VA Benefit Surviving Spouse --- Application Checklist

Dept of Veteran Affairs: Phone# 1-800-827-1000
VA Pension Maintenance Center: Phone# 1-877-294-6380

VA Form 21-534

Application for Aid & Attendance Pension Benefit for surviving spouse of a veteran
Spouse must sign on page 8. VA does NOT recognize POA.
Sections on children do not apply. Cross through with an X.
******See attached (sample of pg 7 of app --- for reporting "allowable" medical expenses)***

VA Form 21-0845

Authorization to Disclose Personal Information to a Third Party
Allows a family member to check the status of a claim. Only one authorized party allowed.

VA Form 21-4142

Authorization and consent to release information to the VA
#7B –Dates---Enter "Ongoing" #7C-Conditions---Should match Form 21-2680

VA Form 21-2680 (Sample attached)

Examination for Housebound Status or Permanent Need for Aid & Attendance
This form is to be **completed by family member** and signed by a licensed physician.

Care Provider Statement

Completed and signed by the Assisted Living Facility, nursing home or home health care company providing services.

Discharge Papers --- DD-214

To order a certified copy of discharge papers – Go to: www.archives.gov/veterans
*****Must send original document or certified copy! Not a photocopy!**

Social Security & Pension Statements

Send copy of Soc Sec Benefit Summary statement and/or 1099 for pension if applicable
To order a soc sec statement – Go to: www.ssa.gov/mystatement

Marriage Certificate and Death Certificate is required.

Photocopy of both is sufficient.

***Please note: The processing time for surviving spouse application may exceed 6 months**

Veteran's Advisor Group is a private company and not part of the VA. The information on this page is based on our experience and is not provided by the VA. **Do NOT submit this form to the VA!**

Veteran's Advisor Group

Phone: 480-813-1027 Fax: 480-539-5620 Email: vapensionbenefit@gmail.com

Department of Veterans Affairs

OMB Approved No. 2900-0004
Respondent Burden: 1 hour 15 minutes

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable)
VA Form 21-534

Please read the attached "General Instructions" before you fill out this form.

SECTION I

Tell us what you are applying for and what you and the deceased veteran have applied for

1. Did the veteran ever file a claim with VA? ☐ YES ☐ NO *(If "Yes," answer Item 2)*

2. What is the VA file number?

3. Has the surviving spouse or child ever filed a claim with VA? ☐ YES ☐ NO *(If "Yes," answer Items 4 through 6)*

4. What is the VA file number?

5. What is the name of the person on whose service the claim was filed?
First Middle Last

6. What is your relationship to that person?

7. Are you claiming service connection for cause of death? ☐ YES ☐ NO

SECTION II

Tell us about you and the deceased veteran

8. What is the veteran's name?
First Middle Last Suffix *(If applicable)*

9. What is the veteran's Social Security number?

10a. Did the veteran serve under another name? ☐ YES ☐ NO *(If "Yes," answer Item 10b)*

10b. Please list the other name(s) the veteran served under:

11. What is the veteran's date of birth?
mo day yr

Attach a copy of the death certificate unless the veteran died in active service of the Army, Navy, Air Force, Marine Corps, or Coast Guard, or in a U.S. government institution.

12. What is the veteran's date of death?
mo day yr

13. Was the veteran a former prisoner of war? ☐ YES ☐ NO

14. What is your name? *(First, Middle, Last Name)*

15. What is your relationship to the veteran? *(check one)* ☐ Surviving Spouse ☐ Child

16. What is your address?
Street address, Rural Route, or P.O. Box Apt. number
City State ZIP Code Country

17. What are your telephone numbers? *(Include Area Code)*
Daytime
Evening

18. What is your e-mail address?

19. What is your Social Security number?

20. What is your date of birth?
mo day yr

SECTION III

Tell us about the veteran's active duty service

1. Enter complete information for all periods of service. If more space is needed use Item 48 "Remarks."

2. If the veteran never filed a claim with VA, attach the original DD214 or a certified copy for each period of service listed. We will return original documents to you.

Note: Skip to Section IV if the veteran was receiving VA compensation or pension at the time of his/her death.

21a. Entered Active Service *(first period)* ____ mo day yr	21b. Place	21c. Service Number	
21d. Left This Active Service ____ mo day yr	21e. Place	21f. Branch of Service	21g. Grade, Rank, or Rating
21h. Entered Active Service *(second period)* ____ mo day yr	21i. Place	21j. Service Number	
21k. Left This Active Service ____ mo day yr	21l. Place	21m. Branch of Service	21n. Grade, Rank, or Rating

SECTION IV

Tell us about your and the veteran's marriages

Attach a copy of your marriage certificate showing your marriage to the veteran.

You must furnish complete information about ***all*** marriages of the surviving spouse and the veteran. If you need additional space, please attach a separate sheet of paper providing the requested information.

If you are claiming benefits as the surviving spouse of the veteran you should complete Items 22a through 27. If you are not the surviving spouse, skip to Section V.

The veteran's marriages

22a. How many times was the veteran married? _____

22b. Date of Marriage *(month, day, year)*	22c. Place *(city/state or country)*	22d. To whom married *(first, middle initial, last name)*	22e. Type of marriage *(ceremonial, common-law, proxy, tribal or other*	22f. Date marriage ended *(month, day, year)*	22g. Place *(city/state or country)*	22h. How marriage ended *(death, divorce)*

22i. If you indicated "other" as type of marriage, please explain. _____

22j. 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 you answered "Yes," please explain.

23a. How many times were you married? ____ 23b. Have you remarried since the death of the veteran? ☐ YES ☐ NO

23c. Date of Marriage *(month, day, year)*	23d. Place *(city/state or country)*	23e. To whom married *(first, middle initial, last name)*	23f. Type of marriage *(ceremonial, common-law, proxy, tribal or other*	23g. Date marriage ended *(month, day, year)*	23h. Place *(city/state or country)*	23i. How marriage ended *(death, divorce)*

23j. If you indicated "other" as type of marriage, please explain. _____

SECTION IV Tell us about your and the veteran's marital history (continued)

Answer Item 24 only if you were married to the veteran for less than one year.

24. Was a child born to you and the veteran during your marriage or prior to your marriage?

☐ YES ☐ NO

25. Are you expecting the birth of a child of the veteran?

☐ YES ☐ NO

26. Did you live continuously with the veteran from the date of marriage to the date of his/her death?

☐ YES ☐ NO

(If "No", answer Item 27)

27. 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.

SECTION V

Tell us about the unmarried children of the veteran

Note: You should provide a copy of the public record of birth or a copy of the court record of adoption for each child listed in Item 28a *unless* the veteran was receiving additional VA benefits for the child.

If you need additional space, please attach a separate sheet of paper providing the requested information about each child.

Note: Skip to Section VI if you are not claiming benefits for any children that meet the following criteria.

VA recognizes the veteran's biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:

- under age 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- of any age if they became permanently unable to support themselves before reaching age 18.

"Seriously disabled" (Item 29e) means that the child became permanently unable to support himself/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

Note to surviving spouse: If entitlement to DIC is established, a "seriously disabled" child over age 18 is entitled to receive DIC benefits in his or her own right. A veteran's child who is seriously disabled and over age 18 must submit a separate VA Form 21-534 to apply for benefits.

28a. Name of child *(First, middle initial, Last)*	28b. Date and place of birth *(City/State or Country)*	28c. Social Security Number	29a. Biological	29b. Adopted	29c. Stepchild	29d. 18 - 23 yrs old and in school	29e. Seriously disabled	29f. Child previously married
	mo day yr		☐	☐	☐	☐	☐	☐
	mo day yr		☐	☐	☐	☐	☐	☐
	mo day yr		☐	☐	☐	☐	☐	☐

SECTION V Tell us about the unmarried children of the veteran (continued)

Tell us about the children listed above that don't live with you.

30a. Name of child *(first, middle initial, last)*	30b. Child's Complete Address	30c. Name of person the child lives with *(if applicable)*	30d. Monthly amount you contribute to child's support
			$
			$
			$
			$

SECTION VI

Tell us if you are housebound, in a nursing home or require aid and attendance

If you answered "yes" to Item 31 and are not in a nursing home, submit a statement from your doctor showing the extent of your disabilities. If you are in a nursing home, attach a statement signed by an official of the nursing home showing the date you were admitted to the nursing home, the level of care you receive, the amount you pay out-of-pocket for your care, and whether Medicaid covers all or part of your nursing home costs.

31. Are you claiming aid and attendance allowance and/or housebound benefits because you need the regular assistance of another person, are having severe visual problems, or are housebound?

☐ YES ☐ NO

(If "No," skip to section VII)

32a. Are you now in a nursing home?

☐ YES ☐ NO

(If "Yes," answer Items 32b and 32c also)

32b. What is the name and complete mailing address of the facility?

32c. Does Medicaid cover all or part of your nursing home costs?

☐ YES ☐ NO

(If "No," answer Item 32d also)

32d. Have you applied for Medicaid?

☐ YES ☐ NO

SECTION VII

Tell us the net worth of you and your dependents

Note: If you are filing this application on behalf of a minor or incompetent child of the veteran and you are the child's custodian, you must report your net worth as well as the net worth of the child for whom benefits are claimed.

VA cannot pay you pension if your net worth is sizeable. Net worth is the market value of all interest and rights you have in any kind of property less any mortgages or other claims against the property. However, net worth does not include the house you live in or a reasonable area of land it sits on. Net worth also does not include the value of personal things you use everyday like your vehicle, clothing, and furniture. You must report net worth for yourself and all persons for whom you are claiming benefits.

For Items 33a through 33f, provide the amounts. If none, write "0" or "None."

Source	Surviving spouse or Custodian of children	Child(ren)		
		Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*
33a. Cash, bank accounts, certificates of deposit (CDs)				
33b. IRAs, Keogh Plans, etc.				
33c. Stocks, bonds, mutual funds				
33d. Value of business assets				
33e. Real property *(not your home)*				
33f. All other property				

SECTION VIII

Tell us about the income of you and your dependents

Payments from any source will be counted, unless the law says that they don't need to be counted. Report all income, and VA will determine any amount that does not count.

Note: If you are filing this application on behalf of a minor of whom you are the custodian, you must report your income as well as the income of each child for whom benefits are claimed.

Report the total amounts before you take out deductions for taxes, insurance, etc.
Do not report the same information in both tables.
If you expect to receive a payment, but you don't know how much it will be, write "Unknown" in the space.
If you do not receive any payments from one of the sources that we list, write "0" or "None" in the space.
If you are receiving monthly benefits, give us a copy of your most recent award letter. This will help us determine the amount of benefits you should be paid.

34a. Have you claimed or are you receiving benefits from the Social Security Administration on your own behalf or on behalf of child(ren) in your custody?

☐ YES ☐ NO

(If "Yes," answer item 34b)

34b. Is Social Security based on your own employment?

☐ YES ☐ NO

35. Has a surviving spouse or child filed a claim for compensation from the Office of Worker's Compensation Programs based on the death of the veteran?

☐ YES ☐ NO

36. Has a court awarded damages based on the death of the veteran or is a claim or legal action for damages pending?

☐ YES ☐ NO

37. Have you claimed or are you receiving Survivor Benefit Plan (SBP) annuity from a service department based on the death of the veteran?

☐ YES ☐ NO

SECTION VIII Tell us about the income of you and your dependents (continued)

Monthly Income - Tell us the income you and your dependents receive every month

Source	Surviving spouse or Custodian of children	Child(ren)		
		Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*
38a. Social Security				
38b. U.S. Civil Service				
38c. U.S. Railroad Retirement				
38d. Military Retirement				
38e. Black Lung Benefits				
38f. Supplemental Security Income (SSI)/ Public Assistance				
38g. Other income received monthly *(Please write source below:)*				

Expected income next 12 months - Tell us about other income for you and your dependents

Report expected 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 income for the 12 month period from the date you sign this application.

Sources of income for the next 12 months	Surviving spouse or Custodian of children	Child(ren)		
		Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*	Name: *(first, middle initial, last)*
39a. Gross wages and salary				
39b. Total dividends and interest				
39c. Other income expected *(Please write source below:)*				
39d. Other income expected *(Please write source below:)*				

SECTION IX

Tell us about 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. If more space is needed attach a separate sheet.

40a. Amount paid by you	40b. Date Paid	40c. Purpose *(Medicare deduction, nursing home costs, burial expenses, etc.)*	40d. Paid to *(Name of nursing home, hospital, funeral home, etc.)*	40e. Relationship of person for whom expenses paid
$	mo day yr			
$	mo day yr			
$	mo day yr			
$	mo day yr			

SECTION X

Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, ***"All Federal payments..."*** and then either:

1. Attach a voided check, or
2. Answer questions 41-43 to the right.

All Federal payments beginning January 2, 1999, must 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 we will give you a waiver from Direct Deposit, just check the box below in Item 41. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

41. Account number *(Please check the appropriate box and provide that account number, if applicable)*

☐ Checking ☐ Savings

☐ I certify that I **do not** have an account with a financial institution or certified payment agent

Account number _____

42. Name of financial institution

_____

43. Routing or transit number

_____

— SAMPLE —

SECTION IX

Tell us about 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. If more space is needed attach a separate sheet.

40a. Amount paid by you	40b. Date Paid	40c. Purpose *(Medicare deduction, nursing home costs, burial expenses, etc.)*	40d. Paid to *(Name of nursing home, hospital, funeral home, etc.)*	40e. Relationship of person for whom expenses paid
$ 36,000 -	JAN 2012 Thru mo day yr Dec 2012	Projected Assisted Living	ABC Care Home	self
$ 1,200 -	JAN 2012 Thru mo day yr Dec 2012	Projected Medicare Part B	social security	self
$	mo day yr			
$	mo day yr			

SECTION X

Give us direct deposit information

If benefits are awarded we will need more information in order to process any payments to you. Please read the paragraph starting with, ***"All Federal payments..."*** and then either:

1. Attach a voided check, or
2. Answer questions 41-43 to the right.

All Federal payments beginning January 2, 1999, must 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 we will give you a waiver from Direct Deposit, just check the box below in Item 41. The Treasury Department is working on making bank accounts available to you. Once these accounts are available, you will be able to decide whether you wish to sign-up for one of the accounts or continue to receive a paper check. You can also request a waiver if you have other circumstances that you feel would cause you a hardship to be enrolled in Direct Deposit. You can write to: Department of Veterans Affairs, 125 S. Main Street Suite B, Muskogee OK 74401-7004, and give us a brief description of why you do not wish to participate in Direct Deposit.

41. Account number *(Please check the appropriate box and provide that account number, if applicable)*

☐ Checking ☐ Savings

☐ I certify that I **do not** have an account with a financial institution or certified payment agent

Account number _____

42. Name of financial institution

_____

43. Routing or transit number

_____

SECTION XI

Give us your signature

1. Read the box that starts, "I certify and authorize the release of information:"
2. Sign the box that says, "Your signature."
3. If you sign with an "X," then you must have 2 people you know witness you as you sign. They must then sign the form and print their names and addresses also.

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.

44. Your signature	45. Today's date

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

SECTION XII

Remarks - Use this space for any additional statements that you would like to make concerning your application.

48. Remarks *(If you need more space to answer a question or have a comment about a specific item number on this form please identify your answer or statement by the part and item number)*

IMPORTANT

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, or for the fraudulent acceptance of any payment which you are not entitled to.

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

Department of Veterans Affairs

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

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

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

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

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

4. VA FILE NUMBER	5. SOCIAL SECURITY NUMBER

6. CONTACT INFORMATION

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

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

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

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

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

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

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

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 Approved No. 2900-0001
Respondent Burden: 5 Mins.

Department of Veterans Affairs

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

Important Notice About Information Collection: 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 www.whitehouse.gov/library/omb/OMBINVC.html#VA. 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. VETERAN'S VA FILE NUMBER
3. CLAIMANT'S NAME *(If other than Veteran)* LAST NAME, FIRST NAME, MIDDLE NAME	4. VETERAN'S SOCIAL SECURITY NUMBER
5. RELATIONSHIP OF CLAIMANT TO VETERAN	6. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF INFORMATION

7A. LIST THE NAME AND ADDRESS OF THE SOURCE SUCH AS A PHYSICIAN, HOSPITAL, ETC. *(Include ZIP Codes, and also a telephone number, if available)*	7B. DATE(S) OF TREATMENT, HOSPITALIZATIONS, OFFICE VISITS, DISCHARGE FROM TREATMENT OR CARE, ETC. *(Include month and year)*	7C. CONDITION(S) *(Illness, injury, etc.)*

8. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 9C.

SECTION III - CONSENT TO RELEASE INFORMATION

READ ALL PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 9C.

9A. 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 Rehabilitation Records - VA, and 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.

9B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 7A 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 7A 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 7A. 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).

9C. I (AUTHORIZE) (DO NOT AUTHORIZE) the source shown in Item 7A 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:

_____

_____

10A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	10B. 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)*	10C. DATE

10D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*	10E. 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.

11A. SIGNATURE OF WITNESS	11B. DATE

11C. MAILING ADDRESS OF WITNESS

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?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*		

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	13. HEIGHT
		ACTUAL: LBS. ESTIMATED: LBS.	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)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

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.

— SAMPLE —

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
John W. Smith	—	self

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER
123-45-6789	—	

6. DATE OF EXAMINATION	7. HOME ADDRESS
1-3-12	veteran's physical address

8A. IS CLAIMANT HOSPITALIZED?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☒ NO *(If "Yes," complete Items 8B and 9)*	—	—

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)*
Dementia, Alzheimer's, Severe Osteoporosis, Neuropathy

11A. AGE	11B. SEX	12. WEIGHT	13. HEIGHT
87	M	ACTUAL: LBS. ESTIMATED: LBS. 145	FEET: 5 INCHES: 7

14. NUTRITION	15. GAIT
Normal	shuffles

16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?
120/80	72		Dementia, Alzheimers

20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED
From 9 PM To 9 AM: 12 From 9 AM To 9 PM: 4

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 Claimant needs regular assistance with bathing and other hygiene needs.

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☒ NO		

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*
☒ YES ☐ NO Claimant needs to be in a secure protected environment. Claimant needs regular care + assistance with ADL's

26. DOES CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*
☒ YES ☐ NO Claimant has Dementia. Needs regular assistance with med. mgmt.

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*
☐ YES ☒ NO Dementia. Cannot understand financial affairs.

VA FORM JUN 2008 **21-2680**

SUPERSEDES VA FORM 21-2680, OCT 1992, WHICH WILL NOT BE USED.

— SAMPLE —

28. POSTURE AND GENERAL APPEARANCE *(Attach a separate sheet of paper if additional space is needed)*
Poor posture. Difficulty standing up straight. Hunched over.

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)*
Difficulty gripping objects. Unable to open cans, jars. General weakness in arms and hands. Arthritis. Needs help with eating. Cannot feed himself. Needs assistance with dressing and tending to hygiene needs. Needs assistance with bathing and Toileting.

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.
Weakness in legs. Muscular atrophy. Very limited motion without assistance. Weight bearing issues. Poor balance - FALL RISK. CANNOT propel self forward without assistance.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK
Limited mobility. General tightness and stiffness.

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.
INCONTINENCE - No control of bladder. Dizziness causing poor balance. FALL RISK
Memory Loss: General decline from advancing age. Cannot perform self care. Needs assistance with bathing, dressing, eating, Toileting. CANNOT ambulate without assistance. Typical day is spent in room - bed or chair.

33. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES
Claimant cannot and does not leave premises without assistance. Confined to care home. Only leaves premises for doctors appointments.

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)* Walker / wheelchair ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* 5-10 feet

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)*

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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.

Care Provider Statement

Name of Claimant:	Social Security #:
Name of Veteran:	Social Security #:

Facility/Agency Information (to be completed by a Facility/Agency Official)

Name of Care Facility/Agency:	Address:
Phone #:	

Type of service provided: *(please circle)* Skilled Nursing Home | Assisted Living Facility | Rest Home (Senior Living Facility) | Home Care Agency

Date services began *(Month, Day, Year)*	Does Medicaid pay any portion of the monthly care expense:
_____/_____/_____	**YES / NO** *(if yes, provide a breakdown on a separate page)*
Amount claimant is responsible for out of pocket each Month	Amount claimant is expected to pay out of pocket in the next 12 months
$_____	$_____

This facility/agency provides the following services:

Services:	Yes	No
Assistance with Activities of Daily Living (dressing, bathing, toileting, hygiene)		
Daily monitoring of claimant to ensure health, safety, nutrition, etc.		
24 hours on-sight staff to monitor and respond to emergency alert system		
"Protected environment" to protect the claimant from the hazards and dangers of daily living		
"Secure environment" – entry and exit of the facility is monitored 24 hours/day		
Medication management		
Meal preparation		
Assistance with ambulating		
Homemaker services		
Transportation to medical appointments		

I certify that the claimant requires the services of this facility/agency because of mental or physical disabilities and is receiving such care/services.

Signature of official:	Title:
Official's Printed Name:	Date Signed:

Mailing Instructions

You must keep a copy of all documents submitted to the VA for your records.

Submit the application packet return receipt US Mail or other shipping which provides proof of delivery such as FedEx or UPS. Once the package has been delivered, keep proof of delivery with your copy of the VA application packet.

The application should be mailed to the VA Pension Maintenance Center, as listed below, where the Veteran resides. You should receive a letter of acknowledgement from the VA within 45 days of mailing. If not, please call the Department of Veterans Affairs at 877-294-6380 to confirm their receipt.

Philadelphia Pension Maintenance Center Veterans Administration 5000 Wissahickon Avenue Philadelphia, PA 19144	Philadelphia processes applications for residents of the following states: ME,VT, NH, MA, RI, CT, NY, PA, NJ, DE, MD, DC, WV, VA, NC, SC, GA, FL, and PR
Milwaukee Pension Maintenance Center Veterans Administration 5400 West National Avenue Milwaukee, WI 53214	Milwaukee processes applications for residents of the following states: WI, MI, IL, IN, OH, MO, KY, TN, AR, LA, MS, and AL
St. Paul Pension Maintenance Center Veterans Administration 1 Federal Drive, Fort Snelling St. Paul, MN 55111-4050	St. Paul processes applications for residents of the following states: MN, IA, ND, SD, NE, KS, OK, TX, MT, WY, CO, NM, ID, UT, AZ, WA, NV, OR, CA, AK, and HI