PENSION WITH AID AND ATTENDANCE
DOCUMENTS NEEDED

- Veterans Separation Paperwork (Must be a wartime veteran & meet the minimum service criteria)
- Marriage Certificate
  - Marital History for both vet & spouse
- Death Certificate (Long Form w/ Cause of Death)
- Recent Bank Statement for Checking and Savings account
- Social Security Statement
- Aid and Attendance (VA Form 21-2680)
- Nursing Home Forms – two to be completed *
- Assisted Living Facility Forms – two to be completed *
- In-Home Healthcare Forms – two to be completed *
- Annuity Monthly Statement
- Private Sector Monthly Pension Statement
- Any statements for IRA's, Bonds, Stocks, etc…
- Net worth & combine income limit must be below ***$150,538.00 dollars***
- Direct Deposit information – Bank Name, Account Number & Routing number

(*) There are two different forms for each category – just complete the category of forms that pertain to your situation.

*** Please have all documents available prior your appointment to avoid delays***

Eligible Wartime Periods

Under current law, VA recognizes the following wartime periods to determine eligibility for VA Pension benefits:

- **World War II** (December 7, 1941 - December 31, 1946)
- **Korean Conflict** (June 27, 1950 - January 31, 1955)
- **Vietnam War** (November 1, 1955 - May 7, 1975) - for Veterans who served *"in country" as of January 5, 2021*
  - **Vietnam Era** (August 5, 1964 - May 7, 1975)
- **Gulf War** (August 2, 1990 - through a future date to be set by law or Presidential Proclamation)

** Veterans must have at least 90 days of active duty, including one day during wartime period. If the active duty occurred after September 7, 1980, the vet must have served at least 24 months or the full period that he/she were called up (some exceptions may apply)**

VA PENSION MAXIMUM MONTHLY AMOUNTS FOR 2023
(Effective 12-1-2022)

AID AND ATTENDANCE (A&A)

Veteran:	$2,229
One Dependent:	$2,643
Widow(er) No Dependents:	$1,432
Widow(er) One Dependent:	$1,709

HOUSEBOUND (HB)

Veteran:	$1,633
One Dependent:	$2,047
Widow(er) No Dependents:	$1,095
Widow(er) One Dependent:	$1,371

NOTE THE MAXIMUM YEARLY INCOME TO QUALIFY IS…

Veteran Pension:	$16,037
Veteran w/ One Dependent:	$21,001
Veteran (HB):	$19,598
Veteran w/ One Dependent (HB):	$24,562
Veteran (A&A):	$26,752
Veteran w/ One Dependent (A&A):	$31,714
Widow(er) (Pension):	$10,757
Widow(er) (HB):	$13,147
Widow(er) (A&A)	$17,192

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

IMPORTANT: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

NOTE: If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative.* See Page 4 for information on how to submit the completed form, either by mail, in person at a VA regional office or electronically. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S INFORMATION

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

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

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)* — ___ – ___ – ____

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH — Month ___ – Day ___ – Year ____

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

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'S 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

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

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

11. CLAIMANT'S 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

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

American Legion

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

Veteran Service Officer

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

vso@fdva.state.fl.us

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☒ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☒ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 *or* 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	22B. DATE SIGNED *(MM/DD/YYYY)*
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A *(Do Not Print)*	23B. DATE SIGNED *(MM/DD/YYYY)*

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO:	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*
	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

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

Dr. Fills out From Section III to End

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

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

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

6. SEX
- ◯ MALE
- ◯ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*

8. E-MAIL ADDRESS *(Optional)*

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

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

SECTION II: CLAIM INFORMATION

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

11. CLAIMANT'S SOCIAL SECURITY NUMBER

12. RELATIONSHIP OF CLAIMANT TO VETERAN
◯ SPOUSE ◯ SELF

13. CLAIMANT'S HOME ADDRESS

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

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

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

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

SECTION III: INFORMATION OF EXAMINATION

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

16A. IS CLAIMANT HOSPITALIZED?
◯ YES ◯ NO *(If "Yes," complete Items 16B, 17A & 17B)*

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

17A. NAME OF HOSPITAL

17B. ADDRESS OF HOSPITAL

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

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

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

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

19. NUTRITION	20. GAIT

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

25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

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

◯ YES ◯ NO

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

◯ YES ◯ NO

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

◯ YES ◯ NO

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

◯ YES ◯ NO

29B. CORRECTED VISION	
LEFT EYE	RIGHT EYE

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

◯ YES ◯ NO

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

◯ YES ◯ NO

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

◯ YES ◯ NO

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

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

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE (Attach a separate sheet of paper if additional space is needed)

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

36. DESCRIBE RESTRICTION OF SPINE, TRUNK AND NECK

37. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

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

39. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? (If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 38 above)

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

SECTION IV: CERTIFICATION AND SIGNATURE

40A. PRINTED NAME OF PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED *(MM-DD-YYYY)*
		__ – __ – ____

41. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	42A. TELEPHONE NUMBER OF MEDICAL FACILITY
	___ – ___ – ____

42B. NAME OF MEDICAL FACILITY	42C. ADDESS OF MEDICAL FACILITY

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and 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 Affairs.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet pate at http://www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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

STATEMENT AS TO LEVEL AND COST OF CARE
TO BE COMPLETED BY ASSISTED LIVING FACILITY & NURSING HOME

This information is requested for the purpose of determining the medical level of care the claimant requires. The cost of that medical care is used by the VA to determine if expenses are allowed for maximum benefits.

Last Name	First Name	MI	SSN

Name of Facility	Date of Admission

Facility Address (City, State, ZIP)	Telephone Number

Level of Care *(Please mark with an X)*	**X**
Level 1 (Room and Board Only)	
Level 2 (Room and Board plus medical assistance)	
OTHER (Please Explain)	

The Activities of Daily Living (ADLs) provided to the resident are as follows *(please mark with an X)*

Services Provided	X	Services Provided	X
Provides help getting out of bed		Provides help with feeding	
Provides help with dressing		Provides help with personal hygiene	
Provides help with bathing		Provides frequent need of adjustment of prosthetic/ orthopedic devices	
Provides help with ambulating/ walking		Provides supervision to prevent person from harming self, falling, or wandering	
Provides help with toileting		Provides supervision to prevent person from harming others	
Provides help with incontinence		Provides supervision and properly secured living arrangements for a protected environment	

Total Monthly Charges for Room, Board, and Medical Fees for services provided	$

Administrator's name (printed)	Email Address

Administrator's Signature	Date	Telephone Number

ATTENDANT AFFIDAVIT

TO BE COMPLETED BY CAREGIVER

This information is requested for the purpose of determining Pension with Aid and Attendance Benefits based on medical expenses.

Claimant's Last Name	Claimant's First Name	Claimant's SSN
VA File Number	Telephone Number	Date Service Began
Name of Person/ Company providing Healthcare services		Date Service Ended
Address of Person/ Company providing Healthcare services		

The services I provide are as follows (please mark with an X)

Activities of Daily Living (allowable medical expenses)	X	**Instrumental Activities of Daily Living** (does not count as standalone medical expenses)	X
Provides help getting out of bed	☐	Provides room and board	☐
Provides help with dressing	☐	Provides shopping services	☐
Provides help with bathing	☐	Provides emergency response staff	☐
Provides help with ambulating/ walking	☐	Provides medication supervision and/ or reminders	☐
Provides help with toileting	☐	Provides housework services (cleaning, laundry, etc...)	☐
Provides help with incontinence	☐	Provides respite services for spouse	☐
Provides help with feeding	☐	Provides homemaker services	☐
Provides help with personal hygiene	☐	Provides medical or monitoring alert equipment	☐
Provides frequent need of adjustment of prosthetic/ orthopedic devices	☐	Provides activities and an environment for necessary social stimulation	☐
Provides supervision to prevent person from harming self, falling, or wandering	☐	Physical security such as room checks, emergency pull cords, locked and/ or monitored exterior doors	☐
Provides supervision to prevent person from harming others	☐	Provides transportation for doctor visits and other vital medical purposes	☐
Provides supervision and properly secured living arrangements for a protected environment	☐	Provides meals because care recipient above is physically or mentally incapable of preparing them	☐
Other:	☐	Other:	☐

For these Services, I am paid by the claimant $_____ per month.

$_____ per Hour _____ Hours per day _____ #days per week

Caregiver's Name (Printed)	Cairgiver's Signature	Date
Claimant's Name (Printed)	Claimant's Signature	Date

Revised 01-2023

"Veteran"

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

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

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

(1) Eating

(2) Bathing/Showering

(3) Dressing

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

(5) Using the toilet

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

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

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

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

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

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

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

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

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

◯ YES ◯ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension on Page 6, Item 14A of the attached form?

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

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

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

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

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

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

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

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

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

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

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to

(Name of Person Staying at Facility)

and his or her care at this facility

(Name of Facility)

at

(Address of Facility (Line 1))

(Address of Facility (Line 2))

(Name of Person Certifying for the Facility)

(Signature of Person Certifying for the Facility)

(Title of Person Certifying for the Facility)

(Date Certified)

"Veteran"

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

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

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

(1) Eating

(2) Bathing/Showering

(3) Dressing

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

(5) Using the toilet

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

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

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

Follow the steps below to determine whether or not:

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

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

◯ YES ◯ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Page 6, Item 14A of the attached form?

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

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

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

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

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

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

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

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

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

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

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

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

IADLs: ◯ SHOPPING ◯ FOOD PREPARATION ◯ HOUSEKEEPING ◯ LAUNDERING ◯ MANAGING FINANCES
◯ HANDLING MEDICATIONS ◯ USING THE TELEPHONE ◯ TRANSPORTATION FOR NON-MEDICAL PURPOSES

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

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

_____ (Name of Certifying Official)

_____ (Signature of Certifying Official)

_____ (Title of Certifying Official)

_____ (Date Certified)

"Surviving SPouse"

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)

2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed 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 applicable)

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WESITE ADDRESS?

8. PLEASE 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 BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

○ 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. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (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.)

○ INDEFINITE

13. PLEASE PROVIDE THE 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.

14. SIGNATURE OF PROVIDER (From question 2)

15. DATE SIGNED (MM/DD/YYYY)

"Surviving Spouse"

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)

2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency 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 ○ 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. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

/ / ○ INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

$. PER HOUR

14. 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.

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)

/ /

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

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

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

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

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* — —

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

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

6. SOCIAL SECURITY NUMBER — —

7. VA FILE NUMBER *(If applicable)*

8. DATE OF BIRTH *(MM/DD/YYYY)* — —

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code —

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

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

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

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

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

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

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

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

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

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

18. NURSING HOME OFFICIAL'S TITLE

19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)* — —
Enter International Phone Number *(If applicable)*

SECTION V - CERTIFICATION AND SIGNATURE

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

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

21. DATE SIGNED *(MM/DD/YYYY)* — —

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

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and 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: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.