Veterans Angels Inc.

"Our tribute to those who have gone before, and our service to those who carry on"

501(c)(3)
Tax-Exempt
Public Charity

EIN Number
27-0204290

Veterans Angels, Inc. is a 501 (c) (3) tax-exempt public charity and our service is provided free of charge.

Our mission is to provide you with the information to assist you in preparing your claim for the Non-service improved disability pension or the Death benefit. This benefit is administered through the Department of Veterans Affairs.

The attached forms need to be completed and submitted with the required documents to Veterans Angels, Inc.

The more complete the application, the faster the DVA processing time and possible approval.

Should you have questions before filing, you may contact Veterans Angels, Inc. via email at support@vetangels.org, or you may call toll-free 1 (888) 319-1117.

It is our honor to assist you and your family.

MAKE COPIES FOR YOUR FILE OF EVERYTHING BEFORE MAILING.

MAIL ONLY
10170 W. TROPICANA AVE., # 156-440 • LAS VEGAS, NV 89147-8465 • TOLL FREE **888-319-1117** • FAX 702-450-2259
VETANGELS@COX.NET • WWW.VETANGELS.ORG

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Veterans Angels, Inc. a 501 (c) (3) Public Charity
I_____, on _____, (date), state

that I have requested information and assistance from Veterans Angels, Inc., regarding the non-service connected pension benefit("the benefit") or the death benefit currently available for Veterans and their widows(ers) from the Department of Veterans Affairs.

By signing below, I indicate that I wish to proceed with the application process.

I also indicate that the individual assisting me in applying for "the benefit" is not an employee of the Department of Veterans Affairs.

I also affirm that I have not paid the person for this service.

I give permission to the staff associated with Linda Stone, accredited claims agent with the Department of Veterans Affairs to assist in the preparation of my application.

I further acknowledge that I am aware that this process may have an impact on any future application for benefits from Medicaid.

I further acknowledge that neither the individual assisting me nor any affiliations of that individual can guarantee the "the benefit" will be received.

I realize that there are income and asset qualifications, and that there may be tax consequences. I understand that I may consult with my own attorney, accountant, or other professionals in regard to the application.

By signing below, I hereby agree to hold harmless and release from all liability the individual assisting me as well as any of their affiliations.

I agree to notify Veterans Angels, Inc. of any correspondence, phone calls, or requests for additional information from the Department of Veterans Affairs.

_____ _____
Applicant or Contact person Date

_____ _____
Individual assisting (Counselor) Date

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Veterans Angels, Inc. **Confidential Information**

The following information needs to be completed as accurately as possible. All information is held confidential by Veterans Angels, Inc.

Countable Monthly Income

	Claimant
Social Security (Gross)(Provide statement, if possible)	
Pensions (Government)	
Pensions (Military)	
Pensions (Corporate)	
Long Term Care Insurance	
401 K's, 457	
403 B's, IRA (withdrawals)	

Countable Assets (Provide current statements)

All Checking Accounts	
All Savings Accounts	
CD's, Money Market	
Real Estate (other than Residence)	
IRA's, 401 K's, etc…	
Annuities(non-qualified)	
Stock, Bonds, Mutual Funds	
Life Insurance Cash Value	

Countable Monthly Expenses for Health or Medical (Paid by You)

Medicare Part B	
Supplemental Health Ins. Premiums	
Long Term Care Premiums	
Medicare (Part D)	
Assisted Living or Group Home Cost	
Home Caregiver Cost	
Incontinence products, Oxygen, Insulin	
Prescription co-pays (verified by doctor)	

I/we declare, under the state laws where I reside, that the foregoing information regarding Income, Assets, and Expenses are accurate to the best of my knowledge.

_____ **Date** _____

Signature of Claimant or Responsible Party

CONFIDENTIAL INFORMATION

FINAL CHECKLIST FOR SUBMISSION FOR SURVIVING SPOUSE

PLEASE USE THIS CHECKLIST TO VERIFY ALL FORMS AND DOCUMENTS ARE INCLUDED.

MAIL TO: VETERANS ANGELS, INC.
10170 W. TROPICANA AVE, # 156-440
LAS VEGAS, NV 89147

FORMS TO BE INCLUDED:

Veterans Angels, Inc. Disclosure **- Surviving spouse *or responsible party must sign.***
Veterans Angels, Inc. Confidential Information page- **Surviving spouse *or responsible party must sign.***
21-534EZ - *Application for Death Pension*-**Surviving Spouse *must sign.***
POA signature is not accepted by DVA.
21-0845- *Authorization to Disclose Personal Information to a Third Party*-**Surviving spouse *must sign***. This will allow a family member or authorized person to obtain status information directly from the DVA.
21-22a-*Appointment of Individual as Claimant's Representative*-**Surviving spouse must sign**. This appoints Linda R. Stone as an authorized claims agent regarding the claim.
21-4138-*Statement in Support of Claim*-**Surviving spouse must sign.** This is where the claimant can state the reasons Aid and Attendance are needed.
21P-8416-*Medical Expense Report*-**Surviving spouse must sign.** Medical expenses are to be reported for "one month". The VA will only count medical expenses from the date the claim is received. Health and medical expenses should be recurring, predictable, and unreimbursed. **Example:** Medicare Part B, D, supplemental health, dental, or drug premiums, costs for care (assisted living, group home, home care agencies, Adult Day Care, or family members that are being paid as caregivers), incontinence supplies, oxygen, insulin, equipment rental, etc. **The unreimbursed expenses paid by you for the veteran's last illness and burial may be listed on the Medical Expense Report.**
Include invoice or statements showing date and amount paid.
21-4142-*Authorization to Release Information*-**Surviving spouse must sign.** Use one form for each physician submitting a 21-2680.
21-2680-*Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*-**Must be completed and signed by a Physician, not a PA or RN.**
21-0779-*Request for Nursing Home Information*-Use only if facility is providing skilled or intermediate nursing services. Nursing Home official must sign.
Care Expense Statement-**Surviving spouse must sign and also Official from Care Facility or Care provider (assisted living, group home, Home care agency, or family member if serving as a caregiver AND being paid for Caregiver services).**

SUPPORTING DOCUMENTS CHECKLIST

Original or Certified Copy of Military Separation Papers (DD214). DVA will return originals. You can obtain a Certified Copy online at:
www.archives.gov/veterans/military-service-records
or by mailing the form included with this packet titled "Request Pertaining to Military Records" to the National Personnel Records Center address.

***Copy** of Veterans Death Certificate*

***Copy** of Marriage Certificate to Veteran*

***Copy** of previous marriage(s) death certificate or divorce decree* You must furnish at least the month and year of marriage and death or divorce and places.

Medical Records- Copy of most recent medical record from physician most familiar with claimant's medical history. You don't need to send a book but enough to substantiate the need for help from another person.

Copy of Legal Guardianship papers (if applicable)

Voided Check - on account where the benefit should be deposited.

Copy of sources of income for your household as reported on 21-534EZ, Page 10, Section IX

Copy of Bank Statement(s) (most recent)

Copy of Statement for assets reported on 21-534EZ, Page 10, Section VII

MAKE COPIES! OF ALL FORMS & SUPPORTING DOCUMENTS
BEFORE MAILING TO VETERANS ANGELS, INC.

DO NOT SEND PACKET UNLESS COMPLETE WITH SUPPORTING DOCUMENTS

Mail completed packet to:
Veterans Angels, Inc.
10170 W. Tropicana Ave., # 156-440
Las Vegas, NV 89147

Contact Information:

Name: _____

Address: _____

Phone Numbers: (Home)_____(Cell)_____(Work)_____

Email:_____

Relationship to Claimant:_____

Any questions, please contact Veterans Angels, Inc. via Email at www.support@vetangels.org
OR call our toll-free number, 1-888-319-1117.

Veterans Angels Inc.

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EIN Number
27-0204290

Tribute 21

The number 21 is one of utmost significance in military history. The 21 gun salute is the highest honor that can be bestowed on a deceased veteran. You can continue this time-honored tradition by making your tax-deductible donation of $21.00 or more. Veterans Angels, Inc. is a non-profit, public charity and relies on your generous support to accomplish our mission of helping senior veterans and spouses obtain tax-free money from the Department of Veterans Affairs to help defray the cost of long term care. Thank you for your support.

You may send a check or credit card information to: Veterans Angels, Inc.
10170 W. Tropicana Ave., #156-440
Las Vegas, NV 89147-8465

Or make a donation on our website: www.vetangels.org.

Please fill in the following information.

Donation Amount: $_____

❑ I would like to make this a recurring monthly donation.

Donor Information

First Name_____ Last Name_____

Company (Optional)_____

Address_____

City_____ State_____

ZIP/Postal Code_____ Country_____

Email Address_____

Phone Number _____

Please fill in the following information if paying by credit card

Cardholder's Name_____ Card Type_____

Card Number_____ Card Expiration_____

If billing information differs from donor information, please enter the information below.

First Name_____ Last Name_____

Address_____

City_____ State_____

ZIP/Postal Code_____ Country_____

To make your gift in honor of or in memory of an individual, family, etc. please complete the following section.

❑ Honor Of ❑ Memory Of Honoree:_____

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Veterans Angels Inc

CREATE A LASTING TRIBUTE TO YOUR LOVED ONE

Honor your Veteran with a lasting tribute for their service to their country. **A tax deductible gift of $252.00** will provide a personalized, beautifully engraved, 4 X 8 Donor Brick with a felt backing and stand. This lasting tribute is sure to be treasured and passed on to future generations.

Your tax deductible donation will assist Veterans Angels, Inc., a 501 (c)(3) public charity, to continue our mission of informing and assisting Veterans and their families to obtain little known benefits to help with the cost of long term care.

Veterans Angels, Inc. provides all services *free of charge* to Veterans and their families. Our only funding comes from patriots like you.

Yes, we'd like to create a lasting tribute. Please engrave our brick as follows:
(We recommend engraving with all capital letters. Please print carefully.)

ANY SYMBOL IS CONSIDERED ONE SPACE (PERIOD, COMMA, DASH)
ALL TEXT IS CENTERED UNLESS OTHERWISE NOTED
Maximum number of characters per line, including periods or commas is 21

4 x 8 Brick

EXAMPLE

S	T	E	P	H	E	N		B	.		S	T	O	N	E		U	S	M	C
1	s	t		M	A	R	I	N	E		D	I	V	I	S	I	O	N		
1	9	6	1	-	1	9	6	5												

PLEASE RETURN FORMS AND YOUR DONATION PAYABLE TO:
ORDER SHEET ON BACK.

Veterans Angels, Inc.
10170 W. Tropicana Ave., # 156-440
Las Vegas, NV 89147

EIN # 27-0204290

Date Order Received:______________________________ Date Shipped:_____________________________

****

Name: ____ Phone: (_______) ___________________________

Address: ____

City: ____ State: ____________________ Zip: __________________

Email Address: ____ Donation amount: $252.00

- -

Or enter your Credit Card Payment Information: for Visa - MasterCard - American Express - Discover

Card Number:_________________________________*(enter number without spaces or dashes)

Expiration Date:_______________________________ *(mmyy)

Billing Information: First Name:________________________Last Name:______________________________

Company:____

Address:____

City:____

State/Province:_______________________Zip/Postal Code:______________________

Country____

Email:____

Phone:____________________________________Fax:___________________________

❒ **Shipping Information: Check box to ship to the Billing Information Address**

Alternate Shipping Address:

First Name:______________________Last Name:________________________________

Address:____

City:__________________________________State/Province:______________________

Zip/Postal Code:__________________________Country:_________________________

Please allow 4-6 weeks for delivery

If you have any questions, please call Linda Stone at (888) 319-1117.

YOU CAN ALSO ORDER ON OUR WEBSITE: www.vetangels.org

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available." Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next of kin using eVetRecs at http://www.archives.gov/veterans/military-service-records/.

2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **less than 62 years** ago and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STR's of persons on active duty are generally kept at the local servicing clinic, and usually are available from the Department of Veterans Affairs approximately 40 days after the last day of active duty. (See item 3, Archival Records, if the military member was discharged, retired or died in service over 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations and the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. An authorization signature, of the service member or the member's legal guardian, is needed in Section III of the SF180. Others requesting information from military personnel records and/or STR's must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, surviving next of kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **must provide proof of death**, **such as a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death; funeral director's signed statement of death, or verdict of coroner's jury.**

b. Fees for records: There is no charge for most services provided to service members or next of kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances service fees cannot be determined in advance. If your request involves a service fee, you will be notified.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 or more years** ago have been transferred to the legal custody of NARA and are referred to as "archival" records.

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next of kin is not required. However, in order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and preclude the release of some information.

b. Fees for Archival Records: Access to archival records is granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). You will be notified if there is a charge for photocopies of documents contained in the record you are requesting. For more information see http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS AS INDICATED IN THE ADDRESS LIST ON PAGE 2 OF THE SF 180.

Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 01/31/2015

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/*

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent.** When was the DD Form(s) 214 issued? YEAR(S): _____
If more than one period of service was performed, even in the same branch, there may be more than one DD214.

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

An undeleted copy will be sent unless you specify a deleted copy. Indicate here if you want a deleted copy of the DD Form 214 . ☐.

The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☐ **All Documents in Official Military Personnel File (OMPF)**

☐ **Medical Records** (Includes Service Treatment Records, Health (outpatient) and dental records.) If hospitalized (inpatient), the facility name and date for each admission **must** be provided: _____

☐ **Other** (Specify): _____

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal

☐ Other, explain: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: (*Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.) No signature required for Archival records.*

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran: _____ ***(Relationship)***
☐ Legal guardian (Must submit copy of court appointment.)
☐ Other (specify) _____

MUST HAVE PROOF OF DEATH - See item 2a on instruction sheet.

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Name

Street Apt.

City State Zip Code

3. AUTHORIZATION SIGNATURE WHEN REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct. No signature required for Archival records.

Signature Required - Do not print **Date**

( ) Daytime phone ( ) Fax Number

Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*

RESET

LOCATION OF MILITARY RECORDS

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	ADDRESS CODE	
		Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired on or after 10/1/2004	1	11
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, retired reserve in nonpay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	13	
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired on or after 4/1/1998	14	11
	Active, reserve, or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1905	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired on or after 1/1/1999	4	11
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired after 10/16/1992	14	11
	Active enlisted, officers	7	
	Former National Guard/USAR personnel	14	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired on or after 1/1/1995	10	11
	Active, reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1	**Air Force Personnel Center HQ AFPC/DPSIRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721**	**6**	**National Archives & Records Administration Old Military and Civil Records (NWCTB-Military) Textual Services Division 700 Pennsylvania Ave., N.W. Washington, DC 20408-0001**	**11**	**Department of Veterans Affairs Records Management Center P.O. Box 5020 St. Louis, MO 63115-5020**
2	**Air Reserve Personnel Center Records Management Branch (DPTARA) 18420 E. Silver Creek Ave. Bldg. 390 MS 68 Buckley AFB, CO 80011**	**7**	**US Army Human Resources Command ATTN: AHRC-PDR-V 1600 Spearhead Division Ave., Dept 420 Fort Knox, KY 40122-5402 askhrc.army@us.army.mil**	**12**	**Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852**
3	**Commander, Personnel Service Center (PSD-MR) MS7200 US Coast Guard 4200 Wilson Blvd., Suite 1100 Arlington, VA 29598-7200 http://uscg.mil/psc/adm**	**8**	***Reserved.***	**13**	***Reserved.***
4	**Headquarters U.S. Marine Corps Manpower Management Support Branch (MMSB-10) 2008 Elliot Road Quantico, VA 22134-5030**	**9**	***Reserved.***	**14**	**National Personnel Records Center (Military Personnel Records) 1 Archives Dr. St. Louis, MO 63138-1002 *e*VetRecs! *http://www.archives.gov/veterans/military-service-records/***
5	**Marine Forces Reserve 4400 Dauphine St. New Orleans, LA 70146-5400**	**10**	**Navy Personnel Command (PERS-312E) 5720 Integrity Drive Millington, TN 38055-3120**		

Department of Veterans Affairs

NOTICE TO SURVIVOR OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR DEPENDENCY AND INDEMNITY COMPENSATION, DEATH PENSION, AND/OR ACCRUED BENEFITS

(This notice is applicable to survivors claims for: Death Pension • Dependency Indemnity Compensation (DIC) • DIC under 38 U.S.C. 1151 • Increased Survivor Benefits Based on Need for Aid and Attendance or Being Housebound • Accrued Benefits • Benefits Based on a Veteran's Seriously Disabled Child)

Use this notice and the attached application to submit a claim for DIC, Death Pension, and/or Accrued Benefits. This notice informs you of the evidence necessary to substantiate your claim.

Want your claim processed faster? The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed, and there is no risk to participate! To participate in the FDC Program if you are making a claim for DIC, Death Pension, and/or Accrued Benefits, simply submit your claim in accordance with the "FDC Criteria" shown below. If you are making a claim for veterans disability compensation or related compensation benefits, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. If you are making a claim for veterans non service-connected pension benefits, use VA Form 21-527EZ, *Application for Pension*. VA forms are available at www.va.gov/vaforms.

FDC Criteria (Claim(s) for DIC, Death Pension, and/or Accrued Benefits)

1. Submit your claim on a signed and completed VA Form 21-534EZ, *Application for DIC, Death Pension, and/or Accrued Benefits* (Attached).

2. Submit simultaneously with your claim:

A copy of the veteran's Death Certificate (unless he or she died on active duty); **AND**

If claiming death pension:

- All necessary income and net-worth information
- **If claiming death pension with increased survivor benefits**, a completed VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*, and a completed VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

If claiming DIC:

- All, if any, relevant, private medical treatment records and an identification of any relevant treatment records available at a Federal facility, such as a VA medical center, that support your claim
- Any and all Service Treatment and Personnel Records in the custody of the veteran's Guard or Reserve Unit(s)
- **If claiming DIC as the parent of the veteran**, all necessary income and net-worth information and, if claiming benefits as the foster parent of the veteran, a completed VA Form 21-524, *Statement of Person Claiming to Have Stood in Relation of Parent*
- **If claiming DIC with increased survivor benefits**, a completed VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*, and a completed VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

Requirements for Certain Claimants:

Under the circumstances shown below, you must also submit simultaneously with your claim:

- **If claiming benefits as the surviving spouse of the veteran**, a copy of your marriage certificate showing your marriage to the veteran, or **if claiming benefits for a child or biological/adoptive parent of the veteran**, a copy of the birth certificate or court record of adoption showing relation to the veteran
- **If claiming benefits for a child of the veteran between the ages of 18 and 23**, a completed VA Form 21-674, *Request for Approval of School Attendance*
- **If claiming benefits for a seriously disabled (helpless) child of the veteran,** all, if any, relevant, private medical treatment records for the child's pertinent disabilities

3. Report for any VA medical examinations VA determines are necessary to decide your claim.

The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed, and there is no risk to participate! Participation in the FDC Program is optional and will not affect the quality of care you receive or the benefits to which you are entitled. If you file a claim in the FDC Program and it is determined that other records exist and VA needs the records to decide your claim, then VA will simply remove the claim from the FDC Program (Optional Expedited Process) and process it in the Standard Claim Process. See below for more information. If you wish to file your claim in the FDC Program, see FDC Program (Optional Expedited Process). If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process.

WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession. If your claim involves a disability the veteran had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before the veteran's entry into service.

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Submit your claim in accordance with the "FDC Criteria" (see page 1)	You must: • If you know of evidence not in your possession and want VA to try to get it for you, give VA enough information about the evidence so that we can request it from the person or agency that has it If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. ***It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.***

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

FDC Program (Optional Expedited Process)	Standard Claim Process
VA will: • Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain	VA will: • Retrieve relevant records from a Federal facility that you adequately identify and authorize VA to obtain • Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from state or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records or records from current or former employers

WHEN YOU SHOULD SEND WHAT WE NEED

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Send the information and evidence simultaneously with your claim If you submit additional information or evidence after you submit your "fully developed" claim, then VA will remove the claim from the FDC Program expedited process and process it in the Standard Claim process. If we decide your claim before one year from the date we receive the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.	We strongly encourage you to: • Send any information or evidence as soon as you can You have up to one year from the date we receive the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we receive the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim.

WHERE TO SEND INFORMATION AND EVIDENCE

Mail or take your application and any evidence in support of your claim to the closest VA regional office. VA regional office addresses are available on the Internet at www.va.gov/directory.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See the evidence table titled...
Needs-based benefits based on the veterans wartime service.	Death Pension
• The veteran's death was related to his or her service (DIC), **OR** • DIC benefits because the veteran was receiving or entitled to receive benefits for a service-connected disability rated totally disabling.	Dependency and Indemnity Compensation (DIC)
The veteran's death was a result of VA medical treatment, vocational rehabilitation, or compensated work therapy.	DIC under 38 U.S.C. 1151
DIC and it was previously denied by VA.	Reopened DIC
Increased death pension or DIC benefits because your disabilities cause you to be in need of aid and attendance or to be confined to your residence.	Increased Survivor Benefits Based on Need for Aid and Attendance or Being Housebound
You are eligible to the benefits that were due to the veteran at the time of the veteran's death.	Accrued Benefits
You are eligible to the benefits because a child of the veteran is severely disabled.	Helpless Child

EVIDENCE TABLES

Death Pension

To support your claim for **death pension benefits**, the evidence must show:

1. The veteran met certain minimum requirements regarding active service during a period of war. Generally, those requirements involve:

   • 90 days of consecutive service, at least one day of which was during a period of war; **OR**
   • 90 days of combined service during at least one period of war;

   *(**Note** : If the veteran's service began after September 7, 1980, additional length-of-service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligations.)*

   OR any length of active service during a period of war when:

   • At the time of death, the veteran was receiving (or entitled to receive) VA disability compensation or retirement pay for a service-connected disability; **OR**
   • The veteran was discharged from active service due to a service-connected disability.

2. Your net worth and income do not exceed certain requirements.

Dependency and Indemnity Compensation (DIC)

To support a claim for **Dependency and Indemnity Compensation (DIC) benefits based on a service-connected disability** established during the veteran's lifetime, the evidence must show:

- The veteran died while on active service; **OR**
- The veteran had a service-connected disability(ies) that was either the principal or contributory cause of the veteran's death; **OR**
- The veteran died from non service-connected injury or disease **AND** was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling:
  - For at least 10 years immediately before death; **OR**
  - For at least 5 years after the veteran's release from active duty preceding death; **OR**
  - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999

To support a claim for **DIC benefits based on a disability that was not service-connected** or for which the veteran did not file a claim during his or her lifetime, the evidence must show:

- An injury or disease that was incurred or aggravated during active service, or an event in service that caused an injury or disease; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the disability associated with the cause of death and an injury, disease, or event in service. This may be shown by medical records or medical opinion or, in certain cases, by lay evidence

EVIDENCE TABLES (Continued)

Dependency and Indemnity Compensation (DIC) *(Continued)*

To support your claim for **DIC benefits based upon the service person's *active* duty for training**, the evidence must show:

- The service person was disabled during *active* duty for training due to a disease or injury incurred in the line of duty, and the disease or injury caused or contributed to the service person's death.

If VA granted service connection for a disease or injury during the service person's lifetime, evidence that the service-connected disease or injury caused or contributed to the service person's death may satisfy this requirement.

To support a claim for DIC benefits based on a disability that was not service-connected or for which the service person did not file a claim during his or her lifetime, the evidence must show:

- The service person was disabled during *active* duty for training due to a disease or injury incurred in the line of duty; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the principal or contributory cause of death and the disability due to injury or disease, incurred in the line of duty. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support your claim for **DIC benefits based upon the service person's *inactive* duty training**, the evidence must show:

- The service person died during *inactive* duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident during such training; **OR**
- The service person was disabled during *inactive* duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; and that injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

If VA granted service connection for an injury, acute myocardial infarction, or cerebrovascular accident during the service person's lifetime, evidence that the service-connected condition caused or contributed to the service person's death may satisfy this requirement.

To support a claim for DIC benefits based on a disability that was not service-connected or for which the service person did not file a claim during his or her lifetime, the evidence must show:

- The service person was disabled during *inactive* duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; **AND**
- The injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

DIC under 38 U.S.C. 1151:

In order to support your claim for **DIC under 38 U.S.C. 1151**, the evidence must show:

- The deceased veteran died as a result of undergoing VA hospitalization, medical or surgical treatment, examination, or training; **AND**
- The death was:
  - the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment; **OR**
  - the direct result of an event that was not a reasonably expected result or complication of the VA care or treatment; **OR**
  - the direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program

Reopened DIC:

In order to reopen a claim previously denied by VA, we need new and material evidence. New and material evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.

- To qualify as new, the evidence must currently exist and be submitted to VA for the first time
- In order to be considered material, the additional existing evidence must pertain to the reason your claim was previously denied

EVIDENCE TABLES (Continued)

Increased Survivor Benefits Based on Need for Aid and Attendance or Being Housebound

In order to support your claim for **increased survivor benefits based on the need for aid and attendance**, the evidence must show:

- you have corrected vision of 5/200 or less in both eyes; **OR**
- you have concentric contraction of the visual field to 5 degrees; **OR**
- you are a patient in a nursing home due to mental or physical incapacity; **OR**
- you require the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulation 3.352(a)); OR
- you are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulation 3.352(a)); **OR**

In order to support your claim for **increased benefits based on being housebound**, the evidence must show:

- you are substantially confined to your immediate premises because of permanent disability

Accrued Benefits:

To support a claim for **accrued benefits**, the evidence must show:

- Benefits were due the veteran based on existing ratings, decisions, or evidence in VA's possession at the time of death, but the benefits were not paid before the veteran's death; **AND**
- You are the surviving spouse, child, or dependent parent of the deceased veteran

VA pays accrued benefits in the following order of priority:

1. Spouse
2. Children of the veteran (in equal shares)
3. Dependent parents (in equal shares)

Helpless Child:

To support a claim for **benefits based on a veteran's child being helpless**, the evidence must show that the child, before his or her 18th birthday, became permanently incapable of self-support due to a mental or physical disability.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant a claim for death benefits, the beginning date of your entitlement will generally be based on when we received your claim However, if VA received your claim within one year of the date of the veteran's death, entitlement will be from the first day of the month in which the veteran died.

The veteran's death certificate is evidence relevant to determining the effective date of any benefits we award.

Higher levels of benefits are available for a veteran's surviving spouse and/or parents who are unable to perform certain activities of daily living or leave their home. Higher levels of benefits may be effective from the date medical evidence first establishes entitlement.

For more information on the FDC Program, visit our web site at http://benefits.va.gov/transformation/fastclaims/ For more information on VA benefits, visit our web site at www.va.gov, contact us at http://iris.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 1-800-829-4833. VA forms are available at www.va.gov/vaforms.

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

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, DEATH PENSION, AND/OR ACCRUED BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 11 before completing the form.

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

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

4. VETERAN'S SEX	5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?	6. VA FILE NUMBER
☐ MALE ☐ FEMALE	☐ YES ☐ NO (If "Yes," provide the file number in Item 6)	

7. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?	8. WHAT IS THE VETERAN'S DATE OF DEATH? (MM,DD,YYYY)
☐ YES ☐ NO	

9. WHAT IS YOUR NAME? (First, middle, last name)	10. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)
	☐ SURVIVING SPOUSE ☐ PARENT ☐ CHILD ☐ CUSTODIAN FILING FOR CHILD

11. WHAT IS YOUR SOCIAL SECURITY NUMBER?	12. WHAT IS YOUR DATE OF BIRTH? (MM,DD,YYYY)	13. ARE YOU A VETERAN?
		☐ YES ☐ NO

14A. WHAT IS YOUR ADDRESS?	14B. YOUR TELEPHONE NUMBER(S) (include Area Code)
Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country	DAYTIME ( ) EVENING ( ) CELL PHONE ( )

15A. YOUR PREFERRED E-MAIL ADDRESS (If applicable)	15B. YOUR ALTERNATE E-MAIL ADDRESS (If applicable)

16. WHAT ARE YOU CLAIMING? (Check all that apply)

☐ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☐ DEATH PENSION ☐ ACCRUED BENEFITS

SECTION II: VETERAN'S SERVICE INFORMATION *(COMPLETE ONLY IF THE VETERAN WAS NOT RECEIVING VA COMPENSATION OR PENSION BENEFITS AT THE TIME OF DEATH)*

(Skip to Section III if the veteran was receiving VA compensation or pension benefits at the time of his or her death)

17A. DID THE VETERAN SERVE UNDER ANOTHER NAME?	17B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:
☐ YES ☐ NO (If "Yes," complete Item 17B) (If "No," skip to Item 18A)	

18A. VETERAN ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)	18B. BRANCH OF SERVICE	18C. RELEASE DATE FROM ACTIVE SERVICE (MM,DD,YYYY)

18D. DID THE VETERAN SERVE IN A COMBAT ZONE SINCE 9-11-2001?	18E. PLACE OF LAST SEPARATION
☐ YES ☐ NO	

19A. WAS THE VETERAN ACTIVATED TO FEDERAL ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*?	19B. DATE OF ACTIVATION (MM,DD,YYYY)
☐ YES ☐ NO (If "Yes," answer Items 19B, 19C and 19D)	

19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?	19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)
	( )

20A. WAS THE VETERAN EVER A PRISONER OF WAR?	20B. DATES OF CONFINEMENT
☐ YES ☐ NO (If "Yes," complete Item 20B) (If "No," skip to Section III)	FROM: TO:

SECTION III- MARITAL INFORMATION *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)*

*(Skip to Section IV if you are **NOT** claiming benefits as the surviving spouse of the veteran)*

TELL US ABOUT THE VETERAN'S MARRIAGES

21A. HOW MANY TIMES WAS THE VETERAN MARRIED (including marriage to you)?

21B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country)	21C. TO WHOM MARRIED (first, middle, last name)	21D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21E. HOW MARRIAGE TERMINATED (death, divorce)	21F. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)

21G. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21D, PLEASE EXPLAIN:

TELL US ABOUT YOUR MARRIAGES

22A. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?
☐ YES ☐ NO

22B. HOW MANY TIMES HAVE YOU BEEN MARRIED? (including your marriage to the veteran)

22C. DATE (moth, day, year) and PLACE OF MARRIAGE (city/state or country)	22D. TO WHOM MARRIED (first, middle, last name)	22E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	22F. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	22G. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)

22H. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22E, PLEASE EXPLAIN:

23. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?
☐ YES ☐ NO

24. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?
☐ YES ☐ NO

25. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?
☐ YES ☐ NO (If "No," complete Item 26)

26. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)*

27. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?
☐ YES ☐ NO (If "Yes," provide explanation):

SECTION IV: DEPENDENT CHILDREN *(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)*

*(Skip to Section V if you are **NOT** claiming benefits for a child(ren) of the veteran)*

28A. NAME OF CHILD (First, middle initial, last name)	28B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	28C. SOCIAL SECURITY NUMBER	*(Check all that apply)* 28D. BIOLOGICAL	28E. ADOPTED	28F. STEPCHILD	28G. 18-23 YEARS OLD (in school)	28H. SERIOUSLY DISABLED	28I. CHILD MARRIED	28J. CHILD PREVIOUSLY MARRIED
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

If claiming benefits as the surviving spouse or custodian filing for a child, in items 29A through 29D tell us about the children listed in Item 28A who ***do not*** live with you.

29A. NAME OF CHILD (First, middle initial, last name)	29B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	29C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	29D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION V: VETERAN'S PARENT *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE PARENT OF VETERAN)*

*(Skip to Section VI if you are **NOT** claiming benefits as the parent of a veteran)*

30A. WHAT IS YOUR MARITAL STATUS? (Check one)

☐ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN ☐ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF THE VETERAN ☐ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE ☐ DIVORCED ☐ WIDOWED

☐ NEVER MARRIED

30B. IF YOUR MARRIAGE HAS ENDED, PLEASE SPECIFY THE DATE (month, day, year) AND HOW MARRIAGE ENDED (death, divorce)

30C. IF YOU ARE SEPARATED, WHAT WAS THE CAUSE OF THE SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE **SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER**)*

31A. WHAT IS YOUR SPOUSE'S NAME? (First, middle initial, last name) (Skip to Item 32A if never married or no longer married)	31B. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (MM,DD,YYYY)	31C. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?

31D. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO (If "Yes," complete Item 31E)	31E. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? (If applicable)

32A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF *MAJORITY* (AGE 18 IN MOST STATES)? ☐ YES ☐ NO (If "Yes," skip to Item 34)	32B. DATE(S) OF PARENTAL CONTROL (If veteran did not live in your household continuously before age 18 provide the time period (dates) when he/she was under your parental control) (MM DD YYYY) *to* (MM DD YYYY) (MM DD YYYY) *to* (MM DD YYYY)

32C. WHY WASN'T THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY? (Explain fully)

33. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL CONTROL OVER THE VETERAN OUTSIDE THE DATE(S) SHOWN IN ITEM 32B

A. NAME (FIRST, MIDDLE, LAST)	B. ADDRESS
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country
	Street address, rural route, or P.O. Box Apt. number City State ZIP Code Country

34. IF YOU ARE NOT THE BIOLOGICAL PARENT OF THE VETERAN, PROVIDE THE NAMES OF THE BIOLOGICAL PARENTS, IF DECEASED, PROVIDE THE DATE OF DEATH.

A. NAME (FIRST, MIDDLE, LAST)	B. DATE OF DEATH (MM,DD,YYYY)

SECTION VI: DIC *(COMPLETE ONLY IF CLAIMING DEPENDENCY AND INDEMNITY COMPENSATION (DIC))*

*(Skip to Section VII if you are **NOT** claiming DIC)*

35. WHAT BENEFIT ARE YOU CLAIMING?

☐ DIC ☐ DIC under 38 U.S.C. 1151 (RARE)

36. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

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

SECTION VII: NET WORTH *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

37. **NET WORTH** (DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")

Report total net worth for your household. Identify the ***specific*** owner for each net worth source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your net worth and the child's net worth, if any.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	$		REAL PROPERTY *(Not your home, vehicle, furniture, or clothing)*	$	
INTEREST-BEARING BANK ACCOUNTS	$		ALL OTHER PROPERTY *(Please write source)*	$	
IRA'S, KEOGH PLANS, ETC.	$		ALL OTHER PROPERTY *(Please write source)*	$	
STOCKS, BONDS, MUTUAL FUNDS, ETC.	$		OTHER *(Provide source)*	$	

SECTION VIII: GROSS MONTHLY INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

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

Report total monthly income for your household. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your income and the child's income, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	$		SERVICE RETIREMENT/ SURVIVOR BENEFIT PLAN (SBP) ANNUITY	$	
SOCIAL SECURITY	$		SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE	$	
U.S. CIVIL SERVICE	$		OTHER *(Provide source)*	$	
U.S. RAILROAD RETIREMENT	$		OTHER *(Provide source)*	$	
BLACK LUNG BENEFITS	$		OTHER *(Provide source)*	$	

SECTION IX: EXPECTED INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

39. **EXPECTED INCOME - NEXT 12 MONTHS** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report expected total household income for the 12 month period following the veteran's death. If the claim is filed more than one year after the veteran died, report the expected total household income for the 12 month period from the date you sign this application. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report ***your expected income*** and the ***child's expected income***, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
TOTAL DIVIDENDS AND INTEREST	$		OTHER INCOME EXPECTED *(Provide source)*	$	

SECTION X: MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension or parents DIC)*

40. MEDICAL, LAST ILLNESS, BURIAL, 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 any continuing family medical expenses such as the monthly Medicare deduction or nursing home costs you pay. 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 veteran's or his/her child's last illness and burial and the veteran's just debts. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Do not include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim.

AMOUNT PAID BY YOU	DATE PAID (mm/dd/yyyy)	PURPOSE (Medicare deduction, nursing home costs, burial expenses, etc.)	PAID TO (Name of nursing home, hospital, funeral home, etc.)	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.)
$				
$				
$				
$				
$				

SECTION XI: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of Treasury requires all Federal benefit payments 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 41, 42, and 43 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

41. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

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

Account No.:_____ Account No.:_____

42. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	43. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

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.

I certify I have received the notice attached to this application titled *Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.*

I certify I have enclosed all information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 44, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

44. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the box below **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

45A. CLAIMANT'S SIGNATURE **(REQUIRED)**	45B. DATE SIGNED

SECTION XIII: WITNESSES TO SIGNATURE *(COMPLETE ONLY IF CLAIMANT SIGNED ITEM 45A WITH AN "X")*

46A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	46B. PRINTED NAME AND ADDRESS OF WITNESS
47A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	**47B. PRINTED NAME AND ADDRESS OF WITNESS**

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or 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.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB 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, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. 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.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.

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.

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

Department of Veterans Affairs

INFORMATION AND INSTRUCTIONS TO HELP YOU COMPLETE THE AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

GENERAL INFORMATION

At VA, we recognize and respect the importance of privacy. Personal information that we collect is kept confidential to the extent provided by law. In accordance with the Privacy Act and applicable confidentiality statutes, VA will only disclose the information in its custody or control in the following circumstances: where the individual identifies the particular information and consents to its use; where disclosure of the information is required by law; or where the disclosure is otherwise legally permitted, including release for a purpose compatible with the purpose for which it was collected.

By law, VA must have your written permission (an "authorization") to use or give out your claim or benefit information for any purpose that is not permitted by all applicable legal authorities. You may revoke your written permission at any time, except if VA has already acted based on your permission.

SPECIFIC INSTRUCTIONS

Questions 1 - 6
In this section, give us your pertinent contact information to include name, address, contact numbers, and e-mail address.

Question 7
Tell us the type of information you would like VA to release to your authorized third party.

Question 9
This section tells VA the duration of your consent. If you do not want your authorization to be effective indefinitely, tell us when to stop releasing your personal benefit or claim information to your authorized third party. Check the box that applies and fill in dates, if applicable.

Question 10
VA will give your personal benefit or claim information to the person or organization you fill in here. You may only select one person or one organization. If you designate an organization, you must also identify one or more individuals in that organization to whom VA may disclose your benefit or claim information. This form cannot be used to disclose federal tax information to third parties.

Question 11
Select the security question you would like us to ask your designated third party and provide the answer. This question will be asked each time your designated third party contacts our office.

Where Do I Send My Completed Form?
You can obtain the VA mailing address to send your completed, signed authorization by accessing our Internet website at http://www.va.gov/directory or in the government pages of your telephone book under "United States Government, Veterans."

You should make a copy of your signed authorization for your records before mailing it to VA. You can only have one active VA Form 21-0845 on file with VA at a time.

WHAT IF I CHANGE MY MIND?
If you change your mind and do not want VA to give out your personal benefit or claim information, you may notify us in writing, or by telephone at 1-800-827-1000 or electronically via the Internet at https://iris.va.gov. Upon notification from you VA will no longer give out benefit or claim information (except for the information VA has already given out based on your permission).

(Continued on reverse)

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. This form may not be executed by any beneficiary recognized as incompetent for VA purposes, nor can VA accept this form from any beneficiary recognized as incompetent for VA purposes.

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 *ONE* 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:

Stephen Stone, Karen Weiss, William Weiss

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.

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

Veterans Angels Inc.

"Our tribute to those who have gone before, and our service to those who carry on"

501(c)(3)
Tax-Exempt
Public Charity

EIN Number
27-0204290

Regarding the form:

"Examination for Housebound Status or Permanent Need for Regular Aid and Attendance"

This form, 21-2680, must be signed by a Physician. The VA does not accept the signatures of R.N.'s or P.A.'s

****

Dear Physician:

Thank you for taking the time to fill out the Medical Statement. This is a Department of Veterans Affairs required form. It will help determine the eligibility of your patient for a VA benefit that helps defray the cost of long-term care.

Your completeness is very much appreciated.

Thank you,

Veterans Angels, Inc.
1 (888) 319-1117
www.vetangels.org

MAIL ONLY
10170 W. TROPICANA AVE., # 156-440 • LAS VEGAS, NV 89147-8465 • TOLL FREE **888-319-1117** • FAX 702-450-2259
VETANGELS@COX.NET • WWW.VETANGELS.ORG

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.

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: 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

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: *(Check one)*

☐ 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, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, 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.

RESPONDENT BURDEN: 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/omb/library/OMBINV.VA.EPA.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.

Care Expense Statement

For U.S. Department of Veterans Affairs Purposes

Section 1: General Information *(To be completed by the facility administrator or care provider. Please print.)*

VA claim number: _____

Veteran's name: _____

Patient's name: _____

Check the box which describes the patient's care status:

*☐ In-Home Care

☐ Nursing Home Care

☐ Other Care Facility *(Foster Home, Adult Day Care, Rest Home, Group Home, or Assisted Living)*

*Name of facility or care provider: _____

*Phone number of facility or care provider: _____

*Address of facility or care provider: _____

_____

_____

***Date** entered facility or **in-home care began**: _____

***Will the patient need this care indefinitely?** ☐ Yes ☐ No

If *No*, when will the care end? _____

***Total monthly charge for the patient:** $_____ per month

***Total Paid to provider by claimant in year _____.**

$_____

***Has the patient applied for Medicaid?** ☐ Yes ☐ No

***When did patient apply for Medicaid?** _____.

***Is part of the patient's cost covered by Medicaid, Medicare, or insurance?** ☐ Yes ☐ No

If *Yes*, please answer the following:

What is the source of the payment? _____

What is the monthly amount covered by this source? $_____ per month

When did coverage begin? _____

***What monthly amount does the veteran or patient pay from his/her own funds which is not reimbursed by one of the sources listed above?** *(If the patient is receiving Medicaid, what amount does Medicaid take from the patient?)* $_____ per month

If the patient is receiving Medicaid, attach a copy of the SDS-512 Medicaid Form.

Continue on page 2.
Be sure to sign and date in Section 6. → → → →

Section 2: In-Home Care Information *(To be completed by the care provider only if the patient is being provided in-home care.)*

*** Do you provide any medical or nursing services for the patient?**
(i.e. administering medication; physical or mental therapy; assisting with personal hygiene, dressing, bathing; etc.) ☐ Yes ☐ No

***Describe the services you provide:** _____

*Are you a licensed health professional? *(registered nurse, licensed vocational nurse, or licensed practical nurse* ☐ Yes ☐ No

If *Yes*, provide your license number: _____

****See Section 6 for documentation requirements for in-home care**

Section 3: Nursing Home Information *(To be completed by the facility administrator only if the patient is in a nursing home.)*

Is your facility licensed by the State? ☐ Yes ☐ No

Is your facility Medicaid approved? ☐ Yes ☐ No

Is the patient in your nursing home because of a physical or mental disability? ☐ Yes ☐ No

Do you provide either skilled or intermediate level nursing care to the patient? ☐ Yes ☐ No

What was the admitting diagnosis? _____

Section 4: Other Care Facility Information *(To be completed by the facility administrator only if the patient is in a foster home, adult day care, rest home, group home or assisted living.)*

Indicate type of facility: ☐ Foster Home ☐ Rest Home ☐ Assisted Living ☐ Adult Day Care ☐ Group Home ☐ Other: _____

Do you provide any medical or nursing services for the patient?
(i.e. administering medication; physical or mental therapy; assisting with personal hygiene, dressing, bathing; etc.) ☐ Yes ☐ No

Describe the services you provide: _____

If the patient receives medical or nursing services, are the services provided or supervised by a licensed health professional? *(registered nurse, licensed vocational nurse, or licensed practical nurse)* ☐ Yes ☐ No

We must have the monthly charge broken down into the following two categories:

1. Base Rate *(includes room, meals, laundry, housekeeping)*: $_____ per month
2. Medical and Nursing Services: $_____ per month

Section 5: In-Home Care Information *(To be completed by the care provider only if the patient is being provided in-home care.)*

To allow medical expenses for in-home caregivers, VA regulations require you to submit specific documentation of expenses from all of your caregivers.

What We Need:

In order to allow fees for the in-home attendants, receipts or other documentation is required. Documentation includes:

- A receipt bill
- Statement on the provider's letterhead
- Computer summary
- Ledger, or
- Bank statement

The Evidence Submitted Must Include

- The amount paid
- The date payment was made
- The purpose of the payment (the nature of the product or service provided)
- The name of the person to or for whom the product of service was provided
- Identification of the provider to whom payment was made

Note: A family member may be considered an in-home attendant only if he/she is actually ***being paid***. Documentation must be submitted.

Section 6: Signatures *(To be completed by the facility administrator/care provider and the veteran/beneficiary.)*

****I certify that the above statements are true and correct to the best of my knowledge and belief.**

_____ _____

Signature of facility administrator or **care provider** Date

****I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying $ _____ per month for my care from my own funds.**

_____ _____

Signature of veteran or beneficiary Date

Department of Veterans Affairs

INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

VA may be able to pay you at a higher rate if you identify expenses VA considers allowable. Continuing medical and dental expenses paid by you may be deductible from the income VA counts when determining your benefit entitlement.

In Items 5 and 6 below, identify any continuing medical or dental expenses that you paid for a member of your household (self, spouse, child, etc.) for which you were not reimbursed. Below are examples of expenses you should include, if applicable:

- Hospital expenses
- Doctor's office fees
- Dental fees
- Prescription/non-prescription drug costs
- Vision care costs
- Medical insurance premiums
- Monthly Medicare deduction
- Nursing home costs
- Hearing aid costs
- Dental fees
- Home health service expenses
- Expenses related to transportation to a hospital, doctor, or other medical facility

IMPORTANT NOTES

- Do not include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly notify the VA office handling your claim.
- If you are not sure whether a particular expense can be allowed, furnish a complete description of the purposes of the payment. We will let you know if an expense cannot be allowed.
- You may be asked to verify the amounts you actually paid, so keep all receipts or other documentation of payments for at lease 3 years after we make a decision on your medical expense claim. If you are unable to provide documentation of the claimed medical expenses when asked to do so by VA, your benefits may be retroactively reduced or terminated.
- If more space is needed to report expenses, attach a separate sheet of paper with columns corresponding to those on this form. Be sure to write your VA file number on any attachments.

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

RESPONDENT BURDEN: We need this information to determine whether medical expenses you paid may be used to reduce the amount of income we count in determining eligibility to benefits (38 U.S.C. 1503). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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

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.