ***MUST*** include the ***VETERANS SSN***)

__X__1. DD Form 214 or Military Separation/Discharge papers

__X__2. Veterans Social Security number _____

__X__3. copy of Veterans Death Certificate

___X__4. Itemized statement from funeral home **if possible**

__X__5. Spouse and birthdates _____and Social Security numbers _____

__X_6. copy of marriage certificate **if possible**

__X__7. All income information (Social Security, SSI, wages, retirement, interest, dividends, rent, ECT) for Widow **(SEE BACK OF SHEET)**

__X__8. All net worth information (cash in banks, CD's, stocks, bonds, ect & value of real and business property in excess of home) for Widow **(SEE BACK OF SHEET)**

__X__9. Social Security award letter for Widow **(IF POSSIBLE)**

_____10. VA FORM 21-0779 NURSING HOME INFORMATION

__X__11. Itemized list of Medical Expenses: Medicare Premiums, Health Insurance, ect., including amount paid by you (do not include that paid by Medicare, Insurance, Medicaid/Tenncare or someone else) also , **(SEE BACK OF SHEET)**

__X__12. VA Form 21-2680 Examination for Housebound Status or Permanent Need for Regular Aid and Attendance **(DOCTOR FILLS THIS FORM OUT)**

__X_13. Attendant Affadivit for Home Health Care

Address and phone number

_____

_____

PLEASE FILL IN THE BLOCKS ON THIS PAGE

MONTHLY INCOME:(GROSS)	SPOUSE		MONTHLY EXPENSES:	
Social Security			Medicare Part B $104.90 ea	
Wages and Bonuses			Medicare Part D	
Pensions/Retirement			Insurance (medical, dental, vision)	
Civil Service			Prescriptions	N/A
Railroad			Medical/Dental Bills	N/A
Military Retirement			Eye Dr. Bills	N/A
Interest Income				
Dividends Income				
Miscellaneous Income (unemployment, etc.)			**Utilities:**	
Income Subtotal			Electric	N/A
			Gas	N/A
NET WORTH:	**SPOUSE**		Water	N/A
Cash in Checking Accounts			Sewer/Garbage	N/A
Savings Accounts			Telephone	N/A
Savings Bonds			Cable/Satellite	N/A
Stocks				N/A
Certificates of Deposit			**Other Living Exp:**	N/A
Annuities			Mortgage/Rent Payment	N/A
IRA'S, Keogh Plans, ect			Homeowners/Renters Ins	N/A
Mutual Funds			Food	N/A
Automobiles (resale value)	N/A		Clothing	N/A
Boats, Trailers, Campers (resale value)	N/A		Vehicle Payments	N/A
Value of Business Assets	N/A		Vehicle Insurance	N/A
Other Assets	N/A		Vehicle Fuel	N/A
Real estate (not primary home), rental property, vacation home, farm, etc.			Travel for Medical Purposes (.285 per mile)	N/A
			Property Taxes	N/A
Net Worth Subtotal			Personal Loans	N/A
TOTAL ASSETS			Credit Cards	N/A
			Misc.	N/A

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

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 ACTUAL: LBS. ESTIMATED: LBS.	13. HEIGHT 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)* ☐ YES ☐ NO	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE

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.

ATTENDANT AFFIDAVIT

Re: _____
Veteran's Name – Last, First, Middle

_____
VA Claim or Social Security Number

_____
Claimant's Name

_____
Claimant's Address (Street)

_____
City, State and Zip Code

My name is _____, and I provide health care for the above named claimant.

The services which I provide are:

☐	Yes	☐	No	Assistance with bathing
☐	Yes	☐	No	Standing and sitting
☐	Yes	☐	No	Getting in and out of bed
☐	Yes	☐	No	Eating
☐	Yes	☐	No	Walking
☐	Yes	☐	No	Dressing and undressing
☐	Yes	☐	No	Taking medication
☐	Other: (Please describe)			

_____
_____
_____

For these services, I am paid by the claimant _____ per day / week / month / year (please circle only one).

I began employment on _____.

_____
Signature of provider

_____
Street Address

_____
City, State, and Zip Code

_____
Phone number (including area code)

I CERTIFY, under the penalty of law, that the above information is true and correct, that I do pay the above referenced sitter the amount listed for the services listed. (If claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____