# Department of Veterans Affairs

# INSTRUCTIONS FOR COMPLETING APPLICATION FOR HEALTH BENEFITS

### Step 1: Before You Start...

#### What is VA Form 10-10EZ used for?

- To apply for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits.
- To update your personal, insurance, or financial information.

#### Where can I get help filling out the form?

- Contact a National or State Veterans Service Organization.
- Ask VA to help you fill out the form by calling or visiting a VA health care facility. Before you call or go to the VA health care facility, gather the necessary materials identified in Step 2 of the instructions and complete as much of the form as you can.

#### How can I contact VA if I have questions?

- Look in your telephone book blue pages under "United States Government, Veterans" to locate your local VA health care facility.
- Call VA's Health Benefits Service Center toll-free at 1-877-222-VETS (8387).
- Access our website at http://www.va.gov and select "Contact the VA."
- If you desire a health care appointment, contact the Enrollment Coordinator at your local VA health care facility for assistance in scheduling an appointment.

#### Definitions of terms used on this form

- SERVICE-CONNECTED (SC): A veteran with a VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A determination by VA that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A determination by VA that a service-connected disability is not severe enough to warrant monetary compensation.
- NONSERVICE-CONNECTED (NSC): A veteran who does not have a VA determined service-related condition.

#### Which sections of VA Form 10-10EZ should you complete?

If you are applying for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits, look at the table below to find out which sections of VA Form 10-10EZ you should complete. The shaded sections should be completed only if you answer "Yes" to Section VI agreeing to provide income and asset information to establish eligibility for care. You may agree to copayments without providing this detailed financial information.

If you are	Complete the sections marked with an X							
	I-IV	VI	VII	VIII	IX	Х	XII	
Service-connected 50% to 100%.	Х						Х	
Service-connected 30-40%.  Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications for treatment of your nonservice-connected conditions assessed.	х	х	х	х	х		х	
Service-connected 0% (compensable) or service-connected 10-20%.  Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel for treatment of your nonservice-connected conditions assessed.	х	х	х	х	х		х	
A Former POW.  Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for beneficiary travel assessed. Also, complete Section X if applying for long-term care.	х	x	х	х	х		х	
A veteran discharged from the military due to a disability incurred or aggravated in service, Purple Heart Medal recipient or WWI veteran.  Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel assessed. Also, complete Section X if applying for long-term care.	х	x	х	х	х		х	
Receiving nonservice-connected VA Pension, Aid and Attendance or Housebound benefits. Answer YES in Section VI and complete Sections VII-X to have your financial eligibility for long-term care assessed. Unmarried VA Pensioners are excluded from this requirement.	х	x	х	х	х	х	х	
Service-connected 0% (noncompensable), nonservice-connected with no special eligibilities listed above or veterans with combat service discharged within the last two years. Answer YES in Section VI and complete Sections VII-X to have your priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of your nonservice-connected conditions assessed.	x	x	х	x	x	х	х	

Complete only the sections that apply to you and sign and date the form.

- **Step 2: Completing your application** ... Review the table in Step 1 to find out what sections you should complete.
  - Answer all questions in those sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. For each question that you need more room, write "Continuation of Item" and write the section and question number.
- **Section II Insurance Information.** Include information for all health insurance policies that cover you. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.
- **Section IV Military Service Information.** If you are not currently receiving benefits from VA, you should attach a copy of your discharge or separation papers from the military (such as DD 214 or, for WWII veterans, a "WD" Form), with your signed application to expedite processing of your application.
  - If you indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your status as a Purple Heart Medal recipient, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating you were awarded the medal. To reduce processing time, you may submit a copy of this documentation with your signed application.
- **Section VI Financial Disclosure.** The financial assessment is used to determine whether certain veterans qualify for cost-free health care services for their nonservice-connected conditions and to assign their priority for enrollment. You should review the table in Step 1 to see if your eligibility for health care benefits requires or may be based on a financial assessment.
  - If your financial information is used to determine your priority for enrollment and you choose not to disclose this information, you must agree to make copayments. However, please be aware that even if you agree to pay copayments, you may not be eligible for enrollment and other health care benefits for your nonservice-connected conditions, if you are placed in a priority group that is not eligible for enrollment.
  - If a financial assessment is not used to determine your priority for enrollment, you may choose not to disclose your information and agree to make copayments for treatment of your nonservice-connected conditions. If a financial assessment is used to determine your eligibility for travel assistance, and you do not disclose your financial information, you will not be eligible for this benefit for your nonservice-connected conditions.
- **Section VII Dependent Information.** Use a separate sheet of paper for additional dependent children.
- You may count your spouse as your dependent even if you did not live together, as long as you contributed \$600 or more in support last calendar year.
- You may count your biological children, adopted children, and stepchildren as dependents. But these children must be unmarried and under the age of 18, or be at least 18 but under 23 and attending high school, college or vocational school on a full or part-time basis, or have become permanently unable to support themselves before reaching the age of 18.
- Count child support contributions even if not paid in regular set amounts. Contributions can include tuition payments or payments of medical bills.
- Section VIII Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.
  - Use a separate sheet of paper for additional dependent children.
- Report: gross annual income from employment, except for income from your farm, ranch, property or business, including information about your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses
- Report: net income from your farm, ranch, property or business.
- Report: other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities
- Do Not Report: Welfare, Supplemental Security Income (SSI) and need-based payments from a government agency, profit from the
  occasional sale of property, income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs), scholarships and grants
  for school attendance, disaster relief payment or proceeds of casualty insurance, loans, Agent Orange and Alaska Native Claim
  Settlement Acts Income and payments to foster parents.
- Section IX Previous Calendar Year Deductible Expenses. Report nonreimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources.
- **Section X Previous Calendar Year Net Worth.** Use a separate sheet of paper for additional dependent children.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

## Step 3: Submitting your application ...

#### What do I do when I have finished my application?

- Read Section V, Paperwork and Privacy Act Information, Section XI Consent to Copayments and Section XII, Assignment of Benefits.
- Make sure you sign and date VA Form 10-10EZ in Section XII. You or an individual to whom you have delegated your Power of
  Attorney must sign and date the form. If you sign with an "X", then you must have 2 people you know witness you as you sign. They
  must then sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to
  complete. This will result in a delay in processing your application.
- Attach any continuation sheets and necessary material to your application.
- Where do I send my application? Mail the original application with a copy of your supporting materials to your local VA care facility. You can find the address in your local telephone book, by calling toll-free 1-877-222-VETS (8387), or on the Internet at http://www.va.gov.

OMB Approved No. 2900-0091 Estimated Burden Avg. 45 min. Expiration Date: 6/30/2007

Department of Vete	erans Affairs	APPLICAT	ION FO	R HEALT	H BENEFITS	
		ION I - GENERAL INFORMA	TION			
Federal law provides criminal pe or making a materially false state	nalties, including a ement. (See 18 U.S.	a fine and/or imprisonm C. 1001)	ent for up to	5 years, for c	oncealing a material fact	
1. VETERAN'S NAME (Last, First, Middle Name)		2. OTHER NAMES USED	3. MOTH	ER'S MAIDEN NAME	4. GENDER  MALE FEMALE	
5. ARE YOU SPANISH, HISPANIC, OR LATINO?  YES NO	_	Y (You may check more than one.) (In	BLACK OF	red for statistical pur R AFRICAN AMERICA AWAIIAN OR OTHER	N	
7. SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER  9. DATE OF BIRTH (mm/dd/yyyy)					
8. CLAIM NUMBER	9A. PLACE OF BIRTH (City	ty and State)				
11. PERMANENT ADDRESS (Street)		11A. CITY		11B. STATE	11C. ZIP CODE (9 digits)	
11D. COUNTY	D. COUNTY 11E. HOME TELEPHONE NUMBER (Include area code) 11F. E-MAIL ADDRESS					
11G. CELLULAR TELEPHONE NUMBER (Include ar	ea code)	11H. PAGER NUMB	ER (Include area o	code)		
12. TYPE OF BENEFIT(S) APPLIED FOR (You may of	check more than one)	HEALTH SERVICES	NURSING HOME	DOMICILIA	RY DENTAL	
13. IF APPLYING FOR HEALTH SERVICES OR ENRO	OLLMENT, WHICH VA MEDIC	CAL CENTER OR OUTPATIENT CLIN	IIC DO YOU PREFE	ER?		
14. DO YOU WANT AN APPOINTMENT WITH A VA D AVAILABLE?					ALTH CARE FACILITY?	
	rolling in case I need care	e in the future.	YES, LOCA	TION:	□ NO	
16. CURRENT MARITAL STATUS (Check one)	MARRIED	NEVER MARRIED SEP.	ARATED	WIDOWED	DIVORCED UNKNOWN	
17. NAME, ADDRESS AND RELATIONSHIP OF NEXT	Γ OF KIN		17A. NEXT OF	KIN'S HOME TELEP	HONE NUMBER (Include area code)	
			17B. NEXT OF	F KIN'S WORK TELEP	HONE NUMBER (Include area code)	
18. NAME, ADDRESS AND RELATIONSHIP OF EMEI	RGENCY CONTACT			ENCY CONTACT'S HO area code)	OME TELEPHONE NUMBER	
				ENCY CONTACT'S We area code)	ORK TELEPHONE NUMBER	
19. INDIVIDUAL TO RECEIVE POSSESSION OF YOU THIS DOES NOT CONSTITUTE A WILL OR TRAN				UR DEPARTURE OR	AT THE TIME OF DEATH. NOTE:	

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APPLICATION FOR HEALTH BENEFITS, Cont					TERAN'S NAME (Last, First, I	Middle)	SOCIAL SEC	JRITY NUI	MBER		
SECT	ION II - INSURANO	CE INFORM	IATION	(Use a	separate sheet for add	ditional information)					
			2. HEALT	TH INSUR	ANCE COMPANY NAME, ADD	RESS AND TELEPHONE NU	IMBER				
3. NAME OF POLICY HOLDER											
4. POLICY NUMBER	5. GROUP CODE		VEO	NO							
6. ARE YOU ELIGIBLE FOR MEDICAID?			YES	NO	-						
					7A. EFFECTIVE DATE						
7. ARE YOU ENROLLED IN MEDICARE HO	OSPITAL INSURANCE PA	ART A?			(mm/dd/yyyy)						
8. ARE YOU ENROLLED IN MEDICARE HO	OSPITAL INSURANCE PA	ART B?			8A. EFFECTIVE DATE (mm/dd/yyyy)						
9. NAME EXACTLY AS IT APPEARS ON YO	OUR MEDICARE CARD				10. MEDICARE CLAIM NUM	IBER					
11. IS NEED FOR CARE DUE TO ON THE	JOB INJURY? (Check or	ne) NE	s 🔲	NO	12. IS NEED FOR CARE DUE TO ACCIDENT? (Check One)						
		SECTION	III - EMP	PLOYMI	NT INFORMATION						
1. VETERAN'S EMPLOYMENT STATUS (Check one)	IME NOT EMPLO	)VED		1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER							
If employed or retired, complete item 1A PART T	_	Date o	of retirem (dd/yyyy)	ent							
2. SPOUSE'S EMPLOYMENT STATUS (Check one)  If employed or retired, complete item 2A  PART T	of retirem (dd/yyyy)	ent	2A. COMPANY NAME, ADD	RESS AND TELEPHONE NU	MBER						
	SI	ECTION IV	- MILITA	ARY SE	RVICE INFORMATION						
1. LAST BRANCH OF SERVICE	1.4	A. LAST ENTRY	DATE	1B. L/	AST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SE	RVICE NU	JMBER		
2. CHECK YES OR NO	<u>'</u>		YES	NO				YES	NO		
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?					E1. ARE YOU RECEIVING DE VA COMPENSATION?						
B. ARE YOU A FORMER PRISONER OF WAR?					F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?						
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?					G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?						
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE?  9/0					H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?						
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?					I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?						
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?					J. DO YOU HAVE A SPINAL CORD INJURY?						
	SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION										
				<u> </u>	1 . 1	11	1	*.1	. 1		

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**Privacy Act Information:** VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA may be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

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APPLICA	ATION FOR HEALTH	<b>BENEFITS</b> , Continued	ı   ˈ	ETERAN'S N	AME (Last, Fi	rst, Miaale)		SOCIA	AL SECURITY NUMBER		
		SECTION VI -	FINAN	CIAL DIS	CLOSURE						
Failure to disclose your previous year's financial information may affect your eligibility for health care benefits. Your financial information is used by VA to accurately determine if you should be responsible for copayments for office visits, pharmacy, inpatient, nursing home and long term care, and for some veterans, priority for enrollment. You are not required to provide this information. However, completing the financial disclosure section results in a more accurate determination of your eligibility for health care services/benefits.											
NO, I DO NOT WISH TO PROVIDE INFORMATION IN SECTIONS VII THROUGH X. <i>I understand that VA is currently not enrolling veterans who decline to provide financial information unless other special eligibility factors exist.</i> However, if I am enrolled, I agree to pay the applicable VA copayments. Sign and date the application in Section XII.											
YES, I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO ESTABLISH MY ELIGIBILITY FOR CARE. Complete all sections below that apply to you with last calendar year's information. Sign and date the application in Section XII.											
SECTION VII - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)											
	E (Last, First, Middle Name)			2. CHILD'S NAME (Last, First, Middle Name)							
1A. SPOUSE'S MA	IDEN NAME			2A. CHILD'S RELATIONSHIP TO YOU (Check one)  Son Daughter Stepson Stepdaughter							
1B. SPOUSE'S SO	CIAL SECURITY NUMBER			2B. CHILD'S	S SOCIAL SECU	JRITY NUMBE	2C. DATE CHI		CAME YOUR DEPENDENT		
1C. SPOUSE'S DA	TE OF BIRTH (mm/dd/yyyy)	1D. DATE OF MARRIAGE (mm/dd/yy	yy)	2D. CHILD'S DATE OF BIRTH (mm/dd/yyyy)							
1E. SPOUSE'S AD	DRESS AND TELEPHONE NUMBE	R (Street, City, State, ZIP)		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?							
				☐ YES ☐ NO  2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO							
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT.  SPOUSE \$ CHILD \$				2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (e.g., tuition, books, materials)  \$							
SEC	TION VIII - PREVIOUS CA	ALENDAR YEAR GROSS AN (Use a separate st				•	SE AND DEPENI	DENT	CHILDREN		
		(occ a coparate or		VETERA			POUSE		CHILD 1		
GROSS ANNUAL INCOME FROM EMPLOYMENT (wages, bonuses, tips, etc.)     EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS  \$			\$		\$			\$			
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS \$			\$	\$				\$			
3. LIST OTHER INCOME AMOUNTS (eg., Social Security, compensation, pension interest, dividends). EXCLUDING WELFARE. \$				\$				\$			
		ECTION IX - PREVIOUS CA			-			ı			
1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.											
<ol><li>AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YO spouse or child's information in Section VII.)</li></ol>									\$		
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCAT NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.									\$		
SECTION X - PREVIOUS CALENDAR YEAR NET WORTH (Use a separate sheet for additional dependents)						<u> </u>					
CASH, AMOUNT IN BANK ACCOUNTS (e.g., checking and savings accounts, certificates of defindividual retirement accounts, stocks and bonds)			es of depo	osit,	\$		\$ SPOUSE		\$		
	2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. (e.g., second honon-income producing property. Do not count your primary home.)			mes and	es and \$		\$		\$		
<ol> <li>VALUE OF OTHER PROPERTY OR ASSETS (e.g., art, rare coins, collectables) MINUS THE AI YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. Exch household effects and family vehicles.</li> </ol>			THE AM S. <i>Exclud</i>	OUNT de	\$ \$		\$				
SECTION XI - CONSENT TO COPAYMENTS											
If you are a 0% service-connected veteran and do not receive VA monetary benefits or a nonservice-connected veteran (and you are not an Ex-POW, Purple Heart Recipient, WWI veteran or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your nonservice-connected conditions. If you are such a veteran by signing this											
application you are agreeing to pay the applicable VA copayment as required by law.  SECTION XII - ASSIGNMENT OF BENEFITS											
I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.											
ALL A	PPLICANTS MUST SIGN AND	DATE THIS FORM. REFER TO	INSTRU	ICTIONS V	VHICH DEFIN	IE WHO CA	N SIGN ON BEHAL	F OF 1	THE VETERAN.		
SIGNATURE OF A	PPLICANT							DATE	E		

VETERAN'S NAME (Last, First, Middle)

SOCIAL SECURITY NUMBER

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