

INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

VA may be able to pay you a higher benefit rate if you identify expenses VA can deduct from your income. Your benefit rate is based on your income. Your out-of-pocket payments for medical and dental expenses may be deductible.

Report any medical or dental expenses that you paid for yourself or for a relative who is a member of your household (spouse, grandchild, parent, etc.) for which you were not reimbursed and do not expect to be reimbursed. Below are examples of expenses you should include, if applicable:

- Hospital expenses
- Doctor's office fees
- · Dental fees
- Prescription/non-prescription drug costs
- · Vision care costs
- Medical insurance premiums

- Nursing home costs
- · Hearing aid costs
- Home health service expenses
- Expenses related to transportation to a hospital, doctor, or other medical facility
- Monthly Medicare deduction

IMPORTANT NOTES

- Do not include any expenses for which you were or will be reimbursed. If you receive reimbursement after you have filed this claim, promptly notify the VA office handling your claim.
- If you are a veteran, VA can deduct allowable expenses paid by either you or your spouse.
- If you are not sure whether VA can deduct a payment for a particular expense, furnish a complete description of the purpose of the payment. We will let you know if we cannot deduct an expense.
- If you are claiming expenses for an in-home care provider or for assisted living or similar care, you *must* complete the appropriate worksheet to determine whether VA may deduct all or some of your payments to the provider or facility.
- VA may require you to verify the amounts you paid, so keep all receipts or other documentation of payments for at least 3 years after we make a decision on your medical expense claim. If you are unable to provide documentation of your claimed medical expenses when VA asks you to do so, your benefits may be retroactively reduced or discontinued.
- If you need more space to report expenses, attach a separate sheet of paper with columns corresponding to those on this form. Be sure to write your VA file number on any attachments.

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

RESPONDENT BURDEN: We need this information to determine whether medical expenses you paid may be used to reduce the amount of income we count in determining eligibility to benefits (38 U.S.C. 1503). Title 38, United States Code, 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.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. 2900-0161 Respondent Burden: 30 minutes Expiration Date: XX/XX/XXXX

Department of Veter	rans Affa	airs			F	OR VA USE ONLY
MEI	DICAL	EXPENSE RE	PORT			
1. FIRST NAME OF VETERAN	2. MID	DLE NAME OF VETERAN	3. LAST NAME OF VETERAN		4. SUFFIX NAME OF VETERAN	
5. VETERAN'S SOCIAL SECURITY NO.					6. VA FILE	NUMBER
7. FIRST NAME OF CLAIMANT	8. MID	DLE NAME OF CLAIMANT	9. LAST NAME OF CLAIMANT 10. SUFFIX NAME OF C			X NAME OF CLAIMANT
11. STREET ADDRESS OF CLAIMANT					12. APT. N	NO.
13. CITY			14. STATE 15. ZIP CODE		DDE	
16. DAYTIME TELEPHONE NO. OF CLAI	MANT (Include	Area Code)	17. EVENING TELEPHONE NO.	OF CLAIMAN	NT (Include	Area Code)
18. CHANGE OF ADDRESS (Check box if a Items 11-15 is different from last address fu	address in urnished to VA)	19. E-MAIL ADDRES	S OF CLAIMANT (If applicable)			
20. MII FA	GF FOR P	RIVATELY OWNED	VEHICLE TRAVEL FOR MEI	DICAL PU	RPOSES	 S
Report miles traveled to a hospital, docto between the dates and expenses. If you do not have a letter, plea allowable deduction for your mileage bas Administration (GSA).	or, or other me	dical facility in a privately If no dates appear of imbursed medical expense	owned vehicle (POV) such as a car, on this line, refer to the accompanyings on a calendar year basis (ex. 01/01)	truck, or mo g letter for th /XXXX thru	torcycle. It ne dates yo 1 12/31/XX	temize travel occurring u should report medical (XX). We will calculate the
NOTE: You may also claim deductions these types of medical travel expenses in	for other paym Item 22.	nents related to travel for m	nedical purposes, such as taxi fares, b	ouses, or othe	er forms of	public transportation. Report
A. MEDICAL FACILITY TO WHI TRAVELED	ICH E	3. TOTAL ROUNDTRIP MILES TRAVELED	C. AMOUNT REIMBURSED FROM ANOTHER SOURCE (Such as a VA Medical Center)	D. D. TRAV (Month/D	ELED	E. WHO NEEDED TO TRAVEL? (Self, spouse, child)
IMPORTANT: Be sure to s	ign and d	ate this form in Ite	ms 23A & 23B on page 4	. Unsigr	ed repo	orts will be returned.

	21. IN-HOME ATT	ENDANT EXPEN	ISES	
IMPORTANT - You must complete the attached In-Hor Report amounts paid between the dates should report medical expenses. If you do not have a letter	and	. If no dates app	pear on this line refer to the accon	npanying letter for the dates you /01/XXXX thru 12/31/XXXX).
A. NAME OF PROVIDER	B. HOURLY RATE/ NUMBER OF HOURS	C. AMOUNT PA	AID D. DATE PAID (Month/Day/Year)	E. FOR WHOM PAID (Self, spouse, child, etc.)
			(Month Day, Tear)	(Seif, spouse, emia, etc.)
	22. ITEMIZATION O	F MEDICAL EXP	PENSES	
IMPORTANT - If you are claiming expenses for care in Report medical expenses that you paid between the dat letter for the dates you should report medical expenses. I (ex. 01/01/XXXX thru 12/31/XXXX).	n an assisted living, adult tes	day care, or a similar t	facility, you must complete the ap If no dates appear on this	s line refer to the accompanying
A. MEDICAL EXPENSE (Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)	B. AMOUNT PAID	C. DATE PAID (Month/Day/Year)	D. NAME OF PROVIDER (Name of doctor, dentist, hospital, lab, etc.)	E. FOR WHOM PAID (Self, spouse, child, etc.)
MEDICARE (PART B)				
MEDICARE (PART D)				
PRIVATE MEDICAL INSURANCE				

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22. ITEMIZATION OF MEDICAL EXPENSES (Continued)					
IMPORTANT - If you are claiming expenses for care in an assisted living, adult day care, or a similar facility, you must complete the appropriate worksheet (page 6). Report medical expenses that you paid between the dates and If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis					
(ex. 01/01/XXXX thru 12/31/XXXX). A. MEDICAL EXPENSE (Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)	B. AMOUNT PAID	C. DATE PAID (Month/Day/Year)		IAME OF PROVIDER ame of doctor, dentist, hospital, lab, etc.)	E. FOR WHOM PAID (Self, spouse, child, etc.)
MEDICARE (PART B)					
MEDICARE (PART D)					
PRIVATE MEDICAL INSURANCE					
CERTIFICATION: I have not and will not r	eceive reimburseme	nt for these expens	ses. I c	ertify that the above in	formation is true.
23A. SIGNATURE OF CLAIMANT (Do NOT print)				23B. DATE	

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 is false, or fraudulent acceptance of any payment to which you are not entitled.

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 -		
IMPORTANT : The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally <i>does not</i> 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? YES NO (If "NO," skip to Step 6)		
STEP 2. Has VA determined that you are eligible for special monthly pension? (Special monthly pension means pension at the aid and attendance or housebound rate <i>or</i> Parents' DIC at the aid and attendance level) YES NO		
(If "NO," skip to Step 4)		
STEP 3. Is the <i>primary responsibility</i> of the in-home attendant to provide you with health care services or custodial care? (If "YES," payments to this in-home attendant qualify as medical expenses (even if the attendant also assists you with IADLs). You may claim these expenses in Item 21. Skip to Step 8) (If "NO," payments to this in-home attendant for assistance with IADLs <i>do not</i> qualify as medical expenses. Payments for health care		
services and custodial care qualify as medical expenses. You may claim these expenses in Item 21. Skip to Step 8)		
STEP 4. Are you claiming special monthly pension? (If "YES," please complete and attach with this application VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every item on this form is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS)) (If "NO," the attendant must be a health care provider and payments for assistance with IADLs do not qualify as medical expenses. Payments for health care services or assistance with ADLs qualify as medical expenses. You may claim these expenses in Item 21. Skip to Step 8)		
STEP 5. Is the <i>primary responsibility</i> of the in-home attendant to provide you with health care or custodial care? (If "YES," payments to this in-home attendant may qualify as medical expenses <i>if</i> VA rates you as eligible for special monthly pension. Please report separately in Item 21 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 8) (If "NO," payments to this in-home attendant for assistance with IADLs <i>do not</i> qualify as medical expenses. Please report separately in Item 21 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 8)		
STEP 6. 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? (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 attendant provides him or her because of mental or physical disability, and (2) describes the mental or physical disability. The in-home attendant <i>does not</i> need to be a health care provider) (If "NO," the attendant <i>must be a health care provider</i> and payments for assistance with IADLs <i>do not</i> qualify as medical expenses. Payments to the in-home attendant for health care services or assistance with ADLs provided by a health care provider qualify as medical expenses. You may claim these expenses in Item 21. Skip to Step 8)		
STEP 7. Is the primary responsibility of the in-home attendant to provide the disabled person with health care and/or custodial care? YES NO (If "YES," payments to the in-home attendant qualify as medical expenses (even if the attendant also assists the disabled person with IADLs. You may claim these expenses in Item 21) (If "NO," payments to the in-home attendant for assistance with IADLs do not qualify as medical expenses. Payments to the in-home attendant for health care or custodial care qualify as medical expenses. You may report these expenses in Item 21)		
STEP 8. Check all activities below that the attendant assists the disabled person with:		
ADLs: EATING BATHING/SHOWERING DRESSING TRANSFERRING USING THE TOILET SHOPPING FOOD PREPARATION HOUSEKEEPING LAUNDERING MANAGING FINANCES HANDLING MEDICATIONS TRANSPORTANTION FOR NON MEDICAL PURPOSES.		
IADLs: USING THE TELEPHONE TRANSPORTANTION FOR NON-MEDICAL PURPOSES STEP 9. In-Home Attendant Certification: Please submit a current breakdown of the time the attendant spends assisting the 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 and his or her care from (Name of Person Requiring Care)		
(Name of Attendant)		
(Name, Signature and Title of Certifying Official) (Date Certified)		

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) (If "YES," all payments to the facility qualify as medical expenses. You may claim these expenses in Item 22. 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 <i>do not</i> qualify as medical expenses. You are finished completing this worksheet)		
STEP 3. Are you (the claimant) the disabled person? Are you a veteran, surviving spouse, or Parents' DIC claimant?		
YES NO (If "NO," to either of these questions, skip to Step 8)		
STEP 4. Has VA determined that you are eligible for special monthly pension? (Special monthly pension means pension at the aid and attendance or housebound rate or Parents' DIC at the aid and attendance level)		
YES NO (If "NO," skip to Step 6)		
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 <i>primary reason</i> you live in the facility (or attend day care in the facility)?		
(If "YES," all payments to this facility qualify as medical expenses. You may claim these expenses in Item 22. Skip to Step 10) YES NO (If "NO," payments to this facility for meals and lodging <i>do not</i> qualify as medical expenses. Only claim amounts you pay the facility for health care services or custodial care)		
STEP 6. Are you claiming special monthly pension?		
(If "YES," please complete and attach with this application VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every item is complete and the form is signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS))		
(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 Item 22. Skip to Step 10)		
STEP 7. 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)? (If "YES," all payments to this facility may qualify as medical expenses if VA rates you as eligible for special monthly pension or Parents'		
YES NO DIC. Please report separately in Item 22 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 10)		
(If "NO," payments to this facility for meals and lodging do not qualify as medical expenses. Please report separately in Item 22 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 10)		
STEP 8. 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?		
(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		
L YES NO physical disability) (If "NO," claim only amounts you pay the facility for <i>health care services or assistance with ADLs provided by a health care provider</i> in Item 22. Skip to Step 10)		
STEP 9. 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 <i>primary reason</i> the disabled person lives in the facility or attends day care in the facility?		
YES NO (If "YES," claim <i>all</i> payments to this facility (to include meals and lodging) as medical expenses in Item 22) (If "NO," payments to this facility for meals and lodging <i>do not</i> qualify as medical expenses. <i>Only</i> claim amounts you pay the facility for <i>health care services or custodial care</i> in Item 22)		
STEP 10. 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 and his or her care at this		
(Name of person staying at your facility) facility		
(Name and address of facility)		
(Name Signature and Title of Person Certifying for the Facility) (Date Certified)		