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 www.placer.ca.gov/departments/veteran/pension.aspx. This is an application for:

SURVIVING SPOUSE (WIDOW)

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 Widow
- Care Expense Statement for each care provider (2 page form)
- Physicians Report with supplement (Examination for Housebound Status) (3 page form)
- Marriage Certificate to the Veteran
- Veterans Death Certificate
- Military Discharge Documents
    - Report of Separation for WWII Veterans
    - DD-214 for Veterans who served after 1950

All documents requiring a signature MUST be signed by the Widow. 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 Widow 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 Widow. 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

SURVIVING SPOUSE
APPLICATION FOR AID & ATTENDANCE
(PLEASE COMPLETE ALL INFORMATION)

SECTION I: INFORMATION ON THE VETERAN

NAME (Last, First Middle)	**SSN:**
DATE OF BIRTH	**PLACE OF BIRTH (City, State)**
DATE OF DEATH	**PLACE OF DEATH (City, State)**

SECTION II: INFORMATION ABOUT YOU AND YOUR MARRIAGE TO THE VETERAN

FULL MAIDEN NAME (First and Last)	**DATE OF BIRTH**	**SOCIAL SECURITY NUMBER**

DO YOU CURRENTLY RECEIVE MONEY FROM THE VA? YES ☐ **NO** ☐ **IF SO, HOW MUCH?**

HOW MANY TIMES HAVE YOU BEEN MARRIED? **IF MORE THAN ONE TIME COMPLETE THE INFORMATION ON PAGE 3**

DATE OF MARRIAGE (Month, Year) **MONTH** **YEAR**	**PLACE OF MARRIAGE** (City, State) **CITY** **STATE**

SECTION III: WHERE DO WE SEND CORRESPONDENCE?

NAME	**HOME PHONE**	**CELL PHONE**
ADDRESS	**CITY/STATE/ZIP**	
EMAIL ADDRESS	**RELATIONSHIP**	

SECTION IV: MILITARY SERVICE

DATE OF ENTRY	**DATE OF SEPARATION**

ARMY ☐ **NAVY** ☐ **AIR FORCE** ☐ **MARINE** ☐ **COAST GUARD** ☐ **MERCHANT** ☐ **OTHER** ☐

SERIAL NUMBER	**IS ORIGINAL OR CERTIFIED COPY OF DISCHARGE AVAILABLE? YES** ☐ **NO** ☐

REMARKS

SECTION V: INCOME

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

	SOURCE	SURVIVING 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 MINIMUM DISTRIBUTION (ANNUAL)		$
RENTAL INCOME		
OTHER		$

SECTION V: MEDICAL EXPENSES

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

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

SECTION VI: ASSETS

	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 SURVIVING SPOUSE			
WHO MARRIED	NAME	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACE ENDED	
WHO MARRIED	NAME	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACE ENDED	
WHO MARRIED	NAME	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
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

VETERANS DATE OF BIRTH:

DATE ENTERED SERVICE: DATE OF DISCHARGE:

MILITARY SERIAL NUMBER: BRANCH OF SERVICE:

IF CLAIM IS FOR A WIDOW COMPLETE THIS SECTION

VETERANS DATE OF DEATH:

NAME OF SURVIVING SPOUSE:

(CONTINUE ON REVERSE)

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

SIGNATURE	DATE SIGNED	
ADDRESS 1000 Sunset Blvd, Ste 115 Rocklin, CA 95765	TELEPHONE NUMBERS *(Include Area Code)* DAYTIME (916) 780-3290	EVENING

PENALITY: The law provides severe penalties which include fine or inprisonment, or both, for the willful submission of any statement 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

Section 1: General Information (To be completed by the facility administrator. 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, Group Home, 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:

Continue on page 2
Be sure to sign and date

Section 2: In-Home Care *(To be completed by the care provider)*

A. Do You provide any medical or nursing services for the patient? ☐ Yes ☐ No
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) ☐ Yes ☐ No
If Yes, provide your license number: _____

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? ☐ Yes ☐ No

C. Is the patient in your facility because of a physical or mental disability? ☐ Yes ☐ No

D. Do you provide skilled or intermediate level nursing care to the patient? ☐ Yes ☐ No

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 ☐ Foster Home
☐ Adult Day Care ☐ Group Home ☐ Other _____

B. Do You provide any medical or nursing services for the patient? ☐ Yes ☐ No
i.e. administering medication, physical or mental therapy, assisting with ADL's (personal hygiene, dressing bathing; etc.)

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) ☐ Yes ☐ No

E. We must have the monthly charge broken down into the following categories:
1. Base Rate (includes room, meals, laundry, housekeeping): $_____ per month:
2. Medical and Nursing Services: $_____ per month:

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.

#10. Complete diagnosis: "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 Affairs

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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT *(If other than veteran)*	3. RELATIONSHIP OF CLAIMANT TO VETERAN

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER

6. DATE OF EXAMINATION	7. HOME ADDRESS

8A. IS CLAIMANT HOSPITALIZED?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*		

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.

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

11A. AGE	11B. SEX	12. WEIGHT	13. HEIGHT
		ACTUAL: LBS. ESTIMATED: LBS.	FEET: INCHES:

14. NUTRITION	15. GAIT

16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

20. 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:

21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*

☐ YES ☐ NO

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

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

☐ YES ☐ NO

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE, ASSISTED LIVING, OR NEED TO LIVE IN A PROTECTED ENVIRONMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

26. DOES CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*

☐ YES ☐ NO

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

29. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE 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)*

30. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

32. 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.

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

34. 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 32 above)*

☐ YES
☐ NO

(If "YES," give distance)(Check applicable box or specify distance) ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

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 Vocational Rehabilitation Records - VA, and 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. 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 of the SSN 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 page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

SUPPLEMENTAL INFORMATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT *(If other than veteran)*	3. RELATIONSHIP OF CLAIMANT TO VETERAN

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER

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.

6. Is this patient able to live at home without assistance?	☐ Yes	☐ No
7. Can this patient adequately protect themselves from the hazards of their environment?	☐ Yes	☐ No

If no, please explain why and include a medical diagnosis for the inability.

8. Does this patient need to live in a protected environment due to mental or physical condition?	☐ Yes	☐ No

If yes, please explain.

REMARKS

PRINTED NAME OF EXAMINING PHYSICIAN	SIGNATURE AND **TITLE** OF EXAMINING PHYSICIAN	DATE SIGNED

NAME AND ADDRESS OF MEDICAL FACILITY	TELEPHONE NUMBER OF MEDICAL FACILITY