DEPARTMENT OF VETERANS AFFAIRS

VETERANS PENSION BENEFITS 2021

Our staff of VA trained and accredited County Veteran Service Officers can answer your questions, assist in completing the necessary VA forms, and act as the veteran's advocate through the claim process.

ALL SERVICES ARE PROVIDED FREE OF CHARGE.

LAKE COUNTY VETERANS SERVICE OFFICE

An Office of Lake County Government
Located in Building C of the Lake County Administration Center

105 Main St.,
Painesville, OH 44077
(440) 350-2904/2567
Fax (440) 350-5980

If you are a veteran whose disabilities prevent employment or overwhelmed with the high cost of medical care, such as paying for assisted living facilities, home care aides, adult daycare, or skilled nursing, the VA Pension benefit could be the solution to help pay for this care. A wartime veteran with limited income and net worth may be eligible to receive this benefit.

There are three levels of VA Pensions:

Basic Pension—for veterans who are disabled ***OR*** age 65 or older with low income

Aid & Attendance (A&A) – for veterans that require assistance with their activities of daily living

Housebound – for veterans with a permanent disability that prevents them from leaving their home.

You may be eligible if:

- you were discharged from military service under other than dishonorable conditions; ***AND***
- you served 90 days of active duty or more with at least 1 day during a war time period*; ***AND***
- your annual household income and net worth** meet certain limits set by law; ***AND***
- you are permanently and totally disabled, ***OR*** age 65 or older.

*To find the dates of service considered as war time periods, visit: www.va.gov/pension/wartime period. Veterans who enlisted after September 7, 1980 generally must have served at least 24 months of active duty

PENSION RATES effective 12/1/2020	MAXIMUM MONTHLY BENEFIT	MAXIMUM HOUSEHOLD ANNUAL INCOME***
Basic Pension with no dependents	$1,160.00	$13,931.00
Basic Pension with 1 dependent	$1,520.00	$18,243.00
With Housebound benefits with no dependents	$1,418.00	$17,024.00
With Housebound benefits with one dependent	$1,778.00	$21,337.00
With Aid and Attendance with no dependents	$1,936.00	$23,238.00
With Aid and Attendance with one dependent	$2,295.00	$27,549.00
Veteran in Nursing Home receiving Medicaid benefits	$90.00	N/A

***** OUT OF POCKET MEDICAL EXPENSES PAID BY THE HOUSEHOLD ARE USED TO REDUCE THE HOUSEHOLD INCOME.**

Please see the examples on page 2.

****HOUSEHOLD NET WORTH LIMIT MUST BE UNDER $130,773.00**

(as of 12/01/2020 –changes annually) Net worth is the sum of household assets and annual income. It does NOT include a primary residence and lot under 2 acres, automobile, or personal effects. As of 10/18/2018 the VA instituted a **"look back" period of 3 years**. Any assets transferred to reduce net worth after this date must be reported and may prohibit qualifying for the pension benefit for up to 5 years.

DETERMINING THE MONTHLY BENEFIT AMOUNT:

The amount of the possible benefit can be determined by totaling the amount of monthly GROSS household income and then subtracting the monthly total of continuing out of pocket medical expenses which equals the countable income. The countable income is then subtracted from the maximum monthly income limit for the veteran's situation. (See the chart on page 1.) The examples below can help you to understand how the VA calculates the amount. All amounts are monthly figures.

The Pension Worksheet on page 3 can be used to determine the possible benefit.

1. PENSION EXAMPLE:

The veteran is an 80-year-old Korean War veteran. His only source of income is $800.00 (GROSS) in Social Security (SS) benefits. He is still able to care for himself in his home which is paid off. He has no savings or any other assets. Medicare Part B is withheld from his SS benefit and he also pays for a supplemental health insurance.

Medical Expenses:		**Gross Income:**		**Possible Benefit:**	
Medicare Part B	$148.50	SS	$800.00	VA Max. Monthly Limit	$1,160.00
Health Insur	125.00	Less med exps	273.50	Less countable income	526.50
Total med exps	**$273.50**	**Countable inc**	**$526.50**	**VA Pension benefit**	**$633.50**

2. PENSION WITH AID AND ATTENDANCE EXAMPLE:

The veteran is 70 years old and a veteran of the Vietnam era. He receives Railroad Retirement (RR) and a pension from a factory. Medicare Part B is withheld from his RR benefit and health insurance is withheld from his pension. His only asset is a savings account with $60,000.00. He is living in an assisted living facility because his doctor has stated he can no longer live on his own but doesn't yet require nursing home care.

Medical Expenses:		**Gross Income:**		**Possible Benefit:**
Medicare Part B	$148.50	RR	$1,500.00	VA Max. Monthly Limit $1,936.00
Health Insur	200.00	Pension	700.00	Because the veteran's income is less than
Assisted Living	4,500.00	Total income	$2,200.00	his medical expenses, his countable income
Total med exps	**$4,848.50**	Less med exps	4,848.50	is zero. He would receive the full benefit
		Countable income	**0.00**	of **$1,936.00**.

3. NURSING HOME WITH MEDICAID EXAMPLE:

The veteran in example #1 becomes ill and must now be placed in a nursing home. Medicaid pays for his care and he receives just a small amount of his SS benefit. The VA Pension benefit will be reduced to $90.00 per month which can be used for his personal needs such as clothing, etc.

4. VETERAN WHOSE WIFE REQUIRES AID AND ATTENDANCE EXAMPLE:

The veteran served in the Korean War and in good health. His wife has been diagnosed with several disabilities and the veteran cannot care for her at home. She resides in an assisted living facility. Their combined net worth is $100,000.00. All of the household gross income and countable medical expenses are reported.

Medical Expenses:		**Gross Income:**		**Possible Benefit:**
Assisted Living	$6,000.00	Vet-SS	$1,100.00	VA Max. Monthly Limit $1,520.00*
Medicare Part B	297.00	Wife-SS	550.00	Because the household income is less than
Health Insur	250.00	Wife-Pension	200.00	the medical expenses, the countable
Total med exps	**$6,547.00**	Total income	$1,850.00	is zero. He would receive the full benefit of
		Less med exps	6,547.00	**$1,520.00**. *The veteran does not require
		Countable income	**0.00**	aid and attendance so the higher rate of
				$2,295.00 cannot be paid.

VA PENSION WORKSHEET * This worksheet helps to determine only a *POSSIBLE* VA benefit amount.

All claims for benefits must be processed through the VA to determine eligibility and benefit amount.

PLEASE PROVIDE STATEMENTS DOCUMENTING ALL AMOUNTS.

GROSS **MONTHLY INCOME**	**VETERAN**	**SPOUSE**	**OTHER DEPENDENT**	**SOURCE**
SOCIAL SECURITY				
US CIVIL SERVICE				
RAILROAD RETIREMENT				
BLACK LUNG BENS				
ANY RETIREMENT OR PENSIONS				
SSI/PUBLIC ASSISTANCE				
LONG TERM CARE INSUR BENEFITS RECEIVED				
WAGES FROM EMPLOYMENT				
OTHER (PROVIDE SOURCE)				
OTHER (PROVIDE SOURCE)				
OTHER (PROVIDE SOURCE)				
TOTALS			(A)	
			TOTAL HOUSEHOLD INCOME	

CONTINUING ** **MTHLY MED EXPENSES**	**VETERAN**	**SPOUSE**	**OTHER DEPENDENT**	**SOURCE**
MEDICARE PART B				
HEALTH INSUR PREMIUM				
HEALTH INSUR PREMIUM				
RX INSUR PREMIUM				
NURSING HOME				
ASSISTED LIVING				
HOME HEALTH AIDES				
LONG TERM CARE INSUR PREMIUMS PAID				
OTHER (PROVIDE TYPE)				
OTHER (PROVIDE TYPE)				
TOTALS ** List only medical expenses which are the same every month **(B)**				
			TOTAL HOUSEHOLD MEDICAL EXPENSES	

TOTAL HOUSEHOLD INCOME(A)	
LESS TOTAL HOUSEHOLD MEDICAL EXPENSES (B)	
EQUALS COUNTABLE INCOME (C)	
If household income is less than medical expenses, the countable income is "0"	(A-B=C)
VA INCOME LIMIT for your situation (from pg 1-i.e. veteran w/aid & attendance is $1,936.00)	
LESS COUNTABLE INCOME(C) (from above)	
EQUALS POSSIBLE* VA BENEFIT	

LIST BALANCES OF ALL BANK ACCOUNTS, IRAS, MUTUAL FUNDS, STOCKS, TRUSTS, ETC. **

ACCOUNT	**CURRENT BALANCES**
TOTAL NET WORTH	

**TOTAL NET WORTH MUST BE UNDER $130,773

CHECKLIST OF DOCUMENTATION NEEDED TO COMPLETE THE VA FORMS FOR PENSION:

The average processing time for VA Pension is an average of 6 to 9 months. Therefore, it is best to submit all supporting documentation with the original claim forms to expedite the process as much as possible.

FAILURE TO PROVIDE ALL DOCUMENTATION WILL DELAY THE FILING OF THE CLAIM AND A DECISION FROM THE VA.

____ **DD 214/Military Separation Record.** We can assist with obtaining this document if necessary or you can request it FREE OF CHARGE on-line at: www.archives.gov/veterans/military-service-records.

____ **Social Security numbers for veteran and dependents**. Please also provide VA Claim number if available.

____ **Marriage Licenses and Death Certificates.**

____ **Proof of all income.** Please provide statements showing the **GROSS amounts** (before any deductions such as Medicare, health insurance, etc.) of all monthly income including Social Security, pensions, income from investments, rental or business income, long term care insurance benefits received, etc.

____ **Current statements for all assets.** All checking, savings accounts, stocks, bonds, mutual funds, trusts, annuities, long term care insurance, savings bonds, etc.

____ **Direct Deposit account information and/or deposit slip.**

____ **Documentation regarding any transfer of assets you or your dependents have made since 10/18/2018.** Assets transfers include gifts, selling them, purchasing an annuity, or using them to establish a trust.

____ **Amounts of CONTINUING monthly medical expenses.** When initially filing for the VA Pension benefit, we will report household "out of pocket" medical expenses which are the same every month. These include:

- Medicare deductions withheld from Social Security or other benefits for Parts B, C, or D.
- Supplemental insurance premiums for health, dental, prescriptions, vision plans, etc. (sometimes withheld from pension/retirement benefits)
- Prescriptions/over the counter medications/medical supplies (i.e. incontinence supplies) which are the same every month
- Long term care insurance premiums
- Final funeral/burial expenses paid by the veteran for spouse in the last year
- Amounts paid for in home health care, adult day care, assisted living, and nursing home (SEE BELOW)

____ **Documentation from the Ohio Department of Jobs and Family Services (ODJFS) regarding Medicaid.**

____**Any Guardianship Appointments or Power of Attorneys.**

If the claimant is in a Nursing Home:

____ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician. If both the veteran and spouse require care, please have a form completed for each. ***AND***

____ **VA Form 21-0779 included in this packet** (Request for Nursing Home Information) Completed by Nursing Home

If the claimant is in an Assisted Living, Adult Day Care, or similar facility:

____**VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician. If both the veteran and spouse require care, please have a form completed for each. ***AND*** the **following 2 forms** completed by Assisted Living, etc.:

____ **VA Form 21-527EZ, page 13 included in this packet** (Worksheet for an Assisted Living, etc.) ***AND***

____ **VA Form 21-4138 for Assisted Living or other Facility included in this packet**. (Must also be signed by claimant)

If the claimant receives medical care from an In-Home Care Attendant:

____ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician. If both the veteran and spouse require care, please have a form completed for each. ***AND*** the **following 2 forms** completed by In-Home Attendant:

____ **VA Form 21-527EZ, page 14included in this packet** (Worksheet for an In-Home Care, etc.) ***AND***

____ **VA Form 21-4138 for In-Home Care Attendant included in this packet**. (Must also be signed by claimant)

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 09-30-2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

IMPORTANT: Please read Privacy Act and Respondent Burden information before completing the form.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM-DD-YYYY)*

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. SEX
- ◯ MALE
- ◯ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*

8. E-MAIL ADDRESS *(Optional)*

9. PREFERRED MAILING ADDRESS *(Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

SECTION II: CLAIM INFORMATION

10. CLAIMANT'S NAME (First, Middle Initial, Last) (Complete only if you are not the veteran)

11. CLAIMANT'S SOCIAL SECURITY NUMBER

12. RELATIONSHIP OF CLAIMANT TO VETERAN
- ◯ SPOUSE
- ◯ SELF

13. CLAIMANT'S HOME ADDRESS

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

14. BENEFIT YOU ARE APPLYING FOR (*Choose One*)

◯ **Special Monthly Compensation (SMC) -** Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid without eligibility to compensation.

◯ **Special Monthly Pension (SMP) -** Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

SECTION III: INFORMATION OF EXAMINATION

15. DATE OF EXAMINATION *(MM-DD-YYYY)*

16A. IS CLAIMANT HOSPITALIZED?
- ◯ YES
- ◯ NO

(If "Yes," complete Items 16B and 16C)

16B. DATE ADMITTED *(MM-DD-YYYY)*

17A. NAME OF HOSPITAL

17B. ADDRESS OF HOSPITAL

PATIENT/VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

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.

17C. COMPLETE DIAGNOSIS (Diagnosis needs to equate to the level of assistance described in questions 25 through 39)

18A. AGE	18B. WEIGHT	18C. HEIGHT
	ACTUAL LBS. ESTIMATED LBS.	FEET INCHES

19. NUTRITION	20. GAIT

21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

25. 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:

26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? (Fill in Circle. If "No," provide explanation)

◯ YES ◯ NO

27. IS CLAIMANT ABLE TO PREPARE THEIR OWN MEALS? (Fill in Circle. If "No," provide explanation)

◯ YES ◯ NO

28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? (If "Yes," provide explanation)

◯ YES ◯ NO

29A. IS THE CLAIMANT LEGALLY BLIND? (If "Yes," provide explanation)

◯ YES ◯ NO

29B. CORRECTED VISION

LEFT EYE	RIGHT EYE

30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

◯ YES ◯ NO

31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? (If "Yes," provide explanation)

◯ YES ◯ NO

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? (If "No," provide examples and rationale to support your conclusion)

◯ YES ◯ NO

PATIENT/VETERAN'S SOCIAL SECURITY NO. ___ – ___ – ____

33. DESCRIBE POSTURE AND GENERAL APPEARANCE (Attach a separate sheet of paper if additional space is needed)

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE 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)

35. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREEMITY.

36. DESCRIBE RESTRICTION OF SPINE, TRUNK AND NECK

37. 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.

38. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

39. 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 38 above)

◯ YES ◯ NO (If "YES," give distance) (Check applicable box or specify distance) ◯ 1 BLOCK ◯ 5 OR 6 BLOCKS ◯ 1 MILE OTHER (Specify distance) _____

SECTION IV: CERTIFICATION AND SIGNATURE

40A. PRINTED NAME OF PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED *(MM-DD-YYYY)*
		__ – __ – ____
41. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	42A. TELEPHONE NUMBER OF MEDICAL FACILITY	
	___ – ___ – ____	
42B. NAME OF MEDICAL FACILITY	42C. ADDESS OF MEDICAL FACILITY	

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is 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. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure 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 pate at **http://www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 08/31/2023

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

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

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden. We use this form to determine eligibility in connection with a claim for aid and attendance. For more information, contact us at **https://iris.custhelp.va.gov**, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at **www.va.gov/vaforms**. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI, 53547- 4444.**

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* — —

SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION *(Complete this section ONLY IF the claimant is NOT the veteran)*

5. CLAIMANT'S NAME *(First, Middle Initial, Last)*

6. SOCIAL SECURITY NUMBER — —

7. VA FILE NUMBER *(If applicable)*

8. DATE OF BIRTH *(MM/DD/YYYY)* — —

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

10. ADDRESS OF NURSING HOME *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

SECTION IV - GENERAL INFORMATION *(To be completed by a Nursing Home Official)*

NOTE: Your state's Medicaid program may use a different name.

11. DATE ADMITTED TO NURSING HOME *(MM/DD/YYYY)* — —

12. IS THE NURSING HOME A MEDICAID APPROVED FACILITY?
◯ YES ◯ NO

13. HAS THE PATIENT APPLIED FOR MEDICAID?
◯ YES ◯ NO

14A. IS THE PATIENT COVERED BY MEDICAID?
◯ YES ◯ NO *(If "YES," complete Item 14B)*

14B. DATE MEDICAID PLAN BEGAN *(MM/DD/YYYY)* — —

15. MONTHLY AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET $

16. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: *(Check one)*
◯ SKILLED NURSING CARE ◯ INTERMEDIATE NURSING CARE

17. NURSING HOME OFFICIAL'S NAME *(First and Last)*

18. NURSING HOME OFFICIAL'S TITLE

19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)* — —

Enter International Phone Number *(If applicable)*

SECTION V - CERTIFICATION AND SIGNATURE

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

20. SIGNATURE OF NURSING HOME OFFICIAL *(REQUIRED)*

21. DATE SIGNED *(MM/DD/YYYY)* — —

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 12/31/2020

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Read the Privacy Act and Respondent Burden on Page 2 before completing the form. Complete as much of Section I as possible. The information requested will help process your claim for benefits. If you need any additional room, use the second page.

SECTION I: VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

NOTE: You will *either* complete the form online or by hand. Please print the information request in ink, neatly, and legibly to help process the form.

1. VETERAN/BENEFICIARY'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
Month – Day – Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. TELEPHONE NUMBER *(Include Area Code)*

7. E-MAIL ADDRESS *(Optional)*

8. MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

The above-named person resides in _____(name of the facility)

He/she resides in and receives: (circle yes or no for facility and care type)

yes or no -Independent Living with no care services*
yes or no -Independent Living with care services provided and billed by the facility*
yes or no -Independent Living with care services provided by a third party but billed by the facility*
yes or no -Independent Living with care services provided and billed by a third party
yes or no -Assisted Living Care (state-licensed)
yes or no -Assisted Living Care (state-licensed) with higher level care such as memory care services
yes or no -Other Care Facility* please explain:_____

*Mark Activities of Daily Living on page 2

Date he/she entered the facility/began to receive care_____

Amount he/she pays for facility care $_____per month or $_____per week
or $_____day

(continue on page 2)

VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION II: REMARKS *(Continued)*
(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

*For independent living or other facilities as noted on page 1 please mark the ADLs provided. (state-licensed assisted living care and higher not required)

He/she is provided with the following ADLs:

YES / NO Bathing/Showering
YES / NO Standing/Sitting
YES / NO Getting in/out of bed
YES / NO Eating
YES / NO Walking
YES / NO Dressing/Undressing
YES / NO Taking Medication
YES / NO Other (explain):_____
_____

I certify that I have completed this document and that it is accurate and true.

_____ _____
Signature of facility official Date

_____ _____
Printed name of official Title of official

_____ _____
Address of facility Phone number/extension

The Veteran or widow must sign below to verify.

SECTION III: DECLARATION OF INTENT

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

9. SIGNATURE *(Sign in ink)*	10. DATE SIGNED *(MM/DD/YYYY)*

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.

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

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

◯ YES ◯ NO (If "NO," continue to Step 2)

(If "YES," all payments to the facility qualify as medical expenses in Items 30A - 30F. You are finished completing this worksheet)

STEP 2. Do ***all*** of the following apply to the facility?

- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with caregivers

◯ YES ◯ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the veteran) the disabled person?

◯ YES ◯ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

◯ YES ◯ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amounts you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 30A - 30F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the ***primary reason*** you live in the facility (or attend day care in the facility)?

◯ YES ◯ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 30A - 30F applicable amounts you pay the facility for (1) ***lodging and meals,*** (2) ***health care services or assistance with ADLs provided by a health care provider,*** and (3) ***custodial care***. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 30A - 30F. Skip to Step 8)

STEP 7. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the ***primary reason*** the disabled person lives in the facility (or attends day care in the facility)?

◯ YES ◯ NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 30A - 30F)

(If "NO," ***only*** claim payments you pay the facility for assistance with ***health care and/or assistance with custodial care*** as medical expenses in Items 30A - 30F. Payment to this facility for meals and lodging ***do not*** qualify)

STEP 8. Facility Certification: Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received.

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate

and reflects the current environment pertaining to _____
(Name of Person Staying at Facility)

and his or her care at this facility _____
(Name of Facility)

at _____
(Address of Facility (Line 1))

_____
(Address of Facility (Line 2))

_____
(Name of Person Certifying for the Facility)

_____
(Signature of Person Certifying for the Facility)

_____
(Title of Person Certifying for the Facility)

__ __ – __ __ – _____
(Date Certified)

OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 12/31/2020

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Read the Privacy Act and Respondent Burden on Page 2 before completing the form. Complete as much of Section I as possible. The information requested will help process your claim for benefits. If you need any additional room, use the second page.

SECTION I: VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

NOTE: You will *either* complete the form online or by hand. Please print the information request in ink, neatly, and legibly to help process the form.

1. VETERAN/BENEFICIARY'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER – –

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
Month – Day – Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. TELEPHONE NUMBER *(Include Area Code)*

7. E-MAIL ADDRESS *(Optional)*

8. MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

This statement satisfies the Department of Veteran Affairs requirement of Proof of Payment per MR-V.iii.1.G.5.b.

I/We,_____, assist_____beginning_____(date) with the following ADL's (circle all that apply):

YES / NO Bathing/Showering
YES / NO Standing/Sitting
YES / NO Getting in/out of bed
YES / NO Eating
YES / NO Walking
YES / NO Dressing/Undressing
YES / NO Taking Medication
YES / NO Other (explain):

_____

_____

I/We, confirm that the amount paid is based on a rate of $_____per hr/wk/mo (circle one) for these services performed, above.

The total payment of $_____are paid to me/we on a weekly/monthly (circle one) basis.

*****continued on page 2*****

VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION II: REMARKS *(Continued)*
(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

*****continued from page 1*****

This statement certifies that I/We, are paid based on the above frequency and rate, beginning on the date above.

_____
Printed Name of Individual/Facility Performing Services

_____ _____
Signature of the Individual/Facility Performing Services Date Signed

_____
Address of Individual/Facility Performing Services

_____
Phone Number (w/ Area Code) of Individual/Facility Performing Services

The Veteran/Claimant has signed and dated the below Blocks 9 and 10 to certify agreement and accuracy of this Proof of Payment for the above Individual Performing Services.
-OR-
If the Veteran/Claimant is unable to sign, an Alternate Signer has signed and dated on behalf and attached is the 21-0972, Alternate Signer Certification.

SECTION III: DECLARATION OF INTENT

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

9. SIGNATURE *(Sign in ink)*	10. DATE SIGNED *(MM/DD/YYYY)*

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.

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

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IN HOME CARE ATTENDANT
PG 2 OF 2

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: Only complete this worksheet if you are claiming expenses for in-home care.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.

Follow the steps below to determine whether or not:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care

STEP 1. Are you (the veteran) the disabled person?

◯ YES ◯ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

◯ YES ◯ NO (If "NO," payments to this in-home attendant for assistance with IADLs do not qualify as medical expenses. Please report separately in Items 30A - 30F applicable amounts you pay an in-home attendant for (1) health care services or assistance with ADLs provided by a health care provider, and (2) custodial care. Skip to Step 6)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to this in-home attendant ***may*** qualify as medical expenses in Items 30A - 30F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Item 30A - 30F amounts you pay an in-home attendant for (1) health-care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs, and (3) custodial care. Skip to Step 6.)

(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 30A - 30F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6.)

STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," the attendant ***must be a health care provider***. Only report payments to the in-home attendant for ***health care services or assistance with ADLs*** provided by the health care provider as medical expenses in Items 30A - 30F. Payments for assistance with IADLs do not qualify as medical expenses. Skip to Step 6.)

STEP 5. Is the ***primary responsibility*** of the in-home attendant to provide the disabled person with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 30A - 30F.)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 30A - 30F. Payment for assistance with IADLs ***do not*** qualify as a medical expense)

STEP 6. Check all activities below with which the attendant assists the veteran or disabled person with:

ADLs: ◯ EATING ◯ BATHING/SHOWERING ◯ DRESSING ◯ TRANSFERRING ◯ USING THE TOILET

IADLs: ◯ SHOPPING ◯ FOOD PREPARATION ◯ HOUSEKEEPING ◯ LAUNDERING ◯ MANAGING FINANCES

◯ HANDLING MEDICATIONS ◯ USING THE TELEPHONE ◯ TRANSPORTATION FOR NON-MEDICAL PURPOSES

STEP 7. **In-Home Attendant Certification**: Please submit a current breakdown of the time the attendant spends assisting the veteran or disabled person with health care services, ADLs and IADLs.

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment pertaining to _____ (Name of Person Requiring Care) and his or her care from _____ (Name of Attendant)

_____ (Name of Certifying Official)

_____ (Signature of Certifying Official)

_____ (Title of Certifying Official)

__ __ – __ __ – __ __ __ __ (Date Certified)