Veteran Aid and Attendance Pension Claim Dept

_____: Aid & Attendance Pension Benefit

Total Pages ____ (This page included)

Today: ____/____/_____ Fax To: VA Dept (215) 381-3549

From: Scott S. McLean (609)489-5200

Please process the claim for: _____(Veteran / Spouse)

Aid & Attendance Pension Benefit Claim Forms

Necessary Forms and Documents

- ___ 21-2680 Dr Medical Examination Report 2 page(s)
- ___ 21-527ez Veteran (With or without spouse) 6 page(s)
- ___ 21-534ez Spouse Form (Veteran has died)
- ___ Voided Check 1 page(s)
- ___ 21-8416 Medical Expense 2 page(s)
- ___ 21-4142 VA Release Information Form 2 page(s)
- ___ 21-4138 Statement in support of claim 1 page(s)
- ___ 21-0845 3rd Party Authorization 1 page(s)
- ___ 21-22a Representative Authorization 1 page(s)
- ___ Attendant Affidavit For Care Giver 1 page(s)
- ___ Care Giver Agreement 2 page(s)
- ___ FV13 Care Giver Duties (SVSA Form FV13)
- ___ 21-0779 Nursing Home Request *(only if in a facility)* 1 page(s)
- ___ Letter of Explanation 1 page(s)
- ___ Honorable Discharge 1 page(s)
- ___ Notice of Separation DD-214 1 page(s)
- ___ Certificate of Death 1 page(s)
- ___ Birth Certificate(s) (Veteran) 1 page(s)
- ___ Birth Certificate (Veteran Spouse) 1 page(s)
- ___ Marriage or Divorce Certificate 1 page(s)
- ___ Caregiver accounting procedures & expenses diary

Any problems in receiving this fax please call, (609)489-5200

Thank you for your assistance in this matter

2.3 WARTIME OR PEACETIME SERVICE

Military service is classified either as wartime or peacetime service. This distinction is important because there are significant advantages specifically accruing only to veterans with wartime service. For example, only veterans with wartime service are eligible for non-service-connected disability pension benefits.82

The following list sets out the periods of wartime designated by Congress for pension purposes.83 To be considered by the VA to have served during wartime, a veteran need not have served in a combat zone, but simply during one of these designated periods. All other times are considered peacetime. Some veterans served part of their tour of duty during wartime and part during peacetime. Even if a majority of a veteran's service occurred during peacetime, the service member would still meet the wartime service requirement for eligibility for pension benefits if he or she served ninety consecutive days, at least one day of which occurred during a period designated as wartime. All of the listed dates are inclusive.

Indian Wars: January 1, 1817, through December 31, 1898. The veteran must have served thirty days or more, or for the duration of such Indian War. Service must have been with the U.S. forces against Indian tribes or nations.84

Spanish-American War: April 21, 1898, through July 4, 1902, including the Philippine Insurrection and the Boxer Rebellion. Also included are those individuals engaged in the Moro Province hostilities through July 15, 1903.85

Mexican Border War: May 9, 1916, through April 5, 1917. The veteran must have served for one day or more in Mexico, on the borders thereof, or in the waters adjacent thereto.86

World War I: April 6, 1917, through November 11, 1918, extended to April 1, 1920, for those who served in the Soviet Union. Service after November 11, 1918, through July 2, 1921, qualifies for benefits purposes if active duty was performed for any period during the basic World War I period.87

World War II: December 7, 1941, through December 31, 1946, extended to July 25, 1947, where continuous with active duty on or before December 31, 1946.88

Korean Conflict: June 27, 1950, through January 31, 1955.89

Vietnam Era: August 5, 1964, through May 7, 1975.90 However, February 28, 1961, through May 7, 1975, for a veteran who served in the Republic of Vietnam during that period.

Persian Gulf War: August 2, 1990, through a date to be prescribed by Presidential proclamation or law.91

Congress has not enacted legislation that would make the periods covering the 1983-1984 Lebanon crisis or the invasions of Grenada and Panama wartime service.92

Footnotes

82. 38 U.S.C.S. § 1521(j). *See* Chapter 6 of this Manual for a full discussion of the VA needs-based disability pension program and its eligibility criteria.

83. 38 U.S.C.S. § 101(6)-(11); 38 C.F.R. § 3.2 (2005).

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.

Veteran Benefit Advisory Group	Financial Work Sheet	
VET NAME:	**Please fill in as accurate as possible.**	
GROSS INCOME ON ALL LINES	**FILL IN**	**FILL IN**
Monthly Income Items	**Monthly Veteran Income**	**Monthly Spouse Income**
Social Security	$	$
Pension Income **(a)**	$	$
Pension Income **(b)**	$	$
US Civil Service	$	$
Military Retirement	$	$
Disability Income	$	$
Unemployment or Employment	$	$
Stock & Mutual Funds **(Interest & Dividends)**	$	$
Interest & Dividends	$	$
Alimony & Child Support **(Income Only)**	$	$
IRA Distributions **(RMD 70 1/2 taken)**	$	$
Long Term Care Income **(Bring Policy)**	$	$
Other Income:	$	$
Other Income:	$	$
Other Income:	$	$
Total	$	$

Monthly Medical Expenses	Vet Expenses monthly	Spouse Expenses monthly
VET NAME:	**Please fill in as accurate as possible.**	
Medicare Part B **(Look on SSI Statement)**	$	$
Medicare Part C	$	$
Private Insurance **(AARP, Genworth, Mutual of Omaha…)**	$	$
Prescriptions **(Copays Monthly expense added up.)**	$	$
Co-Pays **(Dr's, Hospital, Ambulance, other)**	$	$
Caregiver Services **(Paid for care person)**	$	$
Home Health Aid	$	$
Nursing Home **(Avg monthly payment)**	$	$
Co-Pays **(Dr's, Hospital, Ambulance, other)**	$	$
Other:	$	$
Other:	$	$
Other:	$	$
Other:	$	$
Total MEDICAL Expenses	$	$

List of all assets	VET Assets	Spouse Assets
VET NAME:	**Please fill in as accurate as possible.**	
Total Value of all Real Estate	$	$
Total number of homes	_____	_____
Partnership assets	$	$
Total of all Bonds	$	$
Total of all CD's	$	$
Total of all Stocks and Mutual Funds	$	$
Total of all other financial assets	$	$
Total of all loans/notes you hold	$	$
Total Cash Value in all banks	$	$
Other:	$	$
Other:	$	$
Other:	$	$
Other:	$	$
Total Assets	$	$

OMB Control No. 2900-0747
Respondent Burden: 25 minutes

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

FULLY DEVELOPED CLAIM
(PENSION)

IMPORTANT: Please read the Privacy Act and Respondent Burden on the back before completing the form. This claim must be submitted along with the attached, "Express Claim Certification."

SECTION I: TO BE COMPLETED BY VETERAN

1. VETERAN'S NAME *(Last, first, middle)*	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH

4. SEX	5. HAVE YOU EVER FILED A CLAIM WITH VA?	6. VA FILE NUMBER
☐ MALE ☐ FEMALE	☐ YES ☐ NO *(If "Yes," provide your file number in Item 6)*	

7A. CURRENT ADDRESS	7B. TELEPHONE NUMBERS *(Include Area Code)*
Street address, rural route, or P.O. Box _____ Apt. number	Daytime _____
City _____ State _____ ZIP Code _____ Country	Evening _____
	Cell phone _____

8A. PREFERRED E-MAIL ADDRESS *(If applicable)*	8B. ALTERNATE E-MAIL ADDRESS *(If applicable)*

9. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING AND DATE DISABILITY(IES) BEGAN

A. DISABILITY(IES)	B. DATE BEGAN

10. LIST VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION II: SERVICE INFORMATION

11A. DID YOU SERVE UNDER ANOTHER NAME?	11B. PLEASE LIST OTHER NAME(S) YOU SERVED UNDER
☐ YES *(If "Yes," go to Item 11B)* ☐ NO *(If "No," go to Item 12A)*	

12A. I ENTERED MY MOST RECENT PERIOD OF ACTIVE SERVICE ON	12B. BRANCH OF SERVICE	12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY

12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?	12E. PLACE OF SEPARATION
☐ YES ☐ NO	

13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*?	13B. DATE OF ACTIVATION
☐ YES ☐ NO *(If "Yes," provide date of activation in Item 13B)*	

14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT?	14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? *(Include Area Code)*

15A. DO YOU HAVE ADDITIONAL PERIODS OF ACTIVE SERVICE?	15B. I PREVIOUSLY ENTERED ACTIVE SERVICE ON
☐ YES *(If "Yes," go to Item 15B)* ☐ NO *(If "No," go to Item 16A)*	

16A. DID YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE/RETIRED PAY?	16B. LIST AMOUNT *(If known)*	16C. LIST TYPE *(If known)*
☐ YES ☐ NO *(If "Yes,"complete Items 16B and 16C)*	$	

SECTION III: WORK HISTORY

IN THE TABLE BELOW, TELL US ABOUT ALL OF YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR ONE YEAR BEFORE YOU BECAME DISABLED TO THE PRESENT.

17A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	17B. WHAT WAS YOUR JOB TITLE?	17C. WHEN DID YOUR WORK BEGIN?	17D. WHEN DID YOUR WORK END?	17E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	17F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
					$
					$

SECTION III: INCOME VERIFICATION

18A. MONTHLY INCOME *(GROSS MONTHLY AMOUNTS (If no income was received from a particular source, write "0" or "none." DO NOT LEAVE BLANK)*

SOURCE	VETERAN	SPOUSE
SOCIAL SECURITY	$	$
U.S. CIVIL SERVICE		
U.S. RAILROAD RETIREMENT		
BLACK LUNG BENEFITS		
MILITARY RETIREMENT		
OTHER *(Show source below)*		

18B. ANNUAL INCOME *(If no income was received from a particular source, write "0" or "none." DO NOT LEAVE ANY ITEMS BLANK)*

NOTE: Report last calendar year *(January through December)* income in the left-hand column and current year income in the right-hand column.

SOURCE	VETERAN		SPOUSE	
GROSS WAGES FROM ALL EMPLOYMENT	$		$	
TOTAL INTEREST AND DIVIDENDS				
ALL OTHER *(Show source below)*				
ALL OTHER *(Show source below)*				

18C. NET WORTH *(If no income was received from a particular source, write "0" or "none." DO NOT LEAVE ANY ITEMS BLANK)*

SOURCE	VETERAN	SPOUSE
CASH/NON-INTEREST-BEARING BANK ACCOUNTS	$	$
INTEREST-BEARING BANK ACCOUNTS		
IRA'S, KEOGH PLANS, ETC.		
STOCKS, BONDS, MUTUAL FUNDS, ETC.		
REAL PROPERTY *(Not your home)*		
ALL OTHER PROPERTY		

SECTION V: MEDICAL, LEGAL OR OTHER UNREIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid for yourself 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 paid by you 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 paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. If more space is needed continue on page 6 or attach a separate sheet.

19A. Amount paid by you	19B. Date paid	19C. Purpose *(Doctor's fees, hospital charges, attorney fees, etc.)*	19D. Paid to *(Name of doctor, hospital, pharmacy, etc.)*	19E. Disability or relationship of person for whom expenses paid

SECTION V: MEDICAL, LEGAL OR OTHER UNREIMBURSED EXPENSES *(Continued)*

20A. Amount paid by you	20B. Date paid	20C. Purpose *(Doctor's fees, hospital charges, attorney fees, etc.)*	20D. Paid to *(Name of doctor, hospital, pharmacy, etc.)*	20E. Disability or relationship of person for whom expenses paid

SECTION VI: DIRECT DEPOSIT INFORMATION

Generally, all Federal payments are required to be made by electronic funds transfer (EFT), also called Direct Deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 21, 22 and 23 to enroll in Direct Deposit. If you do not have a bank account, we will give you a waiver from Direct Deposit, just check the box below in Item 21. The Treasury Department is working to make bank accounts available in such situations. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause a hardship if you enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street, Suite B, Muskogee, OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

21. ACCOUNT NUMBER *(Please check the appropriate box and provide the account number, if applicable)*

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

22. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	23. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

SECTION VII: CERTIFICATIONS AND SIGNATURE

I certify and authorize the release of information. I certify 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.

24A. YOUR SIGNATURE *(Do NOT print)*	24B. DATE SIGNED

SECTION VIII: WITNESSES TO SIGNATURE

25A. SIGNATURE OF WITNESS *(If claimant signed above using an "X")*	25B. PRINTED NAME AND ADDRESS OF WITNESS
26A. SIGNATURE OF WITNESS *(If claimant signed above using an "X")*	**26B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: 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 Vocational Rehabilitation 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 obligation to respond 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 25 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.

FULLY DEVELOPED CLAIM CERTIFICATION (PENSION)

Name _____ **Date** _____

Claim Number _____

Social Security Number _____

Your signature on this response will not affect:

- Whether or not you are entitled to VA benefits;
- The amount of benefits to which you may be entitled;
- The assistance VA will provide you in obtaining evidence to support your claim; or
- The date any benefits will begin if your claim is granted.

I have enclosed all the information or evidence that will support my claim to include identifying records from Federal treating facilities, or I have no information or evidence to give VA to support my claim. Please decide my claim as soon as possible.

_____ _____

Claimant/Representative's Signature Date

OMB Control No. 2900-0001
Respondent Burden: 5 minutes

Department of Veterans Affairs

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

RESPONDENT BURDEN: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 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 http://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.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000
(TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. DATE OF BIRTH (MM,DD,YYYY)	3. VETERAN'S VA FILE NUMBER
4. CLAIMANT'S NAME *(If other than veteran)* LAST NAME, FIRST, MIDDLE		5. VETERAN'S SOCIAL SECURITY NUMBER
6. RELATIONSHIP OF CLAIMANT TO VETERAN		7. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF PERTINENT INFORMATION (Please use a separate form for each source)

8A. LIST THE SOURCE OF INFORMATION OR PROVIDER OF MEDICAL TREATMENT FOR YOUR CLAIMED CONDITION(S) *(Include the first and last name, complete address, and telephone number)*	8B. DATE(S) OF TREATMENT: *(Include the time period (month and year) for which the provider in Item 8A treated you for your currently claimed condition(s)*	8C. LIST THE DISABILITY(IES) FOR WHICH YOU FILED YOUR CURRENT CLAIM AND THAT WERE TREATED BY THE PROVIDER IN ITEM 8A
	NOTE - "Treatment" includes office visits, hospitalizations, telephone consultations, etc.	
Source of Information (other than medical treatment provider):		
First Name and Last Name of Medical Treatment Provider:		
Complete Address and Telephone Number of Source of Information or Medical Treatment Provider:		

9. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 10C.

SECTION III - CONSENT TO RELEASE INFORMATION

READ ALL PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 10C.

10A. **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 and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. 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. 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 Federal Statute of law in effect prior to January 1, 1975, and still in effect.

10B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 8A to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the health care provider or health plan identified in Item 8A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 8A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If you do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

10C. I ☐ (AUTHORIZE) ☐ (DO NOT AUTHORIZE) the source shown in Item 8A to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia or psychotherapy notes. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

11A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	11B. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, city, State and ZIP Code. All court appointments must include docket number, county and State)*	11C. DATE

11D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*	11E. TELEPHONE NUMBER *(Include Area Code)*

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

12A. SIGNATURE OF WITNESS	12B. DATE

12C. MAILING ADDRESS OF WITNESS

OMB Control No. 2900-0161
Respondent Burden: 30 minutes

Department of Veterans Affairs

FOR VA USE ONLY

MEDICAL EXPENSE REPORT

1. FIRST NAME OF VETERAN	2. MIDDLE 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. MIDDLE NAME OF CLAIMANT	9. LAST NAME OF CLAIMANT	10. SUFFIX NAME OF CLAIMANT

11. STREET ADDRESS OF CLAIMANT	12. APT. NO.

13. CITY	14. STATE	15. ZIP CODE

10. DAYTIME TELEPHONE NO. OF CLAIMANT *(Include Area Code)*	11. EVENING TELEPHONE NO. OF CLAIMANT *(Include Area Code)*

8. CHANGE OF ADDRESS *(Check box if address in Item 3A is different from last address furnished to VA)* ☐	9. E-MAIL ADDRESS OF CLAIMANT *(If applicable)*

5. ITEMIZATION OF EXPENSES RELATED TO TRANSPORTATION FOR MEDICAL PURPOSES

Report expenses related to transportation to a hospital, doctor, or other medical facility that you paid between the dates _____ and _____. If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates you should report medical expenses.

NOTE: If you claim miles traveled to a medical facility in a personal conveyance (car, motorcycle, other), VA will calculate the allowable expense amount based on the current mileage rate (41.5 cents per mile).

A. MEDICAL FACILITY TO WHICH YOU TRAVELED	B. TOTAL ROUNDTRIP MILES TRAVELED *(Personal conveyance only)*	C. AMOUNT PAID BY YOU *(Taxi, public transportation fares, tolls, parking fees, etc.)*	D. DATE PAID *(Month/Day/Year)*	E. FOR WHOM PAID *(Self, spouse, child)*

IMPORTANT: Be sure to sign this form in Item 7A on the reverse side. Unsigned reports will be returned.

(Continued on Reverse)

6. ITEMIZATION OF MEDICAL EXPENSES

Report medical expenses that you paid between the dates _____ and _____. If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates you should report medical expenses.

A. MEDICAL EXPENSE *(Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)*	B. AMOUNT PAID BY YOU	C. DATE PAID *(Month/Day/Year)*	D. NAME OF PROVIDER *(Name of doctor, dentist, hospital, lab, etc.)*	E. FOR WHOM PAID *(Self, spouse, child)*
MEDICARE (PARTS B AND D)				
PRIVATE MEDICAL INSURANCE				

CERTIFICATION: I have not and will not receive reimbursement for these expenses. I certify that the above information is true.

7A. SIGNATURE OF CLAIMANT *(Do NOT print)*	7B. 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.

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: 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, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. 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. 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 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 under the law. 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 obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO. C/CSS -

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

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

SIGNATURE	DATE SIGNED
ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*
	DAYTIME / EVENING

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.

OMB Approved No. 2900-0736
Respondent Burden: 5 minutes

Department of Veterans Affairs

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs permission to release your personal beneficiary or claim information to a third party.

1. FIRST, MIDDLE, LAST NAME OF VETERAN *(Print clearly)*	2. FIRST, MIDDLE, LAST NAME OF BENEFICIARY/CLAIMANT WHO IS NOT THE VETERAN *(Print clearly)*

3. ADDRESS OF BENEFICIARY/CLAIMANT *(No. and Street or rural route, City or P.O., State and ZIP Code)*

4. VA FILE NUMBER	5. SOCIAL SECURITY NUMBER

6. CONTACT INFORMATION

A. DAYTIME PHONE NUMBER	B. CELL PHONE NUMBER	C. E - MAIL ADDRESS *(If applicable)*

7. I (beneficiary/claimant) authorize the Department of Veterans Affairs (VA) to contact the person or organization listed below for the purposes of providing the following information pertaining to my VA record. *(Check only one box below to tell VA the specific benefit or claim information you want disclosed.)*

☐ Any Information (Go to Item 9) ☐ Limited Information (Go to Item 8)

8. IF YOU SELECTED "LIMITED INFORMATION", CHECK ALL THAT APPLY

☐ Status of pending claim or appeal ☐ Amount of money owed VA ☐ Other
☐ Current benefit and rate ☐ Request a benefit payment letter _____
☐ Payment history ☐ Change of address or direct deposit _____

9. IF YOU SELECTED "ANY INFORMATION", THE TERMS OF SUCH RELEASE OF INFORMATION WILL BE:

☐ One time only ☐ From the date of signing below until _____
(Specify date - month, day, year)
☐ Ongoing until written notice is given to VA to terminate

10. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION AS SPECIFIED ABOVE TO THE PERSON OR ORGANIZATION LISTED BELOW. NOTE: IF AUTHORIZATION IS FOR AN ORGANIZATION, PLEASE PROVIDE THE FIRST AND LAST NAME OF THE ORGANIZATION'S REPRESENTATIVE. *(Please print clearly)*

A. NAME OF PERSON OR ORGANIZATION	B. ADDRESS OF PERSON OR ORGANIZATION

11. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY <u>ONE</u> SECURITY QUESTION BOX IN 11A AND PROVIDE THE ANSWER IN 11B.

A. SECURITY QUESTION	B. ANSWER
☐ The city and state your mother was born in	
☐ The name of the high school you attended	
☐ Your first pet's name	
☐ Your favorite teacher's name	
☐ Your father's middle name	

12A. SIGNATURE *(Do **NOT** print)*	12B. DATE SIGNED

PRIVACY ACT INFORMATION: 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 voluntary. 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. 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 Federal Statute of law in effect prior to January 1, 1975, and still in effect.

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 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.

OMB Control No. 2900-0321
Respondent Burden: 5 minutes

Department of Veterans Affair

1. VA FILE NO(S) *(Include prefix)*

APPOINTMENT OF INDIVIDUAL AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have a service organization assist you with your claim, you may use VA Form 21-22, "Appointment of Veterans Service Organization As Claimant's Representative."

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 voluntary. However, failure to respond provide the requested information could impede the recognition of your representative and/or identification of disclosable records. Except for information protected by 38 U.S.C. 7332, your representative is not prohibited from redisclosing records. 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 recognize the individuals appointed by claimants to act on their behalf in the preparation, presentation, and prosecution of claims for VA benefits (38 U.S.C. 5902, 5903, and 5904) and for those individuals to accept appointment. We will also use the information to verify consent for disclosure of VA records to the appointed representative (38 U.S.C. 5701(b) and 7332) Title 38, United States Code, allows us to ask for this information. We estimate that claimants and individuals appointed for purposes of representation will each need an average of 5 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. A Valid OMB control number 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.

2. NAME OF CLAIMANT (*Veteran, guardian, beneficiary, dependent, or next of kin*)	3. ADDRESS OF CLAIMANT (*No. and street or rural route, city or P.O., State and ZIP Code*)
4. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN	5. SERVICE NUMBERS

6. BRANCH OF SERVICE

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER (*Specify* _____)

7A. NAME OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE

7B. INDIVIDUAL IS *(check appropriate box)*

☐ ATTORNEY ☐ AGENT ☐ INDIVIDUAL PROVIDING REPRESENTATION UNDER SECTION 14.630
*(*See required statement below. Signatures are required in Items 7C and 7D)*

☐ SERVICE ORGANIZATION REPRESENTATIVE (*Specify organization below*)
_____

***INDIVIDUALS PROVIDING REPRESENTATION UNDER SECTION 14.630**

(Skip to Item 8, if the box for "Individual Providing Representation Under Section 14.630" was not checked in Item 7B)

The appointment of the individual named in Item 7A (the representative) authorizes the individual to represent the claimant named in Item 2 for a particular claim pursuant to the provisions of 38 CFR 14.630. By our signatures below, we, the representative and the claimant, attest that no compensation will be charged or paid for the individual named in Item 7A.

7C. SIGNATURE OF REPRESENTATIVE NAMED IN ITEM 7A

7D. SIGNATURE OF CLAIMANT NAMED IN ITEM 2

8. ADDRESS OF INDIVIDUAL APPOINTED AS CLAIMANT'S REPRESENTATIVE *(No. and street or rural route, city or P.O., State, and ZIP code)*

(Continued on Reverse)

9. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.

Unless I check the box below, I do not authorize VA to disclose to the individual named in Item 7A any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☐ I authorize the VA facility having custody of my VA claimant records to disclose to the individual named in Item 7A all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the individual named in Item 7A, either by explicit revocation or the appointment of another representative.

10. LIMITATION OF CONSENT. My consent in Item 9 for the disclosure of records relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia is limited as follows:

11. AUTHORIZATION FOR REPRESENTATIVE TO ACT ON CLAIMANT'S BEHALF TO CHANGE CLAIMANT'S ADDRESS

Unless I check the box below, I do not authorize the individual named in Item 7A to act on my behalf to change my address in my VA records.

☐ I authorize the individual named in Item 7A to act on my behalf to change my address in my VA records. This authorization does not extend to any other individual with out my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the individual named in Item 7A, either by explicit revocation or the appointment of another representative.

CONDITIONS OF APPOINTMENT

I, the claimant named in Item 2, hereby appoint the individual named in Item 7A as my representative to prepare,present, and prosecute my claims for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 4. If the individual named in Item 7A is an accredited agent or attorney, the scope of representation provided before VA may be limited by the agent or attorney as indicated below in Item 15. If the individual indicated in Item 7A is providing representation under 14.630, such representation is limited to a particular claim only. I authorize VA to release any and all of my records (other than as provided in Items 9 and 10) to that individual appointed as my representative, and if the individual in Item 7A is an accredited agent or attorney, this authorization includes the following individually named administrative employees of my representative:

Signed and accepted subject to the foregoing conditions.

12. SIGNATURE OF CLAIMANT	13. DATE OF SIGNATURE	14. CLAIMANT'S RELATIONSHIP TO VETERAN *(If other than the veteran)*

15. LIMITATIONS ON REPRESENTATION - AGENTS OR ATTORNEYS ONLY *(Unless limited by an agent or attorney, this power of attorney revokes all previously existing powers of attorney)*

16. SIGNATURE OF REPRESENTATIVE	17. DATE OF SIGNATURE

FEES: Section 5904, Title 38, United States Code, contains provisions regarding fees that may be charged, allowed, or paid for services of agents or attorneys in connection with a proceeding before the Department of Veterans Affairs with respect to benefits under laws administered by the Department.

CARE PROVIDER CERTIFICATION OF SERVICES (Form FV13)

1. Name of Person Receiving Care Services	2. Name of Veteran (For VA Purposes)		3. Veteran Social Security Number or VA Case Number	
4. Address of Person Receiving Care Services	5. City	6. State	7. Zip	8. Phone(s) and email
9. Name of Care Service Provider	10. Complete Address and Phone Number of Care Service Provider			

Check the appropriate box below for the type of service offered by the care provider.

Congregate or Independent Living ☐ Assisted Living ☐ Professional Home Care Company ☐

Nursing Home ☐ Adult Day (Care) Services ☐ Private In-Home Attendant ☐

Adult Foster Care ☐

If care provider provides 24-hour permanent residence for the care recipient, fill in the information below.

Date service started _____

Monthly charges including room and board, extras and care services $_____

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

If care provider offers assistance during the day at a location other than the care recipient's home, fill in below.

Date service started _____

Number of hours per day of service _____

Number of days per week of service _____

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Monthly charges including meals, site-to-site transportation and care services $_____

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid."

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

If care provider offers assistance in the home of the care recipient or in the home of someone else, fill in below.

Date service started _____

Number of hours per day of service _____

Number of days per week of service _____

Care provider anticipates the need for services will continue month-to-month. Yes ☐ No ☐

Please attach a copy of the care provider contract.

Monthly charges including meals, transportation, housework and care services $_____

Monthly charges must be documented by at least one month's paid services on an invoice marked "paid.")

Care provider provides a "protected environment" for the care recipient. Yes ☐ No ☐

Form FV13 - CARE PROVIDER CERTIFICATION OF SERVICES - Page 2

COMPLETE THIS SECTION FOR ASSISTED LIVING, HOME CARE, ADULT DAY CARE, NURSING HOME, IN-HOME ATTENDANT, etc

Please describe briefly the "protected environment" or care services being furnished for the care recipient above.

Does the care provider provide "Nursing Services" for the care recipient? Yes ___ No ___

Answer this question using VA's definition of "Nursing Services" below.

DEFINITION OF NURSING SERVICES (necessary for allowing deductibility of certain costs)

(M21--1MR, Part V, Subpart iii, Chapter 1, Section G, 43) . . . "Examples of nursing services are assisting an individual with bathing, dressing, feeding him/herself, and **other activities of daily living**. . . ."

DEFINITION OF "OTHER ACTIVITIES OF DAILY LIVING" (ADL's and IADLs):

According to the US government Census Bureau at http://www.census.gov/hhes/www/disability/disab_defn.html, ADLs and IADLs are defined as "Had difficulty with one or more activities of daily living (the ADLs included getting around inside the home, getting in or out of bed or a chair, bathing, dressing, eating, and toileting); Had difficulty with one or more instrumental activities of daily living (the IADLs included going outside the home, keeping track of money and bills, preparing meals, doing light housework, taking prescription medicines in the right amount at the right time, and using the telephone);"

CARE PROVIDER -- LINE 9 ABOVE -- OFFERS THE FOLLOWING SERVICES FOR THE CARE RECIPIENT -- LINE 4 ABOVE:

	Yes	No		Yes	No
Provides help with getting out of bed			Provides shopping services		
Provides help with dressing			Provides supervision to prevent person from harming himself		
Provides help with bathing			Provides transportation for the care recipient		
Provides help with ambulating			Provides supervision and / or reminders for medications		
Provides help with toileting			Provides housework services such as cleaning, laundry, etc		
Provides help with incontinence			Answers phones and / or keeps track of money and bills		
Provides help with feeding			Provides homemaker services		
Provides supervision and properly secured living arrangements for a protected environment			Provides meals because care recipient above is physically or mentally incapable of preparing his or her own meals		
Provides medical or monitoring alert equipment			Provides skilled medical care for the care recipient		
Provides emergency response staff			Provides supervision to prevent person from harming others		
Provides off-premise home care services			Provides supervision to prevent wandering		
Provides training for family caregivers			Provides restraint or direction if care recipient is uncooperative		

This form should be signed by a manager, director, owner or other responsible person with the care provider. For a personal in-home attendant, the in-home attendant should sign this form.

Date Signed:_____ Title of Person Signing the Form: _____

Person's Name: _____ Person's Signature:_____

I, the above signing person, certify the above information is correct and true to the best of my knowledge.

Form Approved: OMB No. 2900-0085
Respondent Burden: 1 Hour

Department of Veterans Affairs

APPEAL TO BOARD OF VETERANS' APPEALS

IMPORTANT: *Read the attached instructions before you fill out this form. VA also encourages you to get assistance from your representative in filling out this form.*

1. NAME OF VETERAN *(Last Name, First Name, Middle Initial)*	2. CLAIM FILE NO. *(Include prefix)*	3. INSURANCE FILE NO., OR LOAN NO.

4. I AM THE:

☐ VETERAN ☐ VETERAN'S WIDOW/ER ☐ VETERAN'S CHILD ☐ VETERAN'S PARENT

☐ OTHER *(Specify)*

5. TELEPHONE NUMBERS		6. MY ADDRESS IS: *(Number & Street or Post Office Box, City, State & ZIP Code)*
A. HOME *(Include Area Code)*	B. WORK *(Include Area Code)*	
7. IF I AM NOT THE VETERAN, MY NAME IS: *(Last Name, First Name, Middle Initial)*		

8. OPTIONAL BVA HEARING

IMPORTANT: *Read the information about this block in paragraph 6 of the attached instructions. This block is used to request a Board of Veterans' Appeals hearing. DO NOT USE THIS FORM TO REQUEST A HEARING BEFORE VA REGIONAL OFFICE PERSONNEL.*
Check one (and only one) of the following boxes:

A. ☐ I DO NOT WANT A BVA HEARING.

B. ☐ I WANT A BVA HEARING BY LIVE VIDEOCONFERENCE.

C. ☐ I WANT A BVA HEARING IN WASHINGTON, DC.

D. ☐ I WANT A BVA HEARING AT A LOCAL VA OFFICE.*

**Due to travel requirements for BVA personnel, selecting Option D may result in a lengthier waiting period for the hearing than the other options. (This option is also not available at the Washington, DC, or Baltimore, MD, Regional Offices.)*

9. THESE ARE THE ISSUES I WANT TO APPEAL TO THE BVA: *(Be sure to read the information about this block in paragraph 6 of the attached instructions.)*

A. ☐ I WANT TO APPEAL ALL OF THE ISSUES LISTED ON THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENTS OF THE CASE THAT MY LOCAL VA OFFICE SENT TO ME.

B. ☐ I HAVE READ THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENT OF THE CASE I RECEIVED. I AM ONLY APPEALING THESE ISSUES:
(List below.)

10. HERE IS WHY I THINK THAT VA DECIDED MY CASE INCORRECTLY: *(Be sure to read the information about this block in paragraph 6 of the attached instructions.)*

(Continue on the back, or attach sheets of paper, if you need more space.)

11. SIGNATURE OF PERSON MAKING THIS APPEAL	12. DATE *(MM/DD/YYYY)*	13. SIGNATURE OF APPOINTED REPRESENTATIVE, IF ANY *(Not required if signed by appellant. See paragraph 6 of the instructions.)*	14. DATE *(MM/DD/YYYY)*

OMB Approved No: 2900-0652
RESPONDENT BURDEN: 10 Minutes

Department of Veterans Affairs

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

VA DATE STAMP
(Do Not Write In This Space)

INSTRUCTIONS: The claimant named in Item 3 has filed a claim for aid and attendance benefits and has stated that he/she is in a nursing home. In order to arrive at a fair decision in this case, we need the information requested below. Please complete Section II and return to VA at the address shown in Item 2. Please be sure to sign and date this form in Items 13A and 13B. For free help in completing this form, call VA toll-free at 1-800-827-1000. (Hearing Impaired TDD line 1-800-829-4833.)

Section I - IDENTIFICATION INFORMATION *(To be completed by VA)*

1A. NAME OF NURSING HOME	1B. ADDRESS OF NURSING HOME

2. ADDRESS OF VA REGIONAL OFFICE

3. FIRST NAME - MIDDLE INITIAL- LAST NAME OF CLAIMANT

4. SOCIAL SECURITY NUMBER	5. VA FILE NUMBER

SECTION II - NURSING HOME INFORMATION *(To be completed by a Nursing Home Official)*

6. DATE ADMITTED TO NURSING HOME *(Month, Day, Year)*	7. DATE MEDICAID BEGAN *(Month, Day, Year)*

8. AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET

$

9. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING:

☐ SKILLED NURSING CARE ☐ INTERMEDIATE NURSING CARE

10. NURSING HOME OFFICIAL'S NAME *(First & Last) (Please print)*

11. NURSING HOME OFFICIAL'S TITLE *(Please print)*	12. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)*

13A. SIGNATURE OF NURSING HOME OFFICIAL	13B. DATE SIGNED

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 5, Code of Federal Regulations 1.526 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 Compensation, Pension, Education, and Rehabilitation Records - VA, and published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

IMPORTANT NOTICE ABOUT INFORMATION COLLECTION: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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/library/omb/OMBINVC.html#VA. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

DIRECT DEPOSIT ENROLLMENT FORM
VA24-0296
ATTENTION VA GUARDIAN / CUSTODIAN:

WE'VE MADE ENROLLING IN DIRECT DEPOSIT EASIER THAN EVER!

The Department of the Treasury has mandated that paper checks will be discontinued effective with payments made March 1, 2013 and must be received by Electronic Funds Transfer (EFT). To sign up for Direct Deposit, all you need to do is complete this form with the assistance of the financial institution, sign Section 3, and submit this using the instructions for scanning, the completed document.

1. VA BENEFIT INFORMATION

Payee Name: _____
this is the person appointed as fiduciary by the VA

VA Beneficiary Name: _____
this is the person entitled to the VA benefit

VA Claim Number: _____

Payee Phone Number:
Home Cell _____

2. DIRECT DEPOSIT ACCOUNT INFORMATION (Your financial institution can provide this information).

Account Title:	
	The VA Custodial Account must be properly titled.Please call for any questions
ROUTING TRANSMIT NUMBER:	CHECKING: SAVINGS:
ACCOUNT NUMBER:	

FINANCIAL INSTITUTION NAME: _____ TELEPHONE: _____

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

3. PAYEE

This form authorizes payment to be sent to the financial institution named above and deposited to the designated account.

Signature: _____ Date: _____

CAREGIVER AGREEMENT

The parties to this agreement are: _____ & _____ who will be referred to in this document as “Client”, who is to receive care and assistance, and _____ & _____ who will be referred to as “Caregiver”, who will furnish care and assistance.

The purpose of this agreement is to set out the terms of employment and to establish what assistance the Caregiver will provide to the Client.

The Client is a person with impaired abilities and is a vulnerable person. The Client will depend on the Caregiver and the Caregiver will take special care to not take advantage of the Client and to not unnecessarily influence the Client’s choices. The Caregiver will under no circumstances assist the Client to write checks unless authorized to do so in writing. The Caregiver will not influence the Client in any way whatsoever regarding the writing or changing of a will or other estate planning unless so authorized by the family member of record.

The Caregiver will assist the Client to have as much control over her home environment and life as possible, under the circumstances.

The Caregiver will be responsible for Services provided which may include any of the following:

Personal Services: Assistance with the activities of daily living such as bathing, dressing, feeding, and other activities which may be deemed necessary to maintain the Client’s immediate environment and accompanying the Client on errands and appointments when necessary.

Personal Care: Assistance in carrying out physician’s directions regarding care of the Client and assistance with mobility and transfers, record keeping and preventing the Client from wandering or otherwise harming themselves.

Household Services: Meal preparation according to an approved plan, shopping, errands, room cleaning and laundry.

The Caregiver will know the whereabouts and the physical condition of the Client at all times while on duty.

The Caregiver will make a written record of any accidents or other sudden events that bring harm or risk of harm to the Client and will report any such incidents to the family member of record. The Caregiver will make use of emergency contact procedures when necessary.

Driving

The Caregiver states that they have a valid Driver's License and agree to provide a copy of such license if transportation is part of this agreement.

☐ The Caregiver will provide transportation for the Client in the Client's vehicle to appointments, errands, shopping, and for social purposes.

☐ Caregiver will provide transportation for the Client in the Caregiver's vehicle to appointments, errands, shopping, and for social purposes. Caregiver agrees to provide proof of liability and uninsured motorist insurance with policy limits of at least: $100,000.00 for bodily injury, $300,000.00 per incident maximum, and $50,000.00 property damage. The Caregiver promises to notify the family member of record if insurance is terminated.

Work Schedule

Caregiver agrees to work according to a schedule and will not alter the schedule without at least 48 hours advance notice to family member of record. Caregiver will not revise this schedule without the consent of family member of record.

Household Expenses

If the Caregiver is provided with funds for household expenses, the Caregiver will keep detailed records on forms provided by family member of record. The Caregiver will only make purchases that are pre-approved by the family member of record.

Termination

This agreement may be terminated at will by the Caregiver with two (2) weeks advance written notice. This agreement may be terminated by the Client without cause and with no advance notice. If this occurs, the Caregiver will be entitled to two weeks severance pay at the rate of the average compensation over the past three months. If the Caregiver has violated the terms of this agreement or has been negligent or acted in a way that could have allowed harm to the client, the Caregiver will be entitled to no severance pay.

This agreement will be interpreted according to the laws of the State of New Jersey and will be construed or interpreted to give effect to the parties' intent in accordance with the terms of this agreement.

Legal Representation

The Caregiver acknowledges they were told that they were free to consult with a lawyer to review this agreement prior to signing it and had ample opportunity to do so. The Caregiver acknowledges that this is an arms-length transaction in which they were free to negotiate and did negotiate the terms of this agreement.

Attorney's Fees

In the event of any breach of this agreement, the party responsible for the breach agrees to pay reasonable attorneys' fees and costs incurred by the other party in the enforcement of this agreement or suit for recovery of damages. The prevailing party in any suit instituted arising out of this agreement will be entitled to receive reasonable attorneys' fees and costs incurred in such suit.

Documentation & Accounting:

The Caregiver must provide a log of the following:

1) all expenses incurred; provide a ledger or bank statement
2) hours provided for care performed for the week
3) a itemized list of duties provided for the week
4) copy of the drivers license (if driving client)
5) ledger or bank statement

Compensation

The hours and the hourly, weekly or monthly compensation paid to the Caregiver are subject to change at any time as agreed between the Client and the Caregiver. The initial arrangement is as follows:

Hours/days 24/7 Care or as needed

Compensation $_____ per day plus any other expense that may be incurred for care.

_____ _____
Client: Date

_____ _____
Client: Date

_____ _____
Caregiver Name: Date

_____ _____
Caregiver Name: Date

Veteran Benefit Advisory Group		"Aid & Attendence Pension Benefit" Means Testing				
Please fill in. Please make sure you included taxes.			*Monthly Caregiver expenses need to be*			*$0.00*
Vet Name & Spouse Below	Started on:	1/0/00	*This is the benefit you may qualify for!*			
GROSS INCOME ON ALL LINES				Yearly	$0.00	Benefit
Monthly Income Items	**Veteran Income yr**	**Spouse Income yr**	**Total**	**Veteran Income mo**	**Spouse Income mo**	
Social Security	$0.00	$0.00	$0.00	$0.00	$0.00	
Pension Income (a)	$0.00	$0.00	$0.00	$0.00	$0.00	
Pension Income (b)	$0.00	$0.00	$0.00	$0.00	$0.00	
US Civil Service	$0.00	$0.00	$0.00	$0.00	$0.00	
Military Retirement	$0.00	$0.00	$0.00	$0.00	$0.00	
Disability Income	$0.00	$0.00	$0.00	$0.00	$0.00	
Unemployment or Employment	$0.00	$0.00	$0.00	$0.00	$0.00	
Interest & Dividends	$0.00	$0.00	$0.00	$0.00	$0.00	
Alimony & Child Support (Income Only)	$0.00	$0.00	$0.00	$0.00	$0.00	
IRA Distributions (RMD 70 1/2 taken)	$0.00	$0.00	$0.00	$0.00	$0.00	
Long Term Care Income	$0.00	$0.00	$0.00	$0.00	$0.00	
Other Income	$0.00	$0.00	$0.00	$0.00	$0.00	
Total	$0.00	$0.00	$0.00	$0.00	$0.00	
Monthly Medical Expenses	**Veteran Expenses yr**	**Spouse Expenses yr**	**Monthly Totals**	**Veteran Expenses mo**	**Spouse Expenses mo**	
Medicare Part B (Look on SSI Statement)	$0.00	$0.00	$0.00	$0.00	$0.00	
Medicare Part C	$0.00	$0.00	$0.00	$0.00	$0.00	
Private Insurance	$0.00	$0.00	$0.00	$0.00	$0.00	
Prescriptions (Copays Monthly expense added up.)	$0.00	$0.00	$0.00	$0.00	$0.00	
Co-Pays (Dr's, Hospital, Ambulance, other)	$0.00	$0.00	$0.00	$0.00	$0.00	
Caregiver Services (Paid for care person)	$0.00	$0.00	$0.00	$0.00	$0.00	
Home Health Aid	$0.00	$0.00	$0.00	$0.00	$0.00	
Nursing Home (Avg monthly payment)	$0.00	$0.00	$0.00	$0.00	$0.00	
Supplies (Depends, Bed, Linens, oxy, etc…)	$0.00	$0.00	$0.00	$0.00	$0.00	
Total	**$0.00**	**$0.00**	**$0.00**	$0.00	$0.00	
Total 'Caregiver Expenses' to Qualify for Benefit	**Veteran Expenses yr**	**Spouse Expenses yr**	**Total Monthly Expenses**	**Veteran Expenses mo**	**Spouse Expenses mo**	
$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
List of all assets		**Totals**	*Mo Benefit or Yearly Benefit Amount*			
$80,000 Maximum Asset Value (Trust may be needed to move assets for protrection & qualification)	**Added up**	**$0.00**	**$0.00**	**$0.00**		
Total of all Real Estate (Not including residential home)		$				**SELECT ONE**
Partnership assets		$	$1,094.00	Spouse Benefit		0
Total of all bonds		$	$1,704.00	Veteran Only		0
Total of all stocks		$	$2,020.00	Veteran & Spouse		0
Total of all other financial assets		$	$2,575.00	Both are Veterans		0
Total of all loans/notes you get income on		$	Notes:	Prepared		0-Jan-00
Total of all bank accounts		$				
Total of all IRA's (Roth & Traditional IRA's)		$				