Date: _____/_____ /_____

Part A:

VA Non-Service Connected Disability Pension Worksheet

Aid and Attendance

Veteran or Surviving Spouse Information

➢ **Veteran Information** Please check if deceased ☐

Veteran Name: _____ Date of Birth _____/_____/_____

Age: ____ Social Security Number _____ - _____ - _____ Place of Birth: _____

➢ **Veteran's Spouse** (if applicable)

Complete Name: _____ Maiden Name: _____

Age: ____ Social Security Number _____ - _____ - _____ Place of Birth: _____

➢ **Claimant** (person apply for this benefit) is a:

☐ Married Veteran ☐ Single Veteran ☐ Surviving Spouse

Claimant Phone Number (_____) _____-_____

➢ **Contact Person** (typically next of kin) Name: _____

Relationship to Veteran: ☐ Child ☐ Spouse ☐ Other: _____

Telephone Number(s): Home (_____) _____-_____ Work (_____) _____-_____

Cell (_____) _____-_____ Email:_____

Contact Address:_____

➢ **Assisted Living, Independent Living Community or Home Care Information**

Name of Community or Agency: _____

Address: _____

Contact Person: _____ Phone Number (_____) _____-_____

Current Resident Since: _____ Move-in Date: _____

Has the Claimant been diagnosed with any of the following?

☐ Cognitive Impairment ☐ Dementia ☐ Alzheimer's

Trust in Place? ☐ Yes ☐ No

Financial Powers of Attorney? ☐ Yes ☐ No

Are you the attorney in fact? ☐ Yes ☐ No

If no, please name _____

Senior Veteran Advisors, LLC

www.SeniorVA.com

Date: ____/____/____

Senior Veteran Advisors

Part B:
Financial Worksheet

Monthly Income:	**Veteran**	**Spouse**	**Total**
Social Security	_____	_____ =	_____
Long-term Care Insurance	_____	_____ =	_____
Retirement or Pension Income	_____	_____ =	_____
Retirement or Pension Income	_____	_____ =	_____
RMD from IRA / 401(k)	_____	_____ =	_____
Rental Income (net) or Other	_____	_____ =	_____
VA or Military *Disability* Income	_____	_____ =	_____
VA or Military *Retirement* Income	_____	_____ =	_____

Total Monthly Joint Income _____

Monthly Medical Expenses:			
Assisted or Independent Living		_____ _____ =	_____
In-home care		_____ _____ =	_____
Health & Dental Ins. Premium		_____ _____ =	_____
LTC Insurance Premium		_____ _____ =	_____
Medicare Deductions	Part B	_____ _____ =	_____
	Part D	_____ _____ =	_____

Total Monthly Medical Expenses - _____

Net Income[1] (income – expense) _____

Additional Expenses (estimates are acceptable):			
Pharmacy Bill	_____	_____ =	_____
Diabetic Supplies	_____	_____ =	_____
Incontinent Supplies	_____	_____ =	_____
Dialysis Direct and Oxygen	_____	_____ =	_____

Total Additional Medical Expenses[1] _____

Combined Net Worth (Please provide copies of statements if requested):			
Checking	_____	_____ =	_____
Savings	_____	_____ =	_____
CD's	_____	_____ =	_____
Stock, Bonds, Mutual Funds	_____	_____ =	_____
Annuities	_____	_____ =	_____
IRA / 401k	_____	_____ =	_____
Life Insurance (cash value)	_____	_____ =	_____
Other Assets	_____	_____ =	_____

Liquid Net Worth[2] _____

Own a Primary Resident? ☐ Yes ☐ No Own a Secondary Residence? ☐ Yes ☐ No
Estimated Value $ _____ Mortgage if any $ _____ Monthly Payment _____

1 - Not all expenses will necessarily qualify 2 - Proper Estate Planning can impact Countable Liquid Net Worth calculations.

The Veterans Administration can obtain access to an applicant's financial records. Please be as accurate as possible.

Recommendations on how to Complete "VA Form 21-2680" & "Supplemental 21-2680"

These are very important forms that must be signed and completed by a doctor (does not have to be a VA doctor). This is the only information the VA will use determine medical eligibility. Incomplete or inaccurate forms could result in a denial of benefits.

The claimant must have a medical condition or medical necessity requiring them to live in an assisted or protected environment and must be receiving and paying for that care.

The claimant must show a need for **Aid and Attendance,** and these forms must show:

- That he or she requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting themselves from the hazards of their daily environment;

OR

- Has corrected vision of 5/200 or less in both eyes; **OR**
- Has contraction of the concentric visual field to 5 degrees or less; **OR**
- Is a patient in a nursing home due to mental or physical incapacity; **OR**
- Is bedridden, in that their disability requires that they remain in bed apart from any prescribed course of convalescence or treatment.

VA Form 21-2680

Only Required for the Claimant

The following are some questions that need special attention and/or clarification.

#10. Complete Diagnosis: This cannot be left blank and the doctor must be VERY thorough in documenting major/minor conditions and problems. The DIAGNOSIS MUST BE WELL-SUBSTANTIATED IN THE REMAINDER OF THE QUESTIONS. A problem list from the doctor can also be attached.

#24A. Legally Blind: Please make sure the doctor also fills in the fields for 24B. An eye doctor's certification should be attached to certify that there is a corrected vision of 5/200 or less to be considered legally blind.

#27. Handle Financial Affairs: This is a question of mental capacity so if there is no diagnosis of mental incapacity like dementia and the doctor marks "NO" to this question, the VA might still deem the claimant as "mentally incompetent". In which case a fiduciary will have to be appointed to receive the benefit on behalf of the claimant and a 'Due Process Waiver' will be required (consult with the veteran's advocate that gave you these forms). Many times the claimant is cognitively able to handle financial affairs, families just choose otherwise for simplicity reasons or blindness.

#35B. Physician's Signature: Make sure that only the doctor signs this form and that he/she puts MD after their signature. PA or FNP signatures are not acceptable.

Supplemental 21-2680

Required for the Claimant and/or Spouse if Spouse is also Receiving and Paying for Care

In order for this form to help meet the medical criteria, question #6 and #7 must be a "NO" and question #8 must be a "Yes" with an explanation.

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.

SUPPLEMENTAL INFORMATION 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

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.

6. Is this patient able to live at home without assistance?	☐ Yes	☐ No
7. Can this patient adequately protect themselves from the hazards of their environment?	☐ Yes	☐ No

If no, please explain why and include a medical diagnosis for the inability.

8. Does this patient need to live in a protected environment due to mental or physical condition?	☐ Yes	☐ No

If yes, please explain.

REMARKS

PRINTED NAME OF EXAMINING PHYSICIAN	SIGNATURE AND **TITLE** OF EXAMINING PHYSICIAN	DATE SIGNED

NAME AND ADDRESS OF MEDICAL FACILITY	TELEPHONE NUMBER OF MEDICAL FACILITY

Acknowledgement of Services Offered by Senior Veteran Advisors, LLC

- Both Claimant and/or Claimant's Representative (I/we and/or Our) understand that Senior Veteran Advisors, LLC (SVA) is NOT a Government Agency and not affiliated with the Department of Veterans Affairs (VA).
- I/we understand that only the VA can approve or deny Our Application for VA Pension Benefits (Benefits). Therefore, SVA CANNOT and does not make any guarantees with regards to any approval of claims or the amount of Benefits awarded by the VA should an approval take place.
- I/we understand that SVA believes the information being provided to me is accurate and up to date but cannot make guarantees to the timeliness or accuracy of such information.
- I/we will use the information provided to me/us by SVA for lawful purposes only.
- I/we Acknowledge and Accept all terms, criteria, stipulations, provisions, etc. within SVA's Terms of Service and Disclosure Statement, fully incorporated herein. These documents have been made available to me both upon request and within SVA's website (www.seniorva.com).
- I/we recognize and acknowledge that we have been advised to seek professional advice from accredited professionals and/or an attorney of our choice regarding the information provided and the potentially negative impacts on Our qualification for Medicaid and/or other Government Benefits.
- I/we acknowledge that only VA Accredited representatives have worked on Our VA Application and that I/we have not relied upon the assistance of anyone who does not hold that Accreditation for assistance or advise as it pertains to Our Benefits.
- I/we acknowledge that I/we have NOT compensated SVA in any manner. Any education or information provided by SVA has been completely free of charge.
- I/we understand that SVA is compensated, as a privately held service company, for the information and marketing assistance it provides to financial, insurance, tax and other professionals, which have indicated to us their accreditation and areas of practice.
- Both Claimant and Claimant's Representative independently Acknowledge and Accept full liability associated with the information that I/we have provided SVA and Providers and/or the actions I/we take as they pertain to Our Benefits and/or the pre-planning for Our Benefits and/or any adverse impacts Our actions may have on any other Government Benefit (Medicaid). Furthermore, I/we will hold harmless and indemnify, including all fees and reasonable costs of attorney(s), SVA, its Executives, Providers and/or Representative(s) from any issue(s) arising from Our Application for Benefits and/or Medicaid.

By offering these invaluable services to our Veterans, surviving spouses and their families, SVA hopes that you will find the assistance to be helpful, professional, knowledgeable and courteous. We appreciate the opportunity to help you and hope you think of SVA if you or any member of your family or friends needs any of the services we offer. This is what enables us to continue to offer free services to all of the families we assist.

Name of claimant: _____

Signature: _____ Date: _____

Name of claimant's representative: _____

Signature: _____ Date: _____