DEPARTMENT OF VETERANS AFFAIRS

SURVIVORS PENSION BENEFITS 2024

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 claimant'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 the surviving spouse of a deceased veteran with low income or overwhelmed with the high cost of medical care, such as paying for assisted living facilities, home care aids, adult daycare, or skilled nursing, the VA Survivors benefit could be the solution to help pay for this care or other needs.

There are three levels of VA Survivors Pensions:

Basic Pension—for surviving spouses with low income

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

Housebound – for surviving spouses with a permanent disability that prevents them from leaving their home

You may be eligible if:

- the deceased veteran was discharged from military service under other than dishonorable conditions; AND
- the veteran 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.

While an un-remarried spouse is eligible at any age, a child of a deceased wartime Veteran must be: under 18, *OR* under age 23 if attending a VA-approved school, *OR* permanently incapable of self-support due to a disability before age 18.

*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 OR the full period for which called or ordered to active duty.

| PENSION RATES effective 12/1/2023 | MAXIMUM MONTHLY BENEFIT | MAXIMUM HOUSEHOLD ANNUAL INCOME*** |
|---|-------------------------|------------------------------------|
| Basic Pension with no dependents* With Housebound benefits with no | \$925.00 | \$11,102.00 |
| dependents* | \$1,130.00 | \$13,568.00 |
| With Aid and Attendance with no dependents* | \$1,478.00 | \$17,743.00 |
| In Nursing Home receiving Medicaid benefits | \$90.00 | N/A |
| *Additional benefits are available for dependent children. Ask for details. | | |

*** 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 \$155,356.00

(as of 12/01/2023–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 surviving spouse is 81 years old. Her monthly income is \$800 (GROSS) in Social Security (SS) benefits. She is still able to live alone in her home which is paid off. She has no savings or any other assets. \$174.70 is withheld from her SS benefits for Medicare and she pays \$75.00 per month for a supplemental health insurance.

| Medical Expenses | : | Income: | | Possible Benefit: | |
|------------------|--------------|-------------------|---------------|-----------------------|---------------|
| Medicare Part B | \$ 174.70 | Social Security | \$800.00 | VA Income Limit | \$925.00 |
| Health insurance | <u>75.00</u> | Less med expenses | <u>249.70</u> | Less countable income | <u>550.30</u> |
| Total med exps | \$249.70 | Countable income | \$550.30 | VA benefit | \$374.70 |

2. PENSION WITH AID AND ATTENDANCE EXAMPLE:

Surviving spouse is 70 years old. His monthly income consists of \$825.00 (GROSS) in Railroad Retirement (RR) and \$1,370.00 in State Teachers Retirement. His doctor stated that he could no longer live alone, and it was a medical necessity to move into an assisted living facility but did not need full nursing home care. The monthly cost of the assisted living facility is \$3,500 per month, \$174.70 is withheld from his RR for Medicare, and he pays \$100 for supplemental health insurance.

| Medical Expenses: | Income: | | Possible Benefit: | |
|----------------------------|------------------|-----------------|-----------------------|-------------------------|
| Assisted Living \$3,500.00 | RR | \$ 825.00 | VA Income Limit | \$1,478.00 |
| Medicare Part B 174.70 | State Teachers | <u>1,370.00</u> | Because the claimar | nt's income is |
| Health insurance 100.00 | Total income | \$2,195.00 | less than his medica | al expense, his |
| Total med exps \$3,774.70 | Less med exps | 3,774.70 | countable income is | zero. He would |
| | Countable income | e 0.00 | receive the full bene | efit \$1,478.00. |

3. NURSING HOME WITH MEDICAID EXAMPLE:

The widow in example #1 becomes ill and the doctors determine she must be placed into a nursing home. Medicaid begins to pay the cost of her care and she receives just a small portion of her Social Security benefit. The VA will reduce her monthly pension benefit to **\$90 per month** which can be used for her personal needs such as clothing, haircuts, etc.

VA SURVIVOR 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.

| | | 1 | | | | | 1 | | | 1 | | Ī | | | | | | | | | | | | | | |
|--|----------------------|-------------------------------|--|---------------------------------------|------------------------------------|---|---|-----------------------|----------------------------|------------------------|-----------------------------|------------------|---|---------------------------------------|--------------------|-----------------|----------------------|----------------------|-----------------|--------------|-----------------|-------------------|-------------------------------------|----------------------|----------------------|---|
| TOTAL HOUSEHOLD INCOME(A) LESS TOTAL HOUSEHOLD | (PENSES (B) | EQUALS COUNTABLE INCOME (C) | If household income is less than medical (A-B=C) | expenses, the countable income is "0" | VA INCOME LIMIT for your situation | (from pg 1-i.e. survivor w/aid & attendance | | | LESS COUNTABLE INCOME(C) | | EQUALS POSSIBLE* VA BENEFIT | | LIST BALANCES OF ALL BANK ACCOUNTS, IRAS, | MUTUAL FUNDS, STOCKS, TRUSTS, ETC. ** | CURRENT BALANCES | | | | | | | | | | NORTH | **TOTAL NET WORTH MUST BE UNDER \$155,356.00 |
| TOTAL HOUS | MEDICAL EXPENSES (B) | EQUALS COL | If household inco | expenses, the cor | VA INCOME | (from pg 1-i.e. su | is \$1,388.00) | | LESS COUNT | (from above) | EQUALS POS | | LIST BALANC | MUTUAL FU | ACCOUNT | | | | | | | | | | TOTAL NET WORTH | **TOTAL NE |
| SOURCE | | | | | | | | | | | | | TOTAL HOUSEHOLD INCOME | | SOURCE | | | | | | | | | | | |
| DEPENDENT | | | | | | | | | | | | (V) | FOTAL HOUSE | | DEPENDENT | | | | | | | | | | | , (B) |
| DEPENDENT | | | | | | | | | | | | <u>)</u> | | | DEPENDENT | | | | | | | | | | | same every month |
| SURVIVOR | | | | | | | | | | | | | | | SURVIVOR | | | | | | | | | | | enses which are the |
| <u>SROSS</u> MONTHLY INCOME | OCIAL SECURITY | JS CIVIL SERVICE | AILROAD RETIREMENT | SLACK LUNG BENS | 'NY RETIREMENT OR PENSIONS | SI/PUBLIC ASSISTANCE | ONG TERM CARE INSUR BENEFITS ECEIVED | VAGES FROM EMPLOYMENT | OTHER (PROVIDE SOURCE) | OTHER (PROVIDE SOURCE) | OTHER (PROVIDE SOURCE) | OTALS | | CONTINUING ** | MTHLY MED EXPENSES | MEDICARE PART B | HEALTH INSUR PREMIUM | HEALTH INSUR PREMIUM | X INSUR PREMIUM | JURSING HOME | ASSISTED LIVING | HOME HEALTH AIDES | ONG TERM CARE INSUR REMIUMS PAID | OTHER (PROVIDE TYPE) | OTHER (PROVIDE TYPE) | $TOTALS^{**}$ List only medical expenses which are the same every month (B) |

DO YOU OWN A HOME?

ADDRESS:

IS THERE ANY RENTAL INCOME?

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

The average processing time for VA **Survivors** 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 |
|---|
| REE OF CHARGE on-line at: www.archives.gov/veterans/military-service-records . |
| Social Security numbers for claimant, 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 <u>GROSS*</u> amounts (before any deductions such as Medicare, health insurance, etc.) of all monthly income including Social Security, pensions, income from investments, ental or business income, long term care insurance benefits received, etc. *This amount can generally be found on innual statements from Social Security and other benefits. |
| Current statements for all assets. All checking, savings accounts, stocks, bonds, mutual funds, trusts, annuities, ong term care insurance, savings bonds, etc. |
| Direct deposit information and/or voided check. |
| Documentation regarding any transfer of assets you or your dependents have made in the last 3 tax years. Assets transfers include gifts, selling them, purchasing an annuity, or using them to establish a trust. |
| eport 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 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. AND VA Form 21-0779 included in this packet (Request for Nursing Home Information) |
| 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 AND VA Form 21P-534EZ, page 19 included in this packet (Worksheet for Residential Care, etc.) |
| 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. AND VA Form 21P-534EZ, page 20 included in this packet (Worksheet for an In-Home Attendant) |

OMB Control No. 2900-0721 Respondent Burden: 30 minutes Expiration Date: 02/28/2026

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

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page

4. Use this form to determine eligibility for aid and attendance or housebound benefits. For more information, you can contact us online through Ask VA; https://ask.va.gov/. Ask us a guestion online or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms. 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 check box to help expedite processing of the form. 1. VETERAN/BENEFICIARY'S NAME (First, Middle Initial, Last) 2. SOCIAL SECURITY NUMBER 3. VA FILE NUMBER (If applicable) 4. VETERAN'S SERVICE NUMBER (If applicable) 5. DATE OF BIRTH (MM/DD/YYYY) SECTION II: CLAIMAINT'S IDENTIFICATION INFORMATION 6. CLAIMANT'S NAME (First, Middle Initial, Last) 8. RELATIONSHIP OF CLAIMANT TO VETERAN 9. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY) 7. CLAIMANT'S SOCIAL SECURITY NUMBER SELF PARENT SPOUSE ☐ CHILD 10. 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 ZIP Code/Postal Code Country 11. TELEPHONE NUMBER (Optional) (Include Area Code) Enter International Phone Number (If applicable) I agree to receive electronic correspondence from VA in regards to my claim. SECTION III: CLAIM INFORMATION 13. SELECT ONE OF THE FOLLOWING BENEFITS (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 or Dependency Indemnity Compensation (DIC). 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 them from the hazards of their daily environment, or are housebound (substantially confined to their 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.

21-2680

| VETERAN'S SOCIAL SECURITY NUMBER | |
|--|--|
| SECTION IV: IS VETERAN | I/CLAIMANT HOSPITALIZED? |
| 14A. IS THE CLAIMANT HOSPITALIZED? 14B. DATE ADMITTED (N | MM/DD/YYYY) |
| YES (If "YES," complete Items 14B, 14C & 14D) | |
| NO (If "NO," skip to Section V) | - |
| 14C. NAME OF HOSPITAL | |
| | |
| | |
| 14D. ADDRESS OF HOSPITAL | |
| | |
| | |
| SECTION V: CERTIFIC | CATION AND SIGNATURE |
| I CERTIFY THAT the statements on this form are true and correct to the bes | st of my knowledge and belief. |
| 15A. VETERAN/CLAIMANT'S SIGNATURE (Required) | 15B. DATE SIGNED (MM/DD/YYYY) |
| | |
| SECTION VI: EXAM | INATION INFORMATION |
| (IMPORTANT: Remainder of for | rm MUST be filled out by Examiner) |
| NOTE: Examiner must be a Medical Doctor (MD) or Doctor of Osteopathic (D | OO) medicine, physician assistant or advanced practice registered nurse. |
| 16. DATE OF EXAMINATION (MM/DD/YYYY) | |
| | |
| NOTE: EXAMINER PLEASE READ CAREFULLY | |
| The purpose of this examination is to record manifestations and findi | ings pertinent to the question of whether the veteran/claimant is |
| | ed of the regular aid and attendance of another person. Please provide |
| as much description as needed for each question as this will assist \nabla physical or mental impairment, loss of coordination or enfeeblement | that require assistance with daily living. Findings should be recorded to |
| show whether the claimant is blind or bedridden. Whether the claima | ant seeks housebound or aid and attendance benefits, the report should |
| reflect how well they ambulate, where they go, and what they are ab | le to do during a typical day. |
| 17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR in Items 26 through 37) (Describe below) | EACH CONDITION (Diagnosis needs to equate to the level of assistance described |
| , | |
| | |
| | |
| | |
| 40 WHAT DISABILITY/IFS) ARE CONSIDERED RES | DMANICNIT AND TOTALLY DISABLINGS (Describe heles) |
| 16. WHAT DISABILITY(IES) ARE CONSIDERED PER | RMANENT AND TOTALLY DISABLING? (Describe below) |
| A. | D. |
| | |
| В. | E. |
| | |
| C. | _ |
| C. | F. |
| 19A. AGE 19B. WEIGHT | 19C. HEIGHT |
| ACTUAL LBS. ESTIMATED LBS. | FEET INCHES |
| 20. NUTRITION | 21. GAIT |
| | |
| 22 PLOOP PRESCRIPE 22 PLUCE PATE AND PEOPLE ATTENDED TO PEOPLE ATTENDE | DE WHAT DISABILITIES DESTRICT THE HOTER ACTIVITIES IS INSTITUTED. |
| 22. BLOOD PRESSURE 23. PULSE RATE 24. RESPIRATORY RATE 2 | 25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS? |
| | |
| | |

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| VETERAN'S SOCIAL SECURITY NUMBER | | |
|---|--|---|
| 26. IF THE PATIENT IS CONFINED TO BED, |), INDICATE THE NUMBER OF HOURS IN BED | |
| From 9 PM to 9 AM: From 9 A | AM to 9 PM: | |
| 27. DOES THE PATIENT REQUIRE ASSISTA | ANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL | |
| BATHING/SHOWERING | TENDING TO HYGIENE NEEDS prepar | TIONAL ACTIVITIES (i.e., housekeeping, laundering, meal ration, etc.) (Specify additional activity below) |
| EATING OR SELF-FEEDING | TRANSFERRING IN OR OUT OF BED/CHAIR | |
| DRESSING | TOILETING | |
| OR LIVING AREA | MEDICATION MANAGEMENT | |
| 28A. IS THE PATIENT LEGALLY BLIND? (If | f "Yes," provide explanation) | 28B. CORRECTED VISION LEFT EYE RIGHT EYE |
| YES | | |
| □ NO | | |
| 29. DOES THE PATIENT REQUIRE NURSIN | NG HOME CARE? (If "Yes," provide explanation) | |
| YES | | |
| NO | | |
| 30. IN YOUR JUDGMENT, DOES THE PATIE DIRECT SOMEONE TO DO SO? | ENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFI | IT PAYMENTS, OR ARE THEY ABLE TO |
| ☐ YES | | |
| □ NO | | |
| (If "NO," provide the disability(ies) that prevent | | |
| them from performing this function and any rationale | | |
| to support your conclusion in the space | | |
| provided) | AL ADDEADANCE OF THE DATIENTS (Describe) | |
| 31. WHAT IS THE POSTURE AND GENERA | AL APPEARANCE OF THE PATIENT? (Describe) | |
| | | |
| | | |
| 32. DESCRIBE RESTRICTIONS OF EACH UP | IPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, F | FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES. |
| TO BUTTON CLOTHING, SHAVE AND ATTE | | |
| | | |
| | | |
| | | |
| 22 DESCRIPE DESTRICTIONS OF EACH LO | OWED EXTREMITY WITH PARTICULAR REFERANCE TO THE EX | VTENT OF LIMITATION OF MOTION ATPOPLIX AND |
| CONTRACTURES OR OTHER INTERFEREN | OWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXNCE. (NOTE : If indicated, comment specifically on weight bearing, ba | alance and propulsion of each lower extremity) |
| | | |
| | | |
| | | |
| | | |
| 34. DESCRIBE RESTRICTION OF SPINE, TR | RUNK, AND NECK | |
| | | |
| | | |
| | | |

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| ETERAN'S SOCIAL SECURITY NUMBER | | | | | | |
|---|---------------------------------|--------------------|----------------|------------------|-----------------|---|
| 35. DESCRIBE ALL OTHER PATHOLOGY LOSS OF MEMORY OR POOR BALANCE AREA | INCLUDING THE , THAT AFFECTS | LOSS OF PATIENT | BOWE S ABIL | L OR E ITY TO | BLADDE PERFO | ER CONTROL OR THE EFFECTS OF ADVANCING AGE; SUCH AS DIZZINESS, ORM SELF-CARE, OR IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| 36. HOW OFTEN PER DAY OR WEEK AN IMMEDIATE PREMISES (Describe) | D UNDER WHAT (| CIRCUMS | TANCE | S (to ir | nclude th | he level of assistance required) IS THE PATIENT ABLE TO LEAVE THE HOME OR |
| | | | | | | |
| 37. ARE AIDS SUCH AS CANES, BRACES YES (If "YES," check the applicable box or specify distance) NO | , CRUTCHES, OR | _ | SISTAN | | _ | HER PERSON REQUIRED FOR LOCOMOTION? 1 MILE OTHER (Specify distance) |
| | | SECT | ION VI | II: EXA | MINE | R'S SIGNATURE |
| 38. PRINTED NAME OF EXAMINER | | | | | | 39. TITLE OF EXAMINER |
| | | | | | | |
| 40. SIGNATURE OF EXAMINER (REQUIRE | (D) | | | | | 41. DATE SIGNED (MM/DD/YYYY) |
| | | 252516 | 22.200 | - TVAI | | |
| 42 MATIONAL PROMIDED IDENTIFIED (N | DIV AU MADED OF F | | | : EXAI | MINER | 'S INFORMATION |
| 42. NATIONAL PROVIDER IDENTIFIER (N | PI) NUMBER OF E | EXAMINE | | | | |
| 43. NAME OF MEDICAL FACILITY | | | | | | |
| 44. ADDRESS OF MEDICAL FACILITY (N | umber and street o | or rural rou | ite, city, | state, 2 | ZIP Cod | de and Country) |
| | | | | | | |
| 45. TELEPHONE NUMBER OF MEDICAL | FACILITY (Include | | | | | |
| | | | nter Int | ernatio | nal Pho | one Number (If applicable) |
| PENALTY : The law provides severe penalti fraudulent receipt of any document you are | | and/or imp | risonme | ent) for | willfully | submitting any statement or evidence of a material fact you know to be false, or for |
| PRIVACY ACT NOTICE: The VA will not | disclose information | collected | on this | form to | any som | urce other than what has been authorized under the Privacy Act of 1974 or Title 38, code of |

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 Veteran Readiness 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

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(e) 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 website 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.

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OMB Approved No: 2900-0652 Respondent Burden: 10 Minutes Expiration Date: 09/30/2026

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 | ON | |
|--|---|----------|
| INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burde page 2. VA uses this form to determine eligibility for pension and aid and attendance benefit on nursing home status. For more information you can contact us online through Ask VA: has va.gov, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov, and vaforms. After completing the form, mail to: Department of Veterans Affairs, Evidence Interpretation Center, P.O. Box 4444, Janesville, WI, 53547-4444. | ts based https://ask. gov/ | |
| SECTION I - VETERAN'S IDENTIFICATION | NINFORMATION | |
| NOTE : You may complete the form online or by hand. If completing by hand, print neatly and legibly in in processing of the form. | k, and completely fill in each applicable checkbox to help expedite | |
| 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 INFO | PRMATION | |
| 9. NAME OF NURSING HOME | | |
| 10. ADDRESS OF NURSING HOME (Number and street or rural route, P.O. Box, City, State, ZIP Code | e and Country) | |
| No. & Street | | |
| Apt./Unit Number City | | |
| State/Province Country ZIP Code/Postal Code | | |
| SECTION IV - GENERAL INFORMATION (To be complete | ed by a Nursing Home Official) | |
| NOTE: Your state's Medicaid program may use | , , | |
| | IURSING HOME A MEDICAID APPROVED FACILITY? | |
| | □ NO | |
| 13. HAS THE PATIENT APPLIED FOR MEDICAID? 14A. IS THE PATIENT COVERED BY MEDICA | AID? 14B. DATE MEDICAID PLAN BEGAN (MM/DD/YY | YY) |
| YES NO YES NO (If "YES," complete Ite | | 7 |
| 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 ☐ SKILLED NURSING CARE ☐ INTERMEDIATE NURSING CARE | PHYSICAL DISABILITY AND IS RECEIVING: (Check one) | |
| 17. NURSING HOME OFFICIAL'S NAME (First and Last) | | |
| 17. NORGING HOWE OFFICIAL 3 NAME (First and East) | | |
| 18. NURSING HOME OFFICIAL'S TITLE | 19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE | |
| | NUMBER (Include Area Code) | \neg |
| | Enter International Phone | |
| OFOTION V. OFFTIFICATION AND O | Number (If applicable) | |
| SECTION V - CERTIFICATION AND S | | |
| I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and believe and selection of the property of the p | ief. 21. DATE SIGNED (MM/DD/YYYY) | \dashv |
| 20. SIGNATURE OF NURSING HOME OFFICIAL (REQUIRED) | ZI. STILE GIGHTED (INIVIDED TITT) | [|
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| PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting | ng any statement or evidence of a material fact you know to be false, | or |

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, o 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 Veteran Readiness 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: VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. 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.

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| 1. WHO ARE | YOU CC | MPLE | HINC | IHI و | SW | JRK. | SHE | : I FC |)R? | (Nai | me of | Car | e Re | cipie | nt, ei | ither | the C | laima | nt or I | Depe | enden | it) | | _ | _ | _ | | | _ | _ | | _ |
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| 2. WHO IS CO | MPLET | NG TH | HIS V | VOR | KSHE | ET? | (Na | me of | f Pro | ovide | r, eith | er a | n Adr | ninis | trato | r or L | icens | sed M | edica | l Pro | fessio | onal |) | | | | | | | | | |
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| 3. WHAT ROL | E OR PO | DSITIC | DN D | 0 Y0 | U PE | RFC | DRM | AT TI | HEI | FACI | LITY? | , | | | | | | | | | | | | | | | | | | | | |
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| 4. WHAT IS TH | HE NAM | E OF 1 | ГНЕ | FACI | LITY | ? (A | s sho | wn oi | n fa | cility l | licens | e or | offici | al we | ebsite | e) | | | | | | | | | | | | | | | | |
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| 5. WHAT IS TH | HE FACI | LITY T | ELE | PHOI | NE N | UME | BER? | | | | Inter | natio | nal P | hone | Nui | mber | (If ap | plicat | ole) | | | | | | | | | | | _ | | |
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| 6. WHAT IS TH | HE MAIL | ING A | DDR | ESS | OF T | HEI | ACII | _ITY'S | 3 A E | DMIN | ISTR | ATI\ | /E OI | FIC | E? | | | | | | | | _ | | | | | | | | | |
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| 7. WHAT IS TH | HE FACI | LITY'S | S WE | BSIT | E AD | DRE | SS? | | | | | | | | | | | | | | | | | | | | | | T | | | |
| 8. PLEASE SI | ELECT E | EACH A | ACT | IVITY | OF I | DAIL | Y LI\ | /ING | (AD | L) TH | HAT T | HEI | FACI | LITY | IS F | PROV | 'IDIN | G TO | THE | CAR | E RE | CIP | PIEN | T. | | | | | _ | | | |
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| 9. FOR EACH | | | | | | | | | | | | | | | | | | | | | ΓY: | | | | | | | | | | | |
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| 10. DOES THE (Custodial Car requires care of | e is regu | ılar ass | sistaı | nce w | ith tv | vo or | more | ADL | .s (C | Quest | ion 8 |), or | supe | rvisio | on be | ecaus | e an | indivi | dual v | vith a | phys | sica | I, me | ental | , dev | /elop | men | tal, d | or cog | anitivo | e disc | order |
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| ○ YE | S | | \bigcirc I | NO, C | care <u>i</u> | <u>s</u> be | ing pı | ovide | d b | y a th | nird-pa | arty p | orovio | der. | | | 0 | NO, C | care <u>is</u> | s not | being | g pr | ovid | ed to | this | clai | mant | t. | | | | |
| If care | is prov | ided b | y a t | hird- | party | pro | vide | , plea | ase | ensı | ıre th | e cla | aima | nt ha | is ea | ich Ir | n-Hoi | ne pr | ovide | er co | mple | te a | n In | -Hor | ne A | Atten | dant | t Wo | rksh | eet. | | |
| 11. PLEASE F STAYING | | | | | | | | FOR | THE | E CAI | RE RI | ECIF | PIENT | - | 12. | | | T DA ⁻ ndefir | | | | | | | | | | | | I/DD/ | YYY\ | () |
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| 13. PLEASE I | PROVID | E THE | МО | NTHL | Y CI | HAR | GES | THE | CAF | RE RI | ECIPI | ENT | STA | YIN | G AT | THE | FAC | ZILITY | 'IS R | ESP | ONSI | IBLE | E FC | R P | AYIN | 1G. | | | | | | |
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| 14. SIGNATU | | | | | | | | • | | | | | - | | | | | | | 15. | DATE | E SI | GNE | ED (N | ЛМ/E | DD/Y | YYY | ´) | | | | |
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| | WORKSHEET FOR IN-HOME ATTENDANT EXPENSES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----|---|--------|------------------|------------------|--------------|-------|--------|--------|-------|-------|-------------------|---------------------------|---------|--------|---------|---------|----------|----------------|--------|---------|--------|------|------|--------------|-------|------|-------|--------|--------|-----------|--------|---------|------|
| a | NOTE : This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, <i>Medical Expense Report</i> . In addition, VA Form 21-2680, <i>Examination for Housebound Status or Permanent Need for Regular Aid and Attendance</i> may be needed to count these expenses. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e | xper | ses. | | | | , | | | | | | | | | | | | | | | | | | , | | ,,,, | | | | | | | .000 |
| 1. | WH | O AR | E YC | U CC | MPLE | TING | 3 THI | S WC | ORKS | HEE | T FOF | R? (Na | ame o | f Care | e Reci | ipient, | either | the C | laima | nt or I | Depe | ende | nt) | | | | | | | | | | |
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| 2. | WH | O IS (| СОМ | PLET | ING T | HIS۱ | WOR | KSHE | ET? | (In-F | Home | Care A | Attend | ant or | r Ager | ncy Ad | lminist | rator, | Provi | der) | | | | | | | | | | | | | |
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| 3. | (A li | cense | ed he | alth ca | | ovide | r refe | | | | | EDICA ed to fu | | | | | y the \$ | State o | or cou | ntry | | 4. | | YOU SANIZ | | | OR A | AN AC | BENC, | YOR | | | |
| | 0 | YES | 3 | 0 | NO | | | | | | | | | | | | | | | | | | 0 | YES | | 0 | NO | (If "I | 10," s | skip to | o ques | stion 7 |) |
| 5. | WH. | AT IS | THE | NAM | E OF | THE | AGE | NCY (| OR O | RGA | NIZA ⁻ | TION? | | | | | | | | | | 6. | WHA | AT IS | THE | AGE | ENC | Y TEL | .EPH0 | SNE | NUME | BER? | |
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| 7. | WH. | AT IS | YOL | IR MA | ILING | AD[| DRES | S OF | THA | T OF | YOU | IR AGI | ENCY | 'S AD | MINIS | STRA | TIVE (| OFFIC | E? | | _ | | | | _ | _ | | | | | | | |
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| 8. | PLE | ASE | SELE | ECT E | ACH A | ACTI | VITY | OF D | AILY | LIVII | NG (A | DL) TI | TAH | HE IN | N-HOI | ME CA | ARE A | SSIST | ANT | PRO\ | VIDE | ED T | O TH | IE CA | ARE I | REC | IPIEI | NT. | | | | | |
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| 9. | PLE | ASE | SELE | CTE | ACH I | NST | RUM | ENTA | L AC | TIVI | TY OF | DAIL | Y LIVI | NG (I | ADL) | THAT | THE | IN-HC | ME C | ARE | ASS | SIST | ANT | PRO | VIDE | STO | O TH | E CA | RE R | ECIP | IENT. | | |
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