DEPARTMENT OF VETERANS AFFAIRS

VETERANS 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 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 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	\$1,379.00	\$16,551.00
Basic Pension with 1 dependent	\$1,806.00	\$21,674.00
With Housebound benefits with no dependents	\$1,685.00	\$20,226.00
With Housebound benefits with one dependent	\$2,112.00	\$25,348.00
With Aid and Attendance with no dependents	\$2,300.00	\$27,609.00
With Aid and Attendance with one dependent	\$2,727.00	\$32,729.00
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 \$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 in the last 3 tax years 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 Expense	s:	Gross Income:		Possible Benefit:	
Medicare Part B	\$174.70	SS	\$800.00	VA Max. Monthly Limit	\$1,379.00
Health Insur	<u>125.00</u>	Less med exps	<u>299.70</u>	Less countable income	<u>500.30</u>
Total med exps	\$299.70	Countable inc	\$500.30	VA Pension benefit	\$878.70

2. PENSION WITH AID AND ATTENDANCE EXAMPLE:

The veteran is 78 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 Expense	es:	Gross Income	:	Possible Benefit:
Medicare Part B	\$174.70	RR	\$1,500.00	VA Max. Monthly Limit \$2,300.00
Health Insur	200.00	Pension	700.00	Because the veteran's income is less than
Assisted Living	<u>4,500.00</u>	Total income	\$2,200.00	his medical expenses, his countable inc.
Total med exps	\$4,874.70	Less med exps	4,874.70	is zero. He would receive the full benefit
		Countable inc	ome 0.00	of \$2,300.00 .

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. The gross income and countable medical expenses for both the veteran and spouse are reported.

Medical Expenses:	Gross Income:	Possible Benefit:
Assisted Living \$6,000.00	Vet-SS \$1,100	0.00 VA Max. Monthly Limit \$1,806.00*
Medicare Part B 349.40*	Wife-SS 550	D.00 Because the household income is less than
Health Insur <u>250.00</u>	Wife-Pension 20	2.00 the medical expenses, the countable
Total med exps \$6,599.40	Total income \$1,850	0.00 is zero. He would receive the full benefit
(* $$174.70 X2$ for both veteran and wife)	Less med exps 6,599	9.40 of \$1806.00 . *The veteran does not
	Countable income	7.00 require aid and attendance so the higher
		rate of \$2,727.00 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			OTHER		TOTAL HOUSEHOLD INCOME(A)	COME(A)
MONTHLY INCOME	VETERAN	SPOUSE	DEPENDENT SOURCE	SOURCE	LESS TOTAL HOUSEHOLD	
SOCIAL SECURITY					MEDICAL EXPENSES (B)	
US CIVIL SERVICE					EQUALS COUNTABLE INCOME (C	COME (C)
RAILROAD RETIREMENT					If household income is less than medical	nedical (A-B=C)
BLACK LUNG BENS					expenses, the countable income is "0"	0 s
ANY RETIREMENT OR PENSIONS					VA INCOME LIMIT for your situation	our situation
SSI/PUBLIC ASSISTANCE					(from pg 1-i.e. veteran w/aid & attendance	ttendance
LONG TERM CARE INSUR BENEFITS RECEIVED					is \$2,050.00)	
WAGES FROM EMPLOYMENT						
OTHER (PROVIDE SOURCE)					LESS COUNTABLE INCOME(C)	ME(C)
OTHER (PROVIDE SOURCE)					(from above)	
OTHER (PROVIDE SOURCE)					EQUALS POSSIBLE* VA BENEFIT	BENEFIT
TOTALS			(∀)			
			TOTAL HOUS	TOTAL HOUSEHOLD INCOME	LIST BALANCES OF ALL	LIST BALANCES OF ALL BANK ACCOUNTS, IRAS,
CONTINUING **			OTHER		MUTUAL FUNDS, STOCKS, TRUSTS, ETC. **	(S, TRUSTS, ETC. **
MTHLY MED EXPENSES	VETERAN	SPOUSE	DEPENDENT SOURCE	SOURCE	ACCOUNT	CURRENT BALANCES
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)					TOTAL NET WORTH	
${ m TOTALS}~**$ List only medical expenses which are the same every month ${ m (B)}$	oenses which are th	ne same every mo	onth (B)		**TOTAL NET WORTH N	**TOTAL NET WORTH MUST BE UNDER \$155,356.00
Page 3 1/2024 Pens Worksheet		TOTAL HOU	SEHOLD MEDI	HOUSEHOLD MEDICAL EXPENSES		

IS THERE ANY RENTAL INCOME?

ADDRESS:

DO YOU OWN A HOME?

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 of	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 availal	hle
Marriage Licenses and Death Certificates.	oic.
Proof of all income. Please provide statements showing the GROSS* amounts (before any deduction Medicare, health insurance, etc.) of all monthly income including Social Security, pensions, income from intental or business income, long term care insurance benefits received, etc. *This amount can generally be annual statements from Social Security and other benefits.	vestments,
Current statements for all assets. All checking, savings accounts, stocks, bonds, mutual funds, all tru long term care insurance, savings bonds, etc.	sts, annuities,
Direct Deposit account information and/or voided check.	
Documentation regarding any transfer of assets you or your dependents have made in the last 3 tax Assets transfers include gifts, selling them, purchasing an annuity, or using them to establish a trust.	x years.
Amounts of CONTINUING monthly medical expenses. When initially filing for the VA Pension benefit 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 b - 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.	penefits)
If the claimant is in a Nursing Home: VA Form 21-2680 included in this packet (Examination for Housebound Status or Permanent Need Regular Aid and Attendance) Must be completed by a physician. If both the veteran and spouse require of please have a form completed for each. AND VA Form 21P-0779 included in this packet (Request for Nursing Home Information) Completed by Nursing	care,
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 Regular Aid and Attendance) Must be completed by a physician. If both the veteran and spouse require a please have a form completed for each. AND VA Form 21P-527EZ, page 16 included in this packet (Worksheet for an Assisted Living, etc.) Complete by the facility.	care,
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 Regular Aid and Attendance) Must be completed by a physician. If both the veteran and spouse require of please have a form completed for each. AND VA Form 21P-527EZ, page 17 included in this packet (Worksheet for an In-Home Care, etc.) Completed In-Home Attendant. Complete a Worksheet for each paid In-Home Attendant.	care,

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 form 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)
SECTION VII: EXAMINER'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	MINEK	'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 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)	[
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.

VA FORM 21-0779, SEP 2023 Page 2

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAY	CARE, OR A SIMILAR FACILITY					
NOTE : This worksheet is to be completed by an administrator or licensed medical professional fithis medical provider as an expense, they must be claimed on your application for benefits or VA 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance	Form 21P-8416, Medical Expense Report. In addition, VA Form					
1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the	Claimant or Dependent)					
2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Lic	rensed Medical Professional)					
3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?						
4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)						
5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applications)	able)					
6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?						
No. & Street						
Apt./Unit Number City						
Apt./offit Number						
State/Province Country ZIP Code						
7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?						
8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDIN	G TO THE CARE RECIPIENT.					
A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF						
O D. DRESSING O E. USING THE TOILET OF. AMBULATING WITHIN HOME O	R LIVING AREA					
9. FOR EACH STATEMENT, PLEASE CHECK THE BOX IF THE STATEMENT IS TRUE FOR THE	FACILITY.					
○ THE STATE OR COUNTRY REQUIRES THIS FACILITY TO BE LICENSED						
THE FACILITY IS LICENSED						
C THE FACILITY IS RESIDENTIAL						
○ THE FACILITY IS STAFFED 24 HOURS						
10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.						
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or						
cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)						
YES NO, Care is being provided by a third-party provider. NO, Care is not being provided to this claimant. If care is provided by a third-party provider, please ensure the claimant has each in-home provider complete an In-Home Attendant Worksheet.						
	DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) definite" if the care you provide is not temporary.)					
	/ O INDEFINITE					
13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FAC	CILITY IS RESPONSIBLE FOR PAYING.					
\$ PER MONTH						
FACILITY CERTIFICATION	ON CONTRACTOR OF THE PROPERTY					
I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CAR reflects the current environment of the care recipient and the facility.	E, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and					
14. SIGNATURE OF PROVIDER (From question 2)	15. DATE SIGNED (MM/DD/YYYY)					
, , ,						

VA FORM 21P-527EZ, FEB 2023 Page 16

WORKSHEET FOR IN-HOM	E ATTENDANT EXPENSES
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, Medical Expense Report. In addition, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance may be needed to count these expenses.	
1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)	
2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agend	vy Administrator, Provider)
3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL? (A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.) (YES O NO (If "NO," skip to question 7)	
5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?	6. WHAT IS THE AGENCY TELEPHONE NUMBER?
7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?	
No. & Street	
Apt./Unit Number City	
State/Province Country ZIP Code — —	
8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.	
○ A. EATING○ B. BATHING/SHOWERING○ C. TRANSFERRING IN OR OUT OF BED OR CHAIR○ D. DRESSING○ E. USING THE TOILET○ F. AMBULATING WITHIN HOME OR LIVING AREA	
9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT. C A. SHOPPING C B. FOOD PREPARATION C C. NON-MEDICAL TRANSPORTATION C D. LAUNDERING C E. USING TELEPHONE C F. MANAGING FINANCES C G. HOUSEKEEPING C H. HANDLING MEDICATIONS	
10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.) YES NO	
11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. $(MM/DD/YYYY)$	12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.)
	/ / O INDEFINITE
13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.	14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.
\$ PER HOUR	HOURS PER MONTH
CERTIFICATION	
I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.	
15. SIGNATURE OF PROVIDER (From question 2)	16. DATE SIGNED (MM/DD/YYYY)
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