NOTICE TO SURVIVOR OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

This notice provides information regarding evidence necessary to substantiate a claim for:

- Survivors Pension
- Dependency Indemnity Compensation (D.I.C.)
- D.I.C. under 38 U.S.C. 1151
- D.I.C. re-evaluation based on PL 117-16 (PACT ACT)
- Increased Survivor Benefits Based on Need for Special Monthly Pension or Special Monthly D.I.C.
- Accrued Benefits
- Benefits Based on a Veteran's Seriously Disabled Child

If you are making a claim for:

Pension Benefits	Complete and Submit VA Form 21P-527EZ, *Application for Veterans Pension*
Compensation Benefits	Complete and Submit VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*
Parents' D.I.C Benefits	Complete and Submit VA Form 21P-535, *Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation when Applicable)*
Accrued Benefits	Complete and Submit VA Form 21P-601, *Application for Accrued Benefits Due a Deceased Beneficiary*
Supplemental Claim	Complete and Submit VA Form 20-0995, *Decision Review Request: Supplemental Claim*

If you are ***not*** ready to submit a claim for D.I.C., Survivors Pension, and/or Accrued Benefits, please complete a VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or D.I.C.*, to protect your date of claim. If you complete the VA Form 21P-534EZ within one year of filing the VA Form 21-0966, your completed application will be considered filed as of the date of receipt of the VA Form 21-0966.

VA forms are available at www.va.gov/vaforms.

For more information on survivors benefits see https://www.va.gov/family-and-caregiver-benefits/survivor-compensation/dependency-indemnity-compensation/

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)

You may wish to contact an accredited Veteran Service Officer to assist you with your application. For a list of accredited Veteran's Service Organizations go to https://www.va.gov/vso/. You may also contact your state office of Veterans Affairs at https://discover.va.gov/external-resources/?_resource_type=state-veterans-affairs-office. To assign a VSO as your power of attorney for the claims process, submit VA Form 21-22, *Appointment of Veteran's Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents

Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veterans Affairs go to: https://www.va.gov/ogc/apps/accreditation/index.asp. To assign a private attorney for the claims process, submit a VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims

Generally, an accredited attorney or claims agent can ONLY charge claimants a fee after the VA has issued a decision on a claim. Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

WHEN TO USE THIS FORM

The attached application is needed to submit a claim for D.I.C., Survivors Pension and/or Accrued Benefits. There are worksheets included to help verify care expenses if you claim them. This notice details the evidence necessary to substantiate your claim. Leave items in a section blank if they do not apply to you.

THIS APPLICATION HAS 14 SECTIONS	
SECTION I: VETERAN'S IDENTIFICATION INFORMATION	SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT ON A CLAIM FOR A SPECIAL MONTHLY PENSION
SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION	SECTION IX: INCOME AND ASSETS
SECTION III: VETERAN'S SERVICE INFORMATION	SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES
SECTION IV: MARITAL INFORMATION	SECTION XI: DIRECT DEPOSIT INFORMATION
SECTION V: MARITAL HISTORY	SECTION XII: CLAIM CERTIFICATION AND SIGNATURE
SECTION VI: CHILD OF VETERAN INFORMATION	SECTION XIII: WITNESSES TO SIGNATURE
SECTION VII: D.I.C	

To qualify you must:

1. Submit your claim on a completed, signed and dated VA Form 21P-534EZ, *Application for D.I.C., Survivors Pension, and/or Accrued Benefits* (Attached).
2. Submit simultaneously with your claim:
   - A copy of the veteran's death certificate (unless the veteran died on active duty); AND

If claiming Survivor's Pension:

- All necessary income and asset information; AND
- Any additional forms and evidence as the situation requires. Special Circumstances below indicate the most common circumstances. The application and other VA Forms may require additional evidence.

If claiming D.I.C.:

- All, if any, of the veteran's relevant, private medical treatment records and an identification of any of the veteran's treatment records available at a Federal facility, such as a VA medical center, that supports your claim that a service-connected disability caused the veteran's death or the veteran's death was caused by the VA;
- Any and all Service Treatment and Personnel Records in the custody of the veteran's Guard or Reserve Unit(s) if applicable; AND
- Any additional forms and evidence as the situation requires. Special Circumstances below indicate the most common circumstances. The application and other VA Forms may require additional evidence.

For more information on VA benefits, visit our website at www.va.gov, contact us at https://www.va.gov/contact-us or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.

SPECIAL CIRCUMSTANCES:

Additional forms may be needed to remain eligible.

This includes VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, which may be required if you:

- Have multiple income sources
- Have more than $75,000 in assets
- Additional forms as noted on the VA Form 21P-0969 may be required

If claiming Special Monthly Pension or Special Monthly D.I.C.:

- Please have a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinic Nurse Specialist (CNS) complete VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*, **OR**
- If you are a patient in a nursing home complete VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

If claiming benefits for a child of the veteran:

- And they are in school between the ages of 18 and 23, a completed VA Form 21-674, *Request for Approval of School Attendance*
- If the child was adopted, please submit the adoption papers or amended birth certificate
- If claiming benefits for a child of the veteran who became seriously disabled prior to reaching the age of 18, submit all, if any, relevant private medical treatment records for the child's pertinent disabilities
- If the child is over 18 and you are claiming DIC, the child will have to apply for DIC with their own application.

SUBMITTING A CLAIM

You must submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession. If your claim involves a disability the veteran had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before the veteran's entry into service. A substantially complete claim must contain: (1) The claimant's name; (2) Their relationship to the veteran; (3) Sufficient service information for VA to verify the claimed service, if applicable; (4) The benefit sought and any medical condition(s) on which it is based; (5) The claimant's signature; (6) A statement of income, if applicable.

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

VA will retrieve evidence on your behalf in some circumstances. If VA is unable to retrieve the necessary evidence, we will notify you and provide you with an opportunity to submit the information or evidence. It is your responsibility to make sure we receive all requested records that are not in the possession of a federal department or agency.

VA will:

- Retrieve relevant records from a Federal facility that you adequately identify and authorize VA to obtain.
- Get a medical opinion if we determine it is necessary to decide your claim.
- Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from State or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records from current or former employers.

WHEN YOU SHOULD SEND WHAT WE NEED

You are strongly encouraged to send any information or evidence as soon as you can.

NOTE: You have up to one year from the date we receive the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we received the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim. In order to go back to your original effective date, you will need to submit a supplemental claim if you choose to submit the necessary information or evidence within that year.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See Evidence Tables titled...
Survivors Pension (an income and asset-based benefit for surviors of a veteran with wartime service)	Military Service Verification Survivors Pension
D.I.C. because the veteran's death was related to the veteran's service, OR D.I.C. because the veteran was receiving or entitled to receive benefits for a service-connected disability rated totally disabling	Dependency and Indemnity Compensation (D.I.C.)
D.I.C. because the veteran's death was a result of VA medical treatment, vocational rehabilitation, or compensated work therapy	D.I.C. under 38 U.S.C. 1151
D.I.C. re-evaluation of a previously denied claim based on eligibility under PL 117-168 (PACT Act)	D.I.C. re-evaluation based on PL 117-168 (PACT Act)
D.I.C. that was previously denied by VA	Supplemental D.I.C.
Special Monthly Pension or Special Monthly D.I.C. based on the need for aid and attendance or housebound benefits	Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly D.I.C.
Benefits that were due to the veteran at the time of the veteran's death	Accrued Benefits
Benefits because the child of the veteran is severely disabled	Child incapable of self-support

EVIDENCE TABLES

MILITARY SERVICE VERIFICATION

To support your claim for Survivors benefits, the veteran's military service must be verified. The following evidence can be submitted to verify the veteran's military service:

- A photocopy of the veteran's DD 214 (or equivalent) for all periods of military service. You may request a copy of the DD 214 through the National Archives' National Personnel Records Center (NPRC) using Standard Form 180 (SF-180), *Request Pertaining to Military Records*, (available at https://www.gsa.gov/forms) or through your local public custodian of records

Fire Related Military Records

As you may know, there was a fire at the National Archives and Records Administration on July 12, 1973, which destroyed approximately:

- 80 percent of the records NPRC held for Veterans who were discharged from the Army between November 1, 1912, and January 1, 1960, and
- 75 percent of the records NPRC held for Veterans with surnames beginning (alphabetically) with Hubbard and running through the end of the alphabet, and who were discharged from the Air Force between September 25, 1947, and January 1, 1964.

If the veteran's military records were stored there on that date, they may have been destroyed in the fire. If you believe the veteran's military records may have been destroyed in the fire, NA Form 13075, *Questionnaire About Military Service*, should be completed to avoid delays in processing your claim. NA Form 13075 is available at: https://www.archives.gov/files/st-louis/military-personnel/na-13075-questionnaire-about-military-service.pdf.

NOTE: The Veterans Benefits Administration (VBA) is no longer able to retrieve or return original documents submitted. Please ***do not*** submit original documents to VA since they ***will not*** be returned to you.

SURVIVORS PENSION

To support your claim for **Survivors Pension**, the evidence must show:

1. The veteran met certain minimum active service requirements during a period of war. Generally, those requirements are:
   - 90 days of service during a period of war; **OR**
   - 90 days of consecutive service at least one day of which was during a period of war; **OR**
   - 90 days of combined service during more than one period of war (**Note**: If the veteran's service began after September 7, 1980, additional length-of-service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligations.); **OR**
   - any length of active service during a period of war when:
     - at the time of death, the veteran was receiving (or entitled to receive) VA disability compensation or retirement pay for a service-connected disability; **OR**
     - the veteran was discharged from active service due to a service-connected disability.
2. Your income and assets do not exceed certain requirements.

Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the primary residence including the residential lot area that does not exceed 2 acres, unless the additional acreage is not marketable) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

EVIDENCE TABLES (Continued)

DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

To support a claim for **Dependency and Indemnity Compensation (D.I.C.) based on a service-connected disability:**

- The veteran died while on active service; **OR**
- The veteran had a service-connected disability(ies) that was either the principal or contributory cause of the veteran's death; **OR**
- The veteran died from non-service-connected injury or disease **AND** was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling:
  - For at least 10 years immediately before death; **OR**
  - For at least 5 years after the veteran's release from active duty preceding death; **OR**
  - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999.

To support a claim for **D.I.C. based on a disability VA had not previously determined was service-connected** or for which the veteran did not file a claim during their lifetime, the evidence must show:

- An injury or disease that was incurred or aggravated during active service, or an event in service that caused an injury or disease; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the disability associated with the cause of death and an injury, disease, or event in service. This may be shown by medical records or medical opinion or, in certain cases, by lay evidence.

To support your claim for **D.I.C. based upon the service person's active duty for training**, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty and the disease or injury caused or contributed to the service person's death.

NOTE: If VA granted service connection for a disease or injury during the service person's lifetime, evidence that the service-connected disease or injury caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **D.I.C. based on a disability that was not service-connected** or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the principal or contributory cause of death and the disability due to injury or disease, incurred in the line of duty. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support your claim for **D.I.C. based upon the service person's inactive duty training**, the evidence must show:

- The service person died during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident during such training; **OR**
- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; and that injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death.

NOTE: If VA granted service connection for an injury, acute myocardial infarction, or cerebrovascular accident during the service person's lifetime, evidence that the service-connected condition caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **D.I.C. based on a disability that was not service-connected** or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; **AND**
- The injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death.

D.I.C. UNDER 38 U.S.C. 1151

In order to support your claim for **D.I.C. under 38 U.S.C. 1151**, the evidence must show:

- The deceased veteran died as a result of undergoing VA hospitalization, medical or surgical treatment, examination, or training; **AND**
- The death was:
  - the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment; **OR**
  - the direct result of an event that was not a reasonably expected result or complication of the VA care or treatment; **OR**
  - the direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program.

D.I.C. RE-EVALUATION BASED ON PL 117-168 (PACT ACT)

Public Law 117-168 (PACT ACT) was signed into law on August 10, 2022. This resulted in a substantial expansion of a veteran's military service that qualifies for presumptive toxic exposure and new presumptive conditions linked to that exposure. The law allows prior claimants for D.I.C. to request a re-evaluation based on the expanded eligibility within the PACT Act. More information about the PACT Act can be found at https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

In order to support your claim for **D.I.C. re-evaluation based on PL 117-168 (PACT Act)** the evidence must show:

- A claim was submitted and denied prior to August 10, 2022, the date the PACT Act went into effect; **AND**
- The claimant has elected re-evaluation of the previously denied claim.

SUPPLEMENTAL CLAIM D.I.C.

In order to reopen a **claim previously denied by VA**, we need:

- The prescribed supplemental claim form, VA Form 20-0995, *Decision Review Request: Supplemental Claim*; **AND**
- New and relevant evidence. New and relevant evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.
  - To qualify as new evidence is evidence not previously part of the actual record before agency adjudicators.
  - In order to be considered relevant, the evidence is information that tends to prove or disprove a matter at issue in a claim. Relevant evidence includes evidence that raises a theory of entitlement that was not previously addressed.

INCREASED SURVIVOR BENEFITS BASED ON SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY D.I.C.

In order to support your claim for **increased survivor benefits based on the need for aid and attendance**, the evidence must show:

- you have corrected vision of 5/200 or less in both eyes; **OR**
- you have concentric contraction of the visual field to 5 degrees; **OR**
- you are a patient in a nursing home due to mental or physical incapacity; **OR**
- you require the aid of another person to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulations 3.352(a)); **OR**
- you are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulations 3.352(a)); **OR**

In order to support your claim for **increased benefits based on being housebound**, the evidence must show:

- you are substantially confined to your immediate premises because of permanent disability

ACCRUED BENEFITS

To support a claim for **accrued benefits**, the evidence must show:

- Benefits were due the veteran based on existing ratings, decisions, or evidence in VA's possession at the time of death, but the benefits were not paid before the veteran's death; **AND**
- You are the surviving spouse, child, or dependent parent of the deceased veteran

VA pays accrued benefits in the following order of priority: spouse, children of the veteran (in equal shares) and dependent parents (in equal shares)

NOTE: Child means an unmarried child of the veteran who is under 18 years of age, or at least 18 but under 23 years of age and pursuing an approved course of education or became incapable of self-support prior to reaching age 18.
If there are no living persons who are entitled on the basis of relationship, accrued benefits may be used to reimburse the person or persons who paid for or are responsible to pay the expenses of last illness and burial of a beneficiary. The claim should be filed by the person or persons whose funds were or will be used to pay such expenses using VA Form 21P-601, *Application for Accrued Amounts Due a Deceased Beneficiary*.

CHILD INCAPABLE OF SELF-SUPPORT

To support a **claim for benefits based on a veteran's child being incapable of self-support**, the evidence must show that the child, before their 18th birthday became permanently incapable of self-support due to mental or physical disability. The information necessary to establish the extent of the child's disability includes:

- the extent to which the child is and was, prior to reaching their 18th birthday, physically or mentally deficient as evidenced by factors such as their ability to perform self-care functions, and ordinary tasks expected of a child of that age
- whether or not the child attended school and, if so, the maximum grade attended
- if any material improvement in the child's condition has occurred
- if the child has ever been employed and, if so, the nature and dates of such employment, and amount of pay received
- whether or not the child has ever been married, and
- a description of the child's present condition

PRESUMPTIVE SERVICE CONNECTION

To support a claim for presumptive service connection the evidence must show:

- The veteran served in a recognized location that qualifies for the presumption of exposure; **AND/OR**
- The veteran died of a disability that qualifies for the presumption of service connection. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable.

Under certain circumstances, VA may presume that certain current diseases were caused by service, even if there is no specific evidence proving this in your particular claim. Service connection is presumed for certain diseases for the following veterans:

- Former prisoners of war;
- Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;
- Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;
- Veterans who were exposed to certain herbicides, such as by service in/on:
  - Vietnam or qualifying offshore waters, from January 9, 1962, through May 7, 1975;
  - a unit determined by VA or the Department of Defense to have operated in the Korean DMZ, from September 1, 1967, through August 31, 1971;
  - individuals who performed service in the Air Force or Air Force Reserve and regularly and repeatedly operated, maintained, or served on board C-123 aircraft known to have used to spray an herbicide agent during the Vietnam era;
  - Thailand at any United States or Royal Thai base, from January 9, 1962, through June 30, 1976;
  - Laos, from December 1, 1965, through September 30, 1969;
  - Cambodia at Mimot or Krek, Kampong Cham Province, from April 16, 1969, through April 30, 1969;
  - Guam or American Samoa, or in the territorial waters thereof, from January 9, 1962, through July 31, 1980;
  - Johnston Atoll or on a ship that called at Johnston Atoll, from January 1, 1972, through September 30, 1977.
- Veterans who served at Camp Lejeune for no less than 30 days (consecutive or nonconsecutive) between August 1, 1953 and December 31,1987; **OR**
- Veterans who served in the Gulf War:
  - On or after August 2, 1990, and served in:
    - Bahrain; Iraq; the neutral zone between Iraq and Saudi Arabia; Kuwait; Oman; Qatar; Saudi Arabia; Somalia; United Arab Emirates; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; the Red Sea; Afghanistan; Israel; Egypt; Turkey; Syria; or Jordan; **OR**
  - On or after September 11, 2001, and served in:
    - Afghanistan; Djibouti; Egypt; Jordan; Lebanon; Syria; Yemen; or Uzbekistan.

IMPORTANT INFORMATION REGARDING MARRIAGE

If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant a claim for Survivors Benefits, the beginning date of your entitlement will generally be the date we received your claim, or the intent to file (ITF) for Survivor Benefits, if received within a year of the ITF. If VA receives your claim within one year after the veteran's death, the entitlement will be from the first day of the month in which the veteran died. The veteran's death certificate is evidence relevant to determining the effective date of any benefits we award.

Aid and attendance or housebound benefits may be available for a veteran's surviving spouse who is unable to perform certain activities of daily living, are a patient in a nursing home, or are substantially confined to their immediate premises. Special monthly pension may be effective from the date medical evidence first shows entitlement.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

When you have completed this application, you can either submit online or mail it to the Pension Intake Center listed below. Attach any materials that support and explain your claim. Also, make a photocopy of your application and any evidence you send to VA before submitting.

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs Pension Intake Center P.O. Box 5365 Janesville, WI 53547-5365	VA gov: www.va.gov QuickSubmit via: access.va.gov

TERMS AND CALCULATIONS FOR PENSION

Maximum Annual Pension Rate (MAPR)
This is the maximum payable amount of the benefit. Your MAPR is based on how many dependents you have, if you're married to another Veteran who qualifies for a pension, and if your disabilities qualify you for housebound or aid and attendance benefits. The MAPR is adjusted each year for cost-of-living increases.

Medical Deductible
The unreimbursed expenses must exceed 5 percent of the applicable **MAPR**. The deductible increases based on the number of dependents but is not adjusted for aid and attendance (A&A) or housebound benefits.

Countable Medical Expenses
Your countable medical expenses are only those medical expenses that exceed the **Medical Deductible**. Medical expenses are typically considered on a calendar year basis. Your initial year is considered separately, and we will count medical expenses which provide the greatest benefit.

Recurring Medical Expenses

- Examples include: Medicare Part B, medical related insurance, in-home care provider, or care provided by a care facility

One-Time Medical Expenses

- Examples include: medical co-payments, prescription medications, and durable medical equipment

Reported Annual Medical Expenses - Medical Deductible = Countable Medical Expenses (Min. Zero)

Countable Income
We count the **gross** income you receive as reported or the income we discover from data matching programs with other federal sources. If our data match shows a significant discrepancy, you will be asked to clarify the discrepancy. We count incomes in three ways:

- One-time income is income that you receive once. VA will count it for one year from the first of the following month from receipt date.
  - Examples include: lottery winnings, gifts, capital gains from property sales, irregular IRA (Individual Retirement Account) or stock disbursements.
- Irregular income is income that you receive at different times or in irregular amounts throughout the year. VA will count it for one year from the first of the following month from receipt date receipt date.
  - Examples include: odd jobs or contract work and interest income.
- Recurring income is counted continuously until we are informed that you are no longer in receipt of it.
  - Examples include: wages from employment, retirement payments, required minimal distributions from an IRA (Individual Retirement Account).

Income for VA Purposes (IVAP)
VA counts all of your family income and considers any unreimbursed medical expenses reported when determining your IVAP. The following calculation is a way for you to estimate your IVAP:

Countable Annual Income - Countable Medical Expenses = IVAP

Pension Rate
Your maximum annual benefit is the difference of the current MAPR and what the VA calculates as your IVAP. To convert into a monthly benefit, take this amount and divide by 12 then rounded down to the nearest dollar.

MAPR - IVAP = Annual Pension Rate

Net Worth
The net worth limit is increased by the same percentage as the Social Security increase when there is a cost-of-living adjustment. For purposes of entitlement to VA Pension, net worth includes your and your spouse's assets and your and your dependent's annual income. VA considers children's net worth separately if their net worth would cause you to exceed the limit. VA won't consider them as a dependent when determining your pension entitlement.

Additional information about how VA calculates net worth, Income, and benefits rates can be found at:
https://www.va.gov/pension/veterans-pension-rates/

SURVIVORS BENEFITS APPLICATION CHECKLIST

In addition to your application, VA may require some of the evidence described in this checklist. Failure to provide needed evidence, may delay the decision on your claim. This checklist does not apply to claims for Accrued benefits. Please carefully read pages 5 and 6 of the Instructions if you are claiming service-connected death (Dependency and Indemnity Compensation (D.I.C.) only. Please note, the items marked with an asterisk (*) are required.

VERIFICATION OF VETERAN'S DEATH* *(Requested on page 2 of Instructions)*

- ☐ A Death certificate for the veteran, clearly showing the primary cause(s) of death and any contributing factors or conditions *(If the veteran's death certificate lists the cause of death as "Pending," please have the medical examiner submit evidence that shows the cause of death)*.

SERVICE VERIFICATION* *(Requested on page 4 of Instructions and Section III of the form)*

- ☐ Copy of the veteran's DD Form 214 (or equivalent) for all periods of military service. Must demonstrate military service dates, type of service and character of discharge.

INCOME AND NET WORTH *(Requested on page 2 of Instructions and Section IX of the form)*

- ☐ VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, is required if instructed in Section IX of this application form. **NOTE**: If you have specific types of income or assets the VA Form 21P-0969 requires additional evidence:
  - ☐ Farm - VA Form 21P-4165, *Pension Claim Questionnaire for Farm Income*
  - ☐ Business - VA Form 21P-4185, *Report of Income from Property or Business*
  - ☐ Rental Property - VA Form 21P-4185, *Report of Income from Property or Business*
  - ☐ Royalties - VA Form 21-4138, *Statement in Support of Claim* (provide details, such as Royalty source, joint owners, etc.)
  - ☐ Trust - Submit complete Trust documents to include the Schedule of Assets

SPECIAL CIRCUMSTANCES REGARDING YOUR MEDICAL CARE
(Requested on page 2 of Instructions and in Sections VIII and X of the form)

Claim for Special Monthly Pension (SMP) - Aid and Attendance or Housebound Status

- ☐ VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Claim for Medicare Nursing Home and/or $90.00 Rate Reduction Request

- ☐ VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

Claim for Fiduciary Assistance

- ☐ VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Statement of Medical Care

- ☐ Care Worksheets (found on pages **19** and **20** of the form)
- ☐ Proof of Payment from care provided (canceled checks, bank statements, etc.)
- ☐ Signed verification from care service provider

DEPENDENT CHILDREN* *(Requested on page 2 of Instructions and Section VI of the form)*

- ☐ A birth certificate must be included clearly showing the veteran as the parent if you do not reside within the U.S. or its territories. (A state includes the District of Columbia, Puerto Rico and other territories and possessions of the U.S.)
- ☐ If child(ren) is/are adopted the adoption decree or a revised birth certificate is required.
- ☐ If your child is over 18 but under 23 please submit VA Form 21-674, *Request for Approval of School Attendance*.
- ☐ Medical records for each seriously disabled child.

MEDICAL EXPENSES *(Requested in Section X of the form)*

- ☐ If additional space is needed, submit VA Form 21P-8416, *Medical Expense Report*.

OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: 08/31/2028

VA | U.S. Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR D.I.C., SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 18. Use this form to submit a claim for D.I.C., Survivors Pension, and/or Accrued Benefits. For additional information or questions contact us online at https://www.va.gov/contact-us or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms. If submitting by mail, send completed form to: **Department of Veterans Affairs, Pension Intake Center, P.O. Box 5365, Janesville, WI 53547-5365**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION *(Must complete)*

NOTE: You may *either* complete the form by typing the information in on the computer or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

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

1B. VETERAN'S SOCIAL SECURITY NUMBER — —

1C. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* / /

1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?
☐ YES ☐ NO

1E. VA FILE NUMBER *(If known)*

1F. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?
☐ YES ☐ NO

1G. VETERAN'S SERVICE NUMBER

1H. VETERAN'S DATE OF DEATH? *(MM/DD/YYYY)* / /

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(Must complete)*

2A. YOUR NAME *(First, Middle Initial, Last)*

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? *(Check one)*
☐ SURVIVING SPOUSE ☐ CHILD 18-23 IN SCHOOL ☐ CUSTODIAN FILING FOR CHILD UNDER 18 ☐ DISABLED ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER — —

2D. YOUR DATE OF BIRTH *(MM/DD/YYYY)* / /

2E. ARE YOU A VETERAN?
☐ YES ☐ NO

2F. 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 —

2G. YOUR TELEPHONE NUMBER *(Include Area Code)* — —

International Phone Number *(If applicable)* _____

2H. E-MAIL ADDRESS *(Optional)*

2I. WHAT ARE YOU CLAIMING? *(Check all that apply)*
☐ DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.) ☐ SURVIVORS PENSION ☐ ACCRUED BENEFITS

SECTION III: VETERAN'S SERVICE INFORMATION

(Skip to Section IV if the veteran was receiving VA compensation or pension benefits at the time of their death)

NOTE: Please refer to instructions page 4, Military Service Verification for more information pertaining to service information and relevant documents.

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME?
☐ YES ☐ NO *(If "YES," list other names the veteran served under below) (First, Middle Initial, Last)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION III: VETERAN'S SERVICE INFORMATION *(Continued)*

3B. DATE VETERAN ENTERED ACTIVE DUTY *(MM/DD/YYYY)*

3C. DATE VETERAN RELEASED FROM ACTIVE DUTY *(MM/DD/YYYY)*

3D. BRANCH OF SERVICE

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS
☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA ☐ USPHS

3E. PLACE OF LAST SEPARATION

3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*

☐ YES ☐ NO *(If "NO," skip to Item 3J)*

3G. DATE OF ACTIVATION *(MM/DD/YYYY)*

3H. WHAT IS THE NAME OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3I. WHAT IS THE ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3J. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? *(Include Area Code)*

3K. WAS THE VETERAN EVER A PRISONER OF WAR?

☐ YES ☐ NO *(If "NO," skip to Section IV)*

3L. START DATE OF CONFINEMENT *(MM/DD/YYYY)*

START:

3M. END DATE OF CONFINEMENT *(MM/DD/YYYY)*

END:

SECTION IV: MARITAL INFORMATION

(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

NOTE: When reporting place, if the country is the United States, VA needs city and state as well.

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

☐ YES ☐ NO *(If "YES," provide explanation below)*

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF HIS/HER DEATH?

☐ YES ☐ NO *(If "NO," complete Item 4C)*

4C. HOW DID YOUR MARRIAGE TO THE VETERAN END?

☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

4D. START DATE OF YOUR MARRIAGE TO THE VETERAN

4E. END DATE OF YOUR MARRIAGE TO THE VETERAN

4F. PLACE OF MARRIAGE *(City/State or Country)*

4G. PLACE OF MARRIAGE TERMINATION *(City/State or Country)*

4H. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, etc.)*

☐ CEREMONIAL ☐ OTHER *(Explain)*:

4I. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

☐ YES ☐ NO

4J. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

☐ YES ☐ NO

4K. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?

☐ YES ☐ NO *(If "YES," skip to Item 4N)*

4L. WHAT WAS THE REASON FOR SEPARATION?

☐ MEDICAL/FINANCIAL REASONS
☐ MARITAL DISCORD/OTHER (*if you select this option fill out 4M)*

4M. EXPLANATION OF SEPARATION (*Give, the reason, date(s), and duration of the separation, to include the court order if separation is due to court order)*

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4N. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?

☐ YES ☐ NO *(If "NO," skip to Item 5A)*

4O. START DATE OF YOUR REMARRIAGE? *(MM/DD/YYYY)*

4P. END DATE OF YOUR REMARRIAGE? *(MM/DD/YYYY)*

4Q. HOW DID YOUR REMARRIAGE END?

☐ DEATH ☐ DIVORCE ☐ DID NOT END ☐ OTHER *(Explain)*

4R. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH?

☐ YES ☐ NO *(If "YES," please submit a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for each marriage)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION V: MARITAL HISTORY

NOTE: When reporting place, if the country is the United States, VA needs city and state as well.

5A. WERE YOU RECOGNIZED AS THE SPOUSE BY VA BEFORE THE DEATH OF THE VETERAN OR WERE YOU AND THE VETERAN ONLY EVER MARRIED TO EACH OTHER? IF YES, SKIP TO SECTION VI.

☐ YES ☐ NO

VETERAN'S PRIOR MARRIAGES *(If None, skip to Item 5O)*

5B. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO *(First, Middle Initial, Last)*

5C. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

5D. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* START: ___/___/____

5E. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* END: ___/___/____

5F. PLACE OF MARRIAGE *(City/State or Country)*

5G. PLACE OF MARRIAGE TERMINATION *(City/State or Country)*

5H. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO *(First, Middle Initial, Last)*

5I. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

5J. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* START: ___/___/____

5K. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* END: ___/___/____

5L. PLACE OF MARRIAGE *(City/State or Country)*

5M. PLACE OF MARRIAGE TERMINATION *(City/State or Country)*

5N. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
☐ YES ☐ NO *(If "YES," please submit a VA Form 21-686c, Application Request to Add And/Or Remove Dependents, or VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)*

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN *(If None, skip to Section VI)*

5O. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN *(First, Middle Initial, Last)*

5P. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

5Q. DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)* START: ___/___/____

5R. DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)* END: ___/___/____

5S. PLACE OF MARRIAGE *(City/State or Country)*

5T. PLACE OF MARRIAGE TERMINATION *(City/State or Country)*

5U. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN *(First, Middle Initial, Last)*

5V. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

5W. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* START: ___/___/____

5X. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* END: ___/___/____

5Y. PLACE OF MARRIAGE *(City/State or Country)*

5Z. PLACE OF MARRIAGE TERMINATION *(City/State or Country)*

6. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?
☐ YES ☐ NO *(If "YES," please submit a VA Form 21-686c, Application Request to Add And/Or Remove Dependents, or VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VI: CHILD OF THE VETERAN INFORMATION

(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)

(Skip to Section VII if you are NOT claiming benefits for a child(ren) of the veteran)

NOTE: Please refer to instructions page 2, under "*Special Circumstances*" for what is considered a dependent child. In most circumstances, children over the age of 23 are not considered dependent for VA purposes, unless the child is determined to be seriously disabled based on a condition that started before turning 18.

NOTE: When reporting place, if the country is the United States, VA needs city and state as well.

6A. HOW MANY DEPENDENT CHILDREN OF THE VETERAN ARE THERE?

*(**NOTE**: Please complete a VA Form 21-686c, Application Request to Add and/or Remove Dependents, if you need more space for additional dependents.)*

6B. CHILD'S NAME *(First, Middle Initial, Last)*

6C. CHILD'S BIRTH DATE *(MM/DD/YYYY)*

6D. CHILD'S SOCIAL SECURITY NUMBER

6E. PLACE OF BIRTH *(City/State or Country)*

6F. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD *(in school)* ☐ SERIOUSLY DISABLED ☐ MARRIED/PREVIOUSLY MARRIED

☐ CHILD DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $

6G. CHILD'S NAME *(First, Middle Initial, Last)*

6H. CHILD'S BIRTH DATE *(MM/DD/YYYY)*

6I. CHILD'S SOCIAL SECURITY NUMBER

6J. PLACE OF BIRTH *(City/State or Country)*

6K. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD *(in school)* ☐ SERIOUSLY DISABLED ☐ MARRIED/PREVIOUSLY MARRIED

☐ CHILD DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $

6L. CHILD'S NAME *(First, Middle Initial, Last)*

6M. CHILD'S BIRTH DATE *(MM/DD/YYYY)*

6N. CHILD'S SOCIAL SECURITY NUMBER

6O. PLACE OF BIRTH *(City/State or Country)*

6P. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD *(in school)* ☐ SERIOUSLY DISABLED ☐ MARRIED/PREVIOUSLY MARRIED

☐ CHILD DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $

6Q. DO YOUR CHILDREN WHO DO NOT LIVE WITH YOU *(If listed above)* RESIDE AT THE SAME ADDRESS?

☐ YES ☐ NO *(If "YES," please complete Item 6R)* *(If "NO," Please complete a VA Form 21-4138, Statement in Support of Claim, with the following information: Name of person the child is currently living with, and the full address of where the child resides.)*

6R. PLEASE PROVIDE THE NAME OF THE CHILD(RENS) CUSTODIAN BELOW:

NAME OF CUSTODIAN *(First, Middle Initial, Last)*

6S. PLEASE PROVIDE THE ADDRESS OF THE CHILD(RENS) CUSTODIAN BELOW:

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 –

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VII: DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

(Skip to Section VIII if you are NOT claiming D.I.C.)

7A. WHAT BENEFIT ARE YOU CLAIMING? *(Check one) Please refer to the Instructions page 5 for guidance on 38 U.S.C. 1151)*
*(**Note**: Please refer to Instructions page 6 for guidance on PACT Act)*

☐ D.I.C. ☐ D.I.C. under U.S.C. 1151 *(**Note**: D.I.C. under 38 U.S.C. is a rare benefit.)* ☐ D.I.C. due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 *(PACT Act)*

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES

NAME OF VA MEDICAL CENTER	LOCATION	START DATE(S) OF TREATMENT *(MM/DD/YYYY)*	END DATE(S) OF TREATMENT *(MM/DD/YYYY)*
		/ /	/ /
		/ /	/ /
		/ /	/ /

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY D.I.C. BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

☐ YES ☐ NO *(If "YES," please complete a VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP/CRNP), or Clinical Nurse Specialist (CNS))*

8B. ARE YOU NOW IN A NURSING HOME?

☐ YES ☐ NO *(If "YES," complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance. For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly D.I.C.")*

SECTION IX: INCOME AND ASSETS

(Skip to Section X if you are NOT claiming survivors pension but claiming any last expenses)

NOTE: **Assets** are all the money and property you or your dependents own. Assets **do not** include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER $75,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?

☐ YES *(If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.))*

☐ NO *(If "No," provide an estimate of the total value of your assets below)* $

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? *(Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust.)*

☐ YES ☐ NO *(If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.))*

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

☐ YES ☐ NO *(If "NO," skip to Item 9G)*

9D. IS THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

☐ YES ☐ NO *(If "NO," skip to Item 9G)*

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES? *(Do **NOT** include the value of the residence or the first 2 acres.)*

$

9F. IS THE LAND OVER 2 ACRES (87, 120 SQ FT) MARKETABLE?

☐ YES ☐ NO *(If "YES," please submit VA Form 21P-0969)*

9G. HOW MANY INCOME SOURCES DOES YOUR FAMILY HAVE?

☐ NO INCOME ☐ 1-4 SOURCES OF INCOME

☐ 5+ SOURCES OF INCOME *(If 5+ please submit VA Form 21P-0969) and ONLY report your Social Security Income)*

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

☐ YES ☐ NO *(If "YES," please submit VA Form 21P-0969)*

SECTION IX: INCOME AND ASSETS *(Continued)*

(Skip to Section X if you are NOT claiming survivors pension but claiming any last expenses)

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim.

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9I(2) SPECIFY THE TYPE OF INCOME	9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CUSTODIAN ☐ CHILD *(Specify Name)* ☐ CUSTODIAN'S SPOUSE	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9I(4) CURRENT GROSS MONTHLY INCOME $
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9J(2) SPECIFY THE TYPE OF INCOME	9J(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CUSTODIAN ☐ CHILD *(Specify Name)* ☐ CUSTODIAN'S SPOUSE	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9J(4) CURRENT GROSS MONTHLY INCOME $
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9K(2) SPECIFY THE TYPE OF INCOME	9K(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CUSTODIAN ☐ CHILD *(Specify Name)* ☐ CUSTODIAN'S SPOUSE	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9K(4) CURRENT GROSS MONTHLY INCOME $
9L(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9L(2) SPECIFY THE TYPE OF INCOME	9L(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CUSTODIAN ☐ CHILD *(Specify Name)* ☐ CUSTODIAN'S SPOUSE	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9L(4) CURRENT GROSS MONTHLY INCOME $

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid.

Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child, educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES OR OTHER EXPENSES?

☐ YES ☐ NO *(If "NO," skip to Section XI)*

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider. **All in-home care fees or facility fees you pay must be reported on this form if you want VA to use them as a deductible expense.**

10B(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10B(2). NAME OF PROVIDER	10B(4). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER *(Specify Name)*	10B(3). TYPE OF CARE *(Select one)*: ☐ NURSING HOME ☐ RESIDENTIAL CARE FACILITY ☐ ADULT DAYCARE ☐ IN-HOME CARE ATTENDANT	Payment Rate (Per Hour) $ 10B(5). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE: Hours Worked (Per Month)

10B(6). PROVIDER START DATE *(MM/DD/YYYY)*	10B(8). PAYMENT FREQUENCY	10B(9). AMOUNT YOU PAY *(Based on frequency selected in Item 10B(8))*
10B(7). PROVIDER END DATE *(MM/DD/YYYY)* ☐ CONTINUING	☐ MONTHLY ☐ ANNUALLY	$

VETERAN'S SOCIAL SECURITY NUMBER ___ — ___ — ____

IN-HOME CARE OR CARE FACILITY *(Continued)*

10C(1). WHOSE EXPENSES WERE PAID? *(Select One)*
- ☐ SURVIVING SPOUSE
- ☐ OTHER *(Specify Name)*

10C(2). NAME OF PROVIDER

10C(3). TYPE OF CARE
- ☐ NURSING HOME
- ☐ RESIDENTIAL CARE FACILITY
- ☐ ADULT DAYCARE
- ☐ IN-HOME CARE ATTENDANT

10C(4). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Payment Rate (Per Hour) $

10C(5). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Hours Worked (Per Month)

10C(6). PROVIDER START DATE *(MM/DD/YYYY)* / /

10C(7). PROVIDER END DATE *(MM/DD/YYYY)* / /
- ☐ CONTINUING

10C(8). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY

10C(9). AMOUNT YOU PAY *(Based on frequency selected in Item 10C(8))*
$

10D(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ OTHER *(Specify Name)*

10D(2). NAME OF PROVIDER

10D(3). TYPE OF CARE *(Select one)*:
- ☐ NURSING HOME
- ☐ RESIDENTIAL CARE FACILITY
- ☐ ADULT DAYCARE
- ☐ IN-HOME CARE ATTENDANT

10D(4). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Payment Rate (Per Hour) $

10D(5). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Hours Worked (Per Month)

10D(6). PROVIDER START DATE *(MM/DD/YYYY)* / /

10D(7). PROVIDER END DATE *(MM/DD/YYYY)* / /
- ☐ CONTINUING

10D(8). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY

10D(9). AMOUNT YOU PAY *(Based on frequency selected in Item 10D(8))*
$

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

10E(2). PAID TO *(Name of Provider, Insurance company, etc.)*

10E(3). PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10E(4). DATE COSTS PAID *(MM/DD/YYYY)* / /

10E(5). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY
- ☐ ONE-TIME

10E(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10E(5))*
$

10F(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

10F(2). PAID TO *(Name of Provider, Insurance company, etc.)*

10F(3). PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10F(4). DATE COSTS PAID *(MM/DD/YYYY)* / /

10F(5). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY
- ☐ ONE-TIME

10F(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10F(5))*
$

10G(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

10G(2). PAID TO *(Name of Provider, Insurance company, etc.)*

10G(3). PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10G(4). DATE COSTS PAID *(MM/DD/YYYY)* / /

10G(5). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY
- ☐ ONE-TIME

10G(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10G(5))*
$

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES *(Continued)*

10H(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

10H(2). PAID TO *(Name of Provider, Insurance company, etc.)*

10H(3). PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10H(4). DATE COSTS PAID *(MM/DD/YYYY)*

10H(5). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10H(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10H(5))*

$

10I(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

10I(2). PAID TO *(Name of Provider, Insurance company, etc.)*

10I(3). PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10I(4). DATE COSTS PAID *(MM/DD/YYYY)*

10I(5). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10I(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10I(5))*

$

10J(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

10J(2). PAID TO *(Name of Provider, any medical Insurance company, etc.)*

10J(3). PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10J(4). DATE COSTS PAID *(MM/DD/YYYY)*

10J(5). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10J(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10J(5))*

$

SECTION XI: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP) and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*

11B. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

11C. ACCOUNT NUMBER *(Check the appropriate box and provide the account number, or simply write "Established," if you have a direct deposit with VA.)*

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

Account No.:

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

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

I certify I have received the notice attached to this application titled ***Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency and Indemnity Compensation, Survivors Death Pension, and/or Accrued Benefits.***

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim.

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE) (Continued)*

12A. CLAIMANT'S SIGNATURE **OR** MARK WITH AN "X" IF UNABLE TO SIGN ***(REQUIRED)***	12B. DATE SIGNED *(MM/DD/YYYY)*
	/ /

SECTION XIII: WITNESSES TO SIGNATURE

(TWO (2) WITNESS SIGNATURES ARE REQUIRED ONLY IF ITEM 12A IS SIGNED WITH AN "X")

13A. SIGNATURE OF WITNESS *(Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12A using an "X")*	13B. PRINTED NAME OF FIRST WITNESS Name:
	13C. PRINTED ADDRESS OF FIRST WITNESS Address:
13D. SIGNATURE OF WITNESS *(Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12A using an "X")*	13E. PRINTED NAME OF SECOND WITNESS Name:
	13F. PRINTED ADDRESS OF SECOND WITNESS Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE *(NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)*

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED *(MM/DD/YYYY)*
	/ /

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

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0004, and it expires 8/31/2028. Public reporting burden for this collection of information is estimated to average 40 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Pleaserefer to OMB Control No. 2900-0004 in any correspondence. Do not send your completed VA Form 21P-534EZ to this email address.

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they 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) (First, Last)*

2. WHO IS COMPLETING THIS WORKSHEET? *(Name of Provider, either an Administrator or Licensed Medical Professional) (First, Last)*

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 applicable)*

– –

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY OR THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

8. SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING 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. FOR EACH STATEMENT BELOW, PLEASE CHECK THE APPROPRIATE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

YES	NO	
☐	☐	THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
☐	☐	THE FACILITY IS LICENSED
☐	☐	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 dangers incident 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.

11. DATE THE CARE RECIPIENT WAS ADMITTED TO THE FACILITY. *(MM/DD/YYYY)*

/ /

12. DO YOU EXPECT THIS CARE TO END? *(If "Yes, "provide the date the care is expected to end in question 13.)*

☐ YES ☐ NO

13. DATE YOU EXPECT CARE TO END. *(MM/DD/YYYY)*

/ /

14. MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

$, . PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

15. SIGNATURE OF PROVIDER *(From question 2)*

16. DATE SIGNED *(MM/DD/YYYY)*

/ /

WORKSHEET FOR IN-HOME 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) (First, Last)*

2. WHO IS COMPLETING THIS WORKSHEET? *(In-Home Care Attendant or Agency Administrator, Provider) (First, Last)*

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 ☐ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?
☐ YES ☐ 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 PROVIDED 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.
☐ A. SHOPPING ☐ B. FOOD PREPARATION ☐ C. NON-MEDICAL TRANSPORTATION
☐ D. LAUNDERING ☐ E. USING TELEPHONE ☐ F. MANAGING FINANCES
☐ G. HOUSEKEEPING ☐ 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 dangers incident to their daily environment.)
☐ YES ☐ NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. *(MM/DD/YYYY)*
/ /

12. DO YOU EXPECT THIS CARE TO END? *(IF YES, PROVIDE THE DATE THE CARE IS EXPECTED TO END IN QUESTION 13.)*
☐ YES ☐ NO

13. DATE YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)*
/ /

14. MONTHLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$, . PER MONTH

15. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.
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.

16. SIGNATURE OF PROVIDER *(From question 2)*

17. DATE SIGNED *(MM/DD/YYYY)*
/ /