Veteran's Benefit --- Application Checklist

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

VA Form 21-527EZ

Fully Developed Claim for Pension with Aid & Attendance
Use this form for the following scenarios:
1) Single veteran filing claim for himself/herself
2) Veteran & spouse – veteran is claimant who needs care
3) Veteran & spouse – spouse is claimant who needs care

This form must be complete with all necessary documents included for expedited processing.
******See attached (sample of pg 5 of app---for reporting income and "allowable" medical expenses)***

VA Form 21-686c

Declaration of Status of Dependents
If married, include photocopy of marriage certificate.
Note: Dependent children section does not apply. Cross through and write N/A

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 21-2680 (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 physician.
If both veteran & spouse require care, complete a form for each.

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

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

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

FULLY DEVELOPED CLAIM
(PENSION)

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

SECTION I: TO BE COMPLETED BY VETERAN

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

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

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

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

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

A. DISABILITY(IES)	B. DATE BEGAN

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

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

SECTION II: SERVICE INFORMATION

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

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

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

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

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

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

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

SECTION III: WORK HISTORY

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

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

SECTION III: INCOME VERIFICATION

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

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

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

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

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

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

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

SECTION V: MEDICAL, LEGAL OR OTHER UNREIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. If more space is needed continue on page 6 or attach a separate sheet.

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

— SAMPLE —

SECTION III: INCOME VERIFICATION

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

SOURCE	VETERAN	SPOUSE
SOCIAL SECURITY	$ 1,248 - (GROSS)	$ 618 -
U.S. CIVIL SERVICE	-0-	-0-
U.S. RAILROAD RETIREMENT	-0-	-0-
BLACK LUNG BENEFITS	-0-	-0-
MILITARY RETIREMENT	-0-	-0-
OTHER *(Show source below)* Pension - U.S. Digital	$ 614 -	-0-

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

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

SOURCE	VETERAN		SPOUSE	
GROSS WAGES FROM ALL EMPLOYMENT	$ -0-	-0-	$ -0-	-0-
TOTAL INTEREST AND DIVIDENDS	$ 108 - (2011)	$ 74 (2012)	$ 108 - (2011)	$ 74 (2012)
ALL OTHER *(Show source below)*	-0-	-0-	-0-	-0-
ALL OTHER *(Show source below)*	-0-	-0-	-0-	-0-

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

SOURCE	VETERAN	SPOUSE
CASH/NON-INTEREST-BEARING BANK ACCOUNTS	$ 1,100 -	$ 1,100 -
INTEREST-BEARING BANK ACCOUNTS	4,850 -	4,850 -
IRA'S, KEOGH PLANS, ETC.	-0-	-0-
STOCKS, BONDS, MUTUAL FUNDS, ETC.	-0-	-0-
REAL PROPERTY *(Not your home)*	-0-	-0-
ALL OTHER PROPERTY	-0-	-0-

SECTION V: MEDICAL, LEGAL OR OTHER UNREIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. Do not include any expenses for which you were reimbursed. If more space is needed continue on page 6 or attach a separate sheet.

19A. Amount paid by you	19B. Date paid	19C. Purpose *(Doctor's fees, hospital charges, attorney fees, etc.)*	19D. Paid to *(Name of doctor, hospital, pharmacy, etc.)*	19E. Disability or relationship of person for whom expenses paid
$ 36,000 -	JAN 2012 Thru Dec 2012	Projected Assisted Living	ABC Care Home	self
$ 1,200 -	JAN 2012 Thru Dec 2012	projected medicare Part B	social security	self

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

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

SECTION VI: DIRECT DEPOSIT INFORMATION

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

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

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

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

SECTION VII: CERTIFICATIONS AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

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

SECTION VIII: WITNESSES TO SIGNATURE

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

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FULLY DEVELOPED CLAIM CERTIFICATION
(PENSION)

Name _____ **Date** _____

Claim Number _____

Social Security Number _____

Your signature on this response will not affect:

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

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

_____ _____

Claimant/Representative's Signature Date

OMB 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 <u>ONE</u> SECURITY QUESTION BOX IN 11A AND PROVIDE THE ANSWER IN 11B.

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

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

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

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Approved No. 2900-0043
Respondent Burden: 15 minutes

Department of Veterans Affairs — DECLARATION OF STATUS OF DEPENDENTS

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 Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your and your dependents' SSN account information is mandatory. Applicants are required to provide their SSN and the SSN of any dependents for whom benefits are claimed under Title 38 USC 5101 (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 Federal Statute of law in effect prior to January 1, 1975, and still in effect. 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 marital status and eligibility for an additional allowance for dependents under 38 U.S.C. 1115. 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 unless a valid OMB 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.

INSTRUCTIONS: Print all answers clearly. Make sure you sign and date this form (Items 17 and 18). Note: Unless the claimant is the veteran's surviving spouse, the veteran must sign in Item 17. When you have completed this form, mail it or take it to a VA regional office.

1A. FIRST - MIDDLE - LAST NAME OF VETERAN	2A. NAME OF CLAIMANT *(If other than veteran)*	3. FILE NUMBER
1B. VETERAN'S SOCIAL SECURITY NUMBER	2B. CLAIMANT'S SOCIAL SECURITY NUMBER	C-

4A. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*

4B. E-MAIL ADDRESS OF CLAIMANT *(If applicable)*

5A. MARITAL STATUS *(Check one)*
☐ MARRIED ☐ DIVORCED ☐ NEVER MARRIED *"(If checked, skip to Item 14)"*
☐ WIDOWED ☐ SEPARATED

5B. IF MARRIED, SPOUSE'S DATE OF BIRTH
_____
month day year

NOTE: You must furnish complete information about all your and your current spouse's previous marriages. If you or your spouse have been married more than three times, list additional marriages in Item 17, "Remarks," or attach a separate sheet.

SECTION I - VETERAN'S MARRIAGES

6. HOW MANY TIMES HAVE YOU BEEN MARRIED? *(Including current marriage)*

7A. DATE AND PLACE OF MARRIAGE *(City/State or Country)*	7B. TO WHOM MARRIED *(First, middle, last name)*	7C. SOCIAL SECURITY NUMBER	7D. HOW MARRIAGE TERMINATED *(Death, Divorce)*	7E. DATE AND PLACE TERMINATED *(City/State or Country)*
_____ *month day year* *Place:*				
_____ *month day year* *Place:*				_____ *month day year* *Place:*
_____ *month day year* *Place:*				_____ *month day year* *Place:*

SECTION II - SPOUSE'S PREVIOUS MARRIAGES

8. HOW MANY TIMES HAS THE VETERAN'S CURRENT SPOUSE OR SURVIVING SPOUSE BEEN MARRIED? *(Including current marriage)*

9A. DATE AND PLACE OF MARRIAGE	9B. TO WHOM MARRIED *(First, middle, last name)*	9C. HOW MARRIAGE TERMINATED *(Death, Divorce)*	9D. DATE AND PLACE TERMINATED
_____ *month day year* *Place:*			_____ *month day year* *Place:*
_____ *month day year* *Place:*			_____ *month day year* *Place:*
_____ *month day year* *Place:*			_____ *month day year* *Place:*

10A. IS YOUR SPOUSE ALSO A VETERAN?	10B. WHAT IS YOUR SPOUSE'S VA FILE NUMBER *(If any)*?
☐ YES ☐ NO *(If "Yes," answer Item 10B also. If "No," skip to Item 11.)*	
11. DO YOU LIVE WITH YOUR SPOUSE?	12. WHAT IS YOUR SPOUSE'S ADDRESS?
☐ YES ☐ NO *(If "Yes," skip to Item 14A. If "No, answer Items 12 and 13 also.)*	
13. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT?	
$	

SECTION III - VETERAN'S UNMARRIED CHILDREN

NOTE: If any child is claimed as "seriously disabled" (Item 14H), it must be shown that the child became permanently unable to support him/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: In Items 14A through 14I, check all boxes that apply.

14A. NAME OF CHILD *(first, middle initial, last)*	14B. DATE AND PLACE OF BIRTH *(city, state or country)*	14C. SOCIAL SECURITY NUMBER	14D. BIO - LOGICAL	14E. ADOPT - ED	14F. STEP - CHILD	14G. 18-23 YRS. OLD AND IN SCHOOL	14H. SERIOUSLY DISABLED	14I. CHILD PREVIOUSLY MARRIED
	_____ *mo day yr* *PLACE:*		☐	☐	☐	☐	☐	☐
	_____ *mo day yr* *PLACE:*		☐	☐	☐	☐	☐	☐
	_____ *mo day yr* *PLACE:*		☐	☐	☐	☐	☐	☐

Note: If any of the children listed above don't live with you, complete Items 15A through 15C.

15A. NAME OF CHILD *(First, middle initial, last)*	15B. CHILD'S COMPLETE ADDRESS	15C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable)*

16. REMARKS

I HEREBY CERTIFY THAT the information I have given above is true and correct to the best of my knowledge and belief.

17. SIGNATURE OF CLAIMANT	18. DATE	19. TELEPHONE NUMBER (S) *(Include Area Code)*	
		A. DAYTIME	B. NIGHTTIME

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 to which you are not entitled.

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