

### PLACER COUNTY

RICK BUCKMAN Veterans Service Officer

# **VETERANS SERVICE OFFICE**

1000 SUNSET BLVD. SUITE 115 ROCKLIN, CA 95765 (916) 780-3290 FAX: (916) 780-3299

Thank you for your interest in the Department of Veterans Affairs Pension Program. Enclosed are the forms you will need to begin the process to submit a claim to the VA. Please take a moment to familiarize yourself with this information before getting started. Additional information and copies of this application may be found at <a href="https://www.placer.ca.gov/departments/veteran/pension.aspx">www.placer.ca.gov/departments/veteran/pension.aspx</a>. This is an application for:

#### MARRIED VETERAN

### YOU NEED TO COMPLETE AND SUBMIT THE FOLLOWING

- Application for Aid & Attendance (3 page form)
- Statement in Support of Claim (Informal Claim) completed and signed by the Veteran
- Care Expense Statement for each provider (2 page form)
  - o If spouse receives care or lives in Assisted Living, provide Care Expense Statement for each care provider for spouse.
- Physicians Report with Supplement (Examination for Housebound Status) 3 page form.
  - o If spouse requires A&A, provide 3 page Physicians Report for Spouse
- Military Discharge Documents
  - o Report of Separation and Honorable Discharge for WWII Veterans
  - o DD-214 for Veterans who served after 1950.

All documents requiring a signature MUST be signed by the Veteran. VA does not recognize Powers of Attorney; therefore an agent's signature is not acceptable. Court appointed conservator or guardian may sign. Please include a copy of your letters of conservatorship. If the Veteran is unable to sign, contact this office for instructions.

Once you have completed the application, send forms and documents by fax (916) 780-3299, e-mail (veterans@placer.ca.gov) or regular mail to the address above. You will receive signature pages by e-mail or regular mail that need to be signed by the Veteran. If you have not received the signature pages in 10 business days, please contact our office. Signature pages must be returned by regular mail as the VA requires that we submit an original signature.

If you have any questions please call 916-780-3290 for assistance.

PLACER COUNTY VETERANS SERVICES

# **MARRIED VETERAN APPLICATION FOR AID & ATTENDANCE** (PLEASE COMPLETE ALL PERTINENT INFORMATION)

SECTION I: INFORMATION FOR THE VETERAN						
NAME (Last, First Middle)	SOCIAL SECURITY NUMBER					
DATE OF BIRTH	PLACE OF I	BIRTH (Cit	y, State)			
DATE OF DEATH	PLACE OF I	DEATH (Ci	ty, State)			
DOES THE VETERAN RECEIVE MONEY FROM THE VA? YES \( \square\) NO \( \square\) IF YES, HOW MUCH?						
DOES VETERAN REQUIRE A&A YI	ES NO		DOES SPO	USE REQUIRE A&A	A Y	ES NO
IF SPOUSE REQUIRES AS	SSISTANCE PI	LEASE PRO	OVIDE A PHY	YSICIANS REPORT	FOF	R THE SPOUSE
SE	ECTION I	I: CUR	RENT M	ARRIAGE		
NEVER MARRIED MARRIED DIVORCE	ED WIDOV	VED	# TIMES VI	ET MARRIED	# T	IMES SPOUSE MARRIED
DATE OF MARRIAGE (Month, Year)	PLACE	OF MARR	IAGE			
MONTH YEAR	CITY			ST	ATE	
IF EITHER THE VETERAN OR SPOU	USE HAS BEE	N MARRIE	D MORE TH	AN ONCE, PROVID	E IN	FORMATION ON PAGE 3
SECT	ION III:	INFOR	MATION	FOR SPOUS	E	
FULL MAIDEN NAME (First and Last)		DATE	OF BIRTH			SOCIAL SECURITY NUMBER
DOES SPOUSE LIVE WITH VETERAN YES	NO	·	IF NO, WH	Y SEPARATED		
SECTION IV:	WHERE	DO W	E SEND (	CORRESPON	DE	NCE?
NAME		HOM: PHON			CE: PH	LL ONE
ADDRESS				CITY/STATE/ZIP		
EMAIL ADDRESS			RELATION	NSHIP		
SECTION V	: INFOR	MATI(	ON ON M	ILITARY SE	RV	ICE
DATE OF ENTRY		DATE O	F SEPARATI	ON		
ARMY NAVY AIR FORCE MARINE COAST GUARD MERCHANT OTHER						
SERIAL NUMBER IS ORIGINAL OR CERTIFIED COPY OF DISCHARGE AVAILABLE? YES NO						
REMARKS						

### SECTION VI: GROSS MONTHLY INCOME

### PLEASE PROVIDE GROSS INCOME. THAT IS THE AMOUNT BEFORE ANY DEDUCTIONS ARE TAKEN OUT

	SOURCE	VETERAN	SPOUSE
SOCIAL SECURITY (Before Medicare Deduction)	Social Security	\$	\$
PENSION		\$	\$
PENSION		\$	\$
CIVIL SERVICE RETIREMENT	Civil Service	\$	\$
MILITARY RETIREMENT	DFAS	\$	\$
VA DISABILITY	VA	\$	\$
INTEREST/DIVIDENDS (ANNUAL)		\$	\$
IRA MIMINUM DISTRIBUTION (ANNUAL)		\$	\$
RENTAL INCOME		\$	\$
OTHER		\$	\$

### SECTION VII: MEDICAL EXPENSES

### PLEASE PROVIDE THE MONTHLY AMOUNT THAT IS NOT REIMBURSED BY ANY SOURCE

	SOURCE	VETERAN	SPOUSE
MEDICARE	Social Security	\$	\$
HEALTH INSURANCE		\$	\$
HEALTH INSURANCE		\$	\$
DENTAL INSURANCE		\$	\$
VISION INSURANCE		\$	\$
LONG TERM CARE INSURANCE		\$	\$

# **SECTION VIII: ASSETS**

	VETERAN	SPOUSE
CHECKING	\$	\$
SAVINGS/CD'S	\$	\$
STOCKS/BONDS/MUTUAL FUNDS	\$	\$
IRA	\$	\$
ANNUITY	\$	\$
RENTAL PROPERTY	\$	\$
OTHER ASSETS	\$	\$

REMARKS:			

# DO NOT RETURN THIS PAGE UNLESS YOU HAVE BEEN MARRIED MORE THAN ONCE

AS A MINIMUM YOU MUST PROVIDE THE MONTH AND YEAR AND CITY AND STATE OF EACH OF YOUR MARRIAGES. WE ALSO NEED THE MONTH AND YEAR AND CITY AND STATE AND THE REASON WHY EACH MARRIAGE ENDED. FAILURE TO PROVIDE THIS INFORMATION MAY RESULT IN A DELAY OR DENIAL OF BENEFITS.

PRIOR MARRIAGE INFORMATION FOR VETERAN							
WHO MARRIED	NAME		WHY ENDED:	DEATH 🖂	DIVORCE		
DATE OF MARRIAGE		PLACE OF MARRIAGI	Ε				
DATE ENDED		PLACE ENDED					
WHO MARRIED	NAME		WHY ENDED:	DEATH	DIVORCE		
DATE OF MARRIAGE		PLACE OF MARRIAGI	E				
DATE ENDED		PLACE ENDED					
WHO MARRIED	NAME		WHY ENDED:	в реатн	DIVORCE		
DATE OF MARRIAGE		PLACE OF MARRIAGE	Ε				
DATE ENDED		PLACE ENDED					
	,						
	PRIOR MARRIAO	GE INFORMATIO	ON FOR SI	POUSE			
WHO MARRIED	NAME		WHY ENDED:	DEATH	DIVORCE		
DATE OF MARRIAGE		PLACE OF MARRIAGI	E				
DATE ENDED		PLACE ENDED					
		1		1			
WHO MARRIED	NAME		WHY ENDED:	DEATH	DIVORCE		
DATE OF MARRIAGE		PLACE OF MARRIAGI	E				
DATE ENDED		PLACE ENDED					
WHO MARRIED	NAME		WHY ENDED:	DEATH	DIVORCE		
DATE OF MARRIAGE		PLACE OF MARRIAGI	E				
DATE ENDED		PLACE ENDED					

OMB Approved No. 2900-0075 Respondent Burden: 15 minutes

# Department of Veterans Affairs

# STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The law authorizes us to request the information we are asking you to provide on this form (38 U.S.C. 501(a) and (b)). The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation 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.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN (Type or print)	SOCIAL SECURITY NO.	VA FILE NO.					
		C/CSS -					
The following statement is made in connection with a claim for benefits in the case of the above-named veteran:							
INFORMAL CLAIM FOR PENSION	WITH A&A						
I intend to apply for pension benefits under	the FDC Program.						
This statement is to preserve my effective of	date for entitlement to benefit	ts.					
I am in the process of assembling my claim	n package for submission.						
VETERANS DATE OF BIRTH:							
DATE ENTERED SERVICE: DATE	E OF DISCHARGE:						
MILITARY SERIAL NUMBER: BRAI	NCH OF SERVICE:						
		(CONTINUE ON REVERSE)					
I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge an	nd belief.	(0002 01112121102)					
(SIGNATURE)	(DATE SIGNED)						
ADDRESS	TELEDHONE NI IN	MBERS (Include Area Code)					
	DAYTIME	EVENING					
1000 Sunset Blvd, Ste 115 Rocklin, CA 95765	(916) 780-3290						
PENALITY: The law provides severe penalties which include fine or inprisonment, or both, for the	ne willful submission of any stateme	ent or evidence of a material fact,					

knowing it to be false.

# **Instructions for completing the Care Expense Statement**

The Care Expense Statement is used to document the type of care and the cost of care that the VA will use to reduce your income. It is very important that this form be filled out completely and accurately. If a married veteran is receiving care under Section 2, 3 or 4 and his spouse is also receiving care under Section 2, 3, or 4 we will need a separate Care Expense Statement for the spouse.

The following are line items from every section that need special attention or clarification.

### Section 1

**Line L:** if someone other than the spouse is helping to defray the cost of the care for the patient, then you would check "Yes." If the patient has sufficient funds to pay for their care for the next 4 to 6 months, then you would check "No."

If you checked YES, then you would indicate the source of the payment. Examples would be; Long Term Care Insurance, family pays, facility is accepting a lesser amount until receipt of VA pension, etc.

Indicate the amount that is being paid by this other source.

Indicate the date that the other source began paying the difference. If the patient started to pay the entire amount of the care and then ran out of money, indicate the actual date that the other source began paying.

**Line M**: List the amount that this patient is paying out of their own funds. This would be Line J minus line L.

### Section 2

This section is used if you are living at home and paying someone to come to your home and provide care. It is to be completed by the Care Provider.

**Line B:** Please write the services you provide, DO NOT put all of the above, or circle the examples. Examples of medical services are; physical therapy, administration of injections, placement of indwelling catheters, and the changing of sterile dressings

Examples of nursing services are; assisting an individual with with feeding, bathing, dressing, grooming, personal hygiene, incontinence & transferring.

Line C: If you are providing nursing services you do not need to be licensed, just indicate "Yes" or "No."

### **Section 3**

This section is used if you are a patient in a skilled or intermediate level nursing facility. This section is to be completed by the Administrator of the facility and is self explanatory.

#### Section 4

This section is used if you are in another type of facility besides a skilled or intermediate level nursing home. This section is to be completed by the administrator.

**Line C:** Indicate the services you provide, DO NOT put all of the above, or circle the examples. Please refer to Section 2, Line B for the list of medical or nursing services that you would list in this section.

**Line E:** If you do not break down the cost of the care by type, just indicate the one amount and note that it is all inclusive. This amount should match the amount in Section 1, Line J.

### Section 5

The facility or care provider must sign and date the top line. The veteran or widow who is applying for the benefit, must sign the bottom line and if unable to write a signature, mark it an "X" and then witness it with two individuals signatures. Powers of Attorney cannot sign on behalf of the claimant.

Indicate the amount that the veteran or widow is paying out of their own funds. This amount should match the amount indicated in Section 1, Line M.

# Care Expense Statement

<b>Section 1: General Information</b> (To be completed by the facilit	y adminis	strator. Please Print.)
A. Social Security Number of the Veteran:		
B. Veterans Name:		_
C. Patient's Name:		_
D: Check the box which describes the patient's care status:		
☐ In Home Care ☐ Nursing Home Care ☐ Other Care Facility (Foster Home, Adult Day Care, Rest Home, G	тоир Ноте	, Assisted Living)
E. Name of facility or care provider:		
F. Phone number of facility or care provider:		
G. Address of facility or care provider:		
H. Date entered facility or in home care began		
I. Will the patient need this care indefinitely		☐ Yes ☐ No
If No, when will the care end?		
J. Total monthly charge for the patient	\$	per month:
K. Has the patient applied for Medi-Cal (Medicaid)		Yes No
L. Is part of the patient's cost covered by Medicaid, Medicare, Insurance or other source?		☐ Yes ☐ No
If Yes, please answer the following: What is the source of payment?		
What is the monthly amount covered by this source?	\$	per month:
When did coverage begin?		
M. What amount does the veteran or patient pay from their own funds which is not reimbursed by one of the sources above?	\$	per month:

Section 2: In-Home Care (To be completed by the care provider)
A. Do You provide any medical or nursing services for the patient?  i.e. administering medication, physical or mental therapy, assisting with ADL's (personal hygiene, dressing bathing; etc.)
B. Describe the services you provide:
C. Are you a licensed health professional? (RN, LVN or LPN)  If Yes, provide your license number:
Section 2. Skilled Nursing Facility (T. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
Section 3: Skilled Nursing Facility (To be completed by the facility administrator)  A. Is your facility licensed by the State?  Yes No
B. Is your facility Medicaid (Medi-Cal) approved?
C. Is the patient in your facility because of a physical or mental disability?
D. Do you provide skilled or intermediate level nursing care to the patient?
E. What was the admitting diagnosis?
Section 4: Other Care Facility (To be completed by the facility administrator)
A. Type of facility  Assisted Living Rest Home Group Home Other Other
B. Do You provide any medical or nursing services for the patient?
C. Describe the services you provide:
D. If the patient receives medical or nursing services, are the services provided or supervised by a licensed health professional (RN, LVN, LPN)
E. We must have the monthly charge broken down into the following categories:
1. Base Rate (includes room, meals, laundry, housekeeping): \$\frac{\partial}{2}\$ per month:
2. Medical and Nursing Services:   \$ per month:
Section 5. Signatures (T. I. J. I. J. C. W. J.
Section 5: Signatures (To be completed by the facility administrator/care provider and veteran/widow)  I certify that the above statements are true and correct to the best of my knowledge and belief.
Signature of facility administrator or care provider  Date
I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying \$ per month for my care from my own funds.
Signature of Veteran or Beneficiary  Date

# Please use the following as recommendations only on how to complete VA Form 21-2680

In order to apply for the VA Aid & Attendance benefit, the claimant must have a medical condition or medical necessity requiring them to live in an assisted or protected environment and to be receiving and paying for that care.

The claimant must show a need for **Aid and Attendance**, and this report must show:

- That he or she requires the aid 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 themselves from the hazards of their daily environment;
- Has corrected vision of 5/200 or less in both eyes; OR
- Has contraction of the concentric visual field to 5 degrees or less; OR
- Is a patient in a nursing home due to mental or physical incapacity; OR
- Is bedridden, in that their disability requires that they remain in bed apart from any prescribed course of convalescence or treatment.

Please have the Claimant's doctor (does not have to be a VA doctor) fill this form out completely and be as thorough as possible in stating the claimant's deficits.

The following are some questions that need special attention and/or clarification.

<u>#10. Complete diagnosis</u>: "Please be VERY thorough; documenting major/minor conditions and problems". The DIAGNOSIS MUST BE WELL-SUBSTANTIATED IN THE REMAINDER OF THE QUESTIONS. This cannot be left blank. If there is no condition or diagnosis the applicant does not meet the medical requirements and will not qualify. A problem list from the doctor can also be attached.

#24A. Legally Blind: Please make sure the doctor also fills in the fields for 24B. An eye doctor's certification should be attached to certify that there is a corrected vision of 5/200 or less to be considered legally blind.

# 25. Require Nursing Home: If 'NO', we would need it to say; But does need to live in a Protected Environment or Assisted Living, whichever is appropriate.

#27. Handle Financial Affairs: This is a question of cognitive ability so if the doctor marks 'NO', the VA will deem the claimant 'incompetent'. A fiduciary will need to be appointed to receive the benefit on behalf of the claimant and a 'Due Process Waiver' will be required. Often the claimant MAY cognitively be able to handle affairs, families just choose otherwise for simplicity reasons or blindness. (a NO will cause a delay in the retro check).

#35B. Physician's Signature: Make sure that only the Doctor signs this form and that he/she puts MD after their signature. A PA or FNP signatures are not acceptable.

This is a very important form and is a major component in determining whether or not a claim is approved.

This is the only information that the VA has to determine the medical eligibility and incomplete or inaccurate forms could result in a denial of benefits.

OMB Control No. 2900-0721 Respondent Burden: 30 minutes

Department of	Veterans Affai	EXA	MINATION	FOR HOUSE	BOUND STAT R AID AND A	TUS OR PERMANENT
1. FIRST NAME - MIDDLE NAM	E - LAST NAME OF \	/ETERAN	2. FIRST NAME - (If other than v	MIDDLE NAME - LAST Na eteran)	AME OF CLAIMANT	3. RELATIONSHIP OF CLAIMANT TO VETERAN
4A. VETERAN'S SOCIAL SECU	RITY NUMBER	4B. CLA	I NIMANT'S SOCIAL S	SECURITY NUMBER	5. CLAIM NUI	MBER
6. DATE OF EXAMINATION	·	7. HOM	E ADDRESS			<u>, , , , , , , , , , , , , , , , , , , </u>
8A. IS CLAIMANT HOSPITALIZ			FE ADMITTED	9. NAME AND A	DDRESS OF HOSPITA	AL.
NOTE: EXAMINER PLEAS The purpose of this examination	on is to record manif	LLY estations and f	indings pertinent to	o the question of whether	the claimant is houseb	ound (confined to the home or
coordination or enfeeblement a presentable. Findings should be recorded to	ent detail for the VA affects the ability: to a show whether the o	decision make dress and und laimant is blin	ers to determine the ress; to feed him/he ad or bedridden.	erself; to attend to the wa	nts of nature; or keep h	or mental impairment, that loss of him/herself ordinarily clean and he/she goes, and what he/she is able
10. COMPLETE DIAGNOSIS (I	diagnosis needs to eq	uate to the lev	el of assistance des	scribed in questions 20 th	rough 34)	
11A. AĞE 11B. SEX	12. WEIGHT			<del></del>	13. HEIGH	T INCHES:
14. NUTRITION	ACTUAL: LB	S	ESTIMATED: LBS	•	FEET: 15. GAIT	INCHES.
16. BLOOD PRESSURE	7. PULSE RATE	18. RESP	RATORY RATE	19. WHAT DISABILITIES	RESTRICT THE LIST	ED ACTIVITIES/FUNCTIONS?
20. IF THE CLAIMANT IS CONI From 9 PM To 9 AM:	FINED TO BED, INDI		MBER OF HOURS	IN BED		
21. IS THE CLAIMANT ABLE TO	O FEED HIM/HERSE	LF? <i>(If "No," j</i>	provide explanatio	n)		
☐ YES ☐ NO						
22. IS CLAIMANT ABLE TO PR	EPARE OWN MEAL	S? (If "Yes," p	rovide explanation,		•	
23. DOES THE CLAIMANT NEI	ED ASSISTANCE IN	BATHING AND	TENDING TO OTI	HER HYGIENE NEEDS?	(If "Yes," provide explo	anation)
YES NO						
24A. IS THE CLAIMANT LEGAL	LY BLIND? (If "Yes,	" provide expl	anation)		24B. CORREC	CTED VISION
YES NO				LEFT EYE		RIGHT EYE
25. DOES THE CLAIMANT REC	UIRE NURSING HON	ME CARE, ASSIS	TED LIVING, OR N	EED TO LIVE IN A PROTE	CTED ENVIRONMENT	? (If "Yes," provide explanation)
☐ YES ☐ NO						
26. DOES CLAIMANT REQUIR	E MEDICATION MAI	NAGEMENT?	(If "Yes," provide e	explanation)		
☐ YES ☐ NO						
27. DOES THE CLAIMANT HAV	/E THE MENTAL CAP	ACITY TO MA	NAGE HIS/HER OW	VN FINANCIAL AFFAIRS?	(If "No," provide explana	tion)
YES NO						

28. POSTURE AND GENERAL APPEARANCE (Attach a	a separate sheet of paper if additiona	l space is needed)		
29. DESCRIBE RESTRICTIONS OF EACH UPPER EXTR	REMITY WITH PARTICULAR REFER	FNCE TO GRIP, FINE MO	OVEMENTS, AND ABILITY TO F	EED HIM/HERSELF.
TO BUTTON CLOTHING, SHAVE AND ATTEND TO	THE NEEDS OF NATURE (Attach a s	eparate sheet of paper ij	additional space is needed)	,
30. DESCRIBE RESTRICTIONS OF EACH LOWER EXT CONTRACTURESOR OTHER INTERFERENCE. IF I EXTREMITY.	REMITY WITH PARTICULAR REFER NDICATED, COMMENT SPECIFICAL	ENCE TO THE EXTENT LLY ON WEIGHT BEARIN	OF LIMITATION OF MOTION, A' IG, BALANCE AND PROPULSIO	TROPHY, AND N OF EACH LOWER
31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK	AND NECK			
32. SET FORTH ALL OTHER PATHOLOGY INCLUDING LOSS OF MEMORY OR POOR BALANCE ,THAT AF THE HOME, OR, IF HOSPITALIZED, BEYOND THE A TYPICAL DAY.	FEECTS CLAIMANT'S ABILITY TO PE	REORM SELF-CARE, Al	MBULATE OR TRAVEL BEYOND	THE PREMISES OF
33. DESCRIBE HOW OFTEN PER DAY OR WEEK AND	UNDER WHAT CIRCUMSTANCES T	THE CLAIMANT IS ABLE	TO LEAVE THE HOME OR IMME	EDIATE PREMISES
34. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES effectiveness in terms of distance that can be traveled	S, OR THE ASSISTANCE OF ANOTH	ER PERSON REQUIRED	FOR LOCOMOTION? (If so, spe	cify and describe
YES (If "YES," give distance)(Check	☐ 1 BLOCK ☐ 5 or 6 BLOCK	s ∏1MiLE	OTHER (Specify distance)	
NO applicable box or specify distance)  35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF E		35C. DATE SIGNE	D
36A. NAME AND ADDRESS OF MEDICAL FACILITY			TELEPHONE NUMBER OF MEDI (Include Area Code)	CAL FACILITY
PRIVACY ACT NOTICE: The VA will not disclos 1974 or Title 38, Code of Federal Regulations 1.576 f studies, the collection of money owed to the United delivery of VA benefits, verification of identity and Pension, Education and Vocational Rehabilitation R benefits. Giving us your Social Security Number (SS 5701(c) (1). The VA will not deny an individual benefitect prior to January 1, 1975, and still in effect. Th law. The responses you submit are considered confidered or state agencies for the purpose of determinity our participation in any benefit program administered RESPONDENT BURDEN: We need this information and (e), 1115 (1)(e), 1311(c) and (d), 1315 (h), 1122, 30 minutes to review the instructions, find the information the OMB Internet page at <a href="https://www.whitehouse.gov/osend.comments.or.wiggestions.about this form.">www.whitehouse.gov/osend.comments.or.wiggestions.about this form.</a>	for routine uses (i.e., civil or criminal States, litigation in which the Unite status, and personnel administration (ecords - VA, and published in the RN) account information is mandator fits for refusing to provide his or her her requested information is considered ential (38 U.S.C. 5701). Information in your eligibility to receive VA be do by the Department of Veterans Affirm to determine your eligibility for aid 1541 (d) (e), and 1502(b) and (c) allow mation, and complete this form. Verespond to a collection of informatic	law enforcement, congred States is a party or han) as identified in the V Federal Register. Your y. Applicants are require SSN unless the disclosured relevant and necessary in that you furnish may be mefits, as well as to colleairs.  If and attendance or house your to ask for this infect a cannot conduct or spoon if this number is not of	essional communications, epiders an interest, the administration (A system of records, 58VA21/, obligation to respond is required to provide their SSN under The of the SSN is required by a Fey to determine maximum benefice utilized in computer matching ect any amount owed to the University of the University of the Communication. We estimate that you winsor a collection of information displayed. Valid OMB control in the state of the state of the control of the control of the state o	miological or research of VA programs and 22/28, Compensation, ed to obtain or retain itle 38, U.S.C. U.S.C. deral Statute of law in its provided under the grograms with other ted States by virtue of a States Code 1521 (d) will need an average of a unless a valid OMB umbers can be located

SUPPLEMENTAL INFORMATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR					
REC	GULAR AID AND ATTEN	IDANCE			
1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - L (If other than veteran)	AST NAME OF CLAIMANT	3. RELATIONSHIP OF CLAIMANT TO VETERAN		
4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUI				
NOTE: EXAMINER PLEASE READ CAREFULLY. The claimant is housebound (confined to the home or immediate pleatail for the VA decision makers to determine the extent that the ability: to dress and undress; to feed him/herself; to attend	premises) or in need of the regular aid and at disease or injury produces physical or me	d attendance of another person. nental impairment, that loss of	. The report should be in sufficient coordination or enfeeblement affects		
6. Is this patient able to live at home withou			Yes No		
7. Can this patient adequately protect thems	elves from the hazards of their	environment?	Yes No		
If no, please explain why and include a medi					
8. Does this patient need to live in a protected	ed environment due to mental	or physical condition?	Yes No		
If yes, please explain.					
REMARKS					
PRINTED NAME OF EXAMINING PHYSICIAN	SIGNATURE AND TITLE OF EXAMINING	G PHYSICIAN DATE SIG	GNED		
NAME AND ADDRESS OF MEDICAL FACILITY		TELEPHONE NUMBE	ER OF MEDICAL FACILITY		