



PLACER COUNTY VETERANS SERVICE OFFICE

1000 Sunset Blvd. Suite 115, Rocklin, CA 95675 (916)780-3290 FAX: (916)780-3299

Aid & Attendance Verification Form

Married Veteran

Name: _____

File/SS#: _____

-
- Intent to File (21-0996) POA - Appointment of VSO as Claimant's Rep (21-22)
 DD-214 or other Honorable Discharge Paperwork Third Party Form (21-0845)

Application for Veterans Pension (21P-527EZ)

-
- Income & Asset Statement (21P-0969) - If Assets are over \$10,000
 Medical Expenses – Ongoing monthly expenses
- A&A Application Sheet (3 pages) * Marriage Certificate
- Examination for Housebound Status or Permanent Need for Regular Aid and Attendance (21-2680)
(Completed and signed by a Physician)
- Worksheet for Assisted Living, Adult Day Care or Similar Facility (21P-527EZ)
- Worksheet for In-Home Attendant Expenses (21P-527EZ)
- Care and Expense Statement for Caregiver/Facility (2 pgs.) & Proof of Monthly Payment
- Verification of Gross Income from all Sources for both Veteran and Spouse**
- Social Security Award Letter
 - Pension(s)
 - IRA, Stocks, Bonds, CD's & Annuities
 - Dividends/Interest (previous tax year)
 - Rental Property Report of Income from Property or Business (21P-4185)
- Verification of Assets for both Veteran and Spouse**
- Current Bank Statements, showing all pages
 - Banking Info: Name of Financial Institution, Account & Routing Number
 - Personal Property Documents (Rental)
- Verification of Past Marriages for both Veteran & Surviving Spouse**
(If married more than once)

SERVING THOSE WHO SERVED

Aid & Attendance packet directions in completing all the required documents for you to complete and return to Placer County Veterans Service Office.

Intent to File: Will need to be signed & dated by the Veteran and returned to our VSO. (Unless one has already been filed).

POA: Will need to be signed & dated by the Veteran and returned to our VSO. (This takes 30 days)

Third Party Form: Will need to be completed, signed & dated by the Veteran and returned to our VSO. (Only if needed; Instructions are included).

The first set of pages (1-3)

Aid & Attendance Application - Must be filled in its entirety on behalf of the Veteran & Spouse.

Page 1: Complete all sections (I – V).

Page 2: Complete all sections (VI – VIII). Enter all sources of income, medical expenses, assets and provide current verification. If the Veteran or Spouse do not have the income, medical expense, or asset, you must enter None or N/A in the spot provided for each of you.

- Provide current statements, showing all pages for all income & assets for both the Veteran & Spouse. **Ex:** Social Security Award letter(s), Pension(s), Interest/Dividends for all accounts including Savings or Checking accounts that accrue interest and rental property.

Page 3: Is requesting prior marriages for both the Veteran & spouse. If you were married more than once, you must complete this page providing the date & location of the prior marriage in addition to the date & location it ended.

- If the you had no prior marriages, please write N/A.

Information About Medical Expenses or Other Expenses – Section VIII

Section VII: #29E - No need to answer at this time.

Medical Expenses (Section VIII): Enter a monthly amount of the Veteran & Spouse's ongoing expenses paid each month. This includes IHSS payment, medications, facility/nursing home charge, continence products, Social Security monthly premium & other Medical premiums.

- Verification for each medical expense will be required.

Direct Deposit Information (Section IX): Need name of Financial Institution, Account & Routing Number.

Signature Page

Claim Certification and Signature (Section X): Only Signature of Veteran is required in box 35A **(do not date).**

Worksheets (Facility or In-Home Care) *

(Use the Worksheet that is applicable to the Veteran or Spouse's situation)

Worksheet for an Assisted Living, Adult Day Care or Similar Facility (1 page)

All 7 Steps must be answered & completed by the person certifying for the Facility

Step 8: Add the Veteran's/Spouse's full name on first line, enter the Name & address of the Facility on the second line and the person certifying for the Facility (Manager, Supervisor, Administrator, etc.) must sign & date it.

Worksheet for In-Home Attendant Expenses (1 page)

All 7 Steps must be answered by the care provider.

Step 7: You need to write Veteran's/Spouse's full name on first line, you need to write the care provider's name on the second line and the care provider must sign & date it.

*If both the Veteran & Spouse (Claimant) are applying for A&A, each must complete a worksheet for themselves.

Care & Expense Statement (2 pages) **

Complete & enter the information on behalf of the Veteran or Spouse.

Section 1: Entire section must be completed. Letters J & M in Section 1 need to have the same amount written in. Additionally, the same amount from letters J & M need to match the same amount in Section 4, page 2 of the Care & Expense Statement.

Section 2: In-Home Care - Must be completed by the care provider (Only if applicable).

Section 3: Other Care Facility – Must be completed by the Facility (Manager, Supervisor, Administrator, etc.) [Only if applicable].

Section 4: First line must be signed & dated by the Facility or care provider. You must enter the amount being paid to the Facility or care provider (this amount must match what is entered in letters J & M of Section 1) by the dollar sign and the Veteran or beneficiary (Spouse) must sign & date it.

**If both the Veteran & Spouse (Claimant) are applying for A&A, each must complete a Care and Expense Statement for themselves.

VA Form (21-2680)

Examination for Housebound Status or Permanent Need for Regular Aid & Attendance (21-2680)

- This form is 3 pages and must be completed & signed by a Physician.

Income & Asset Statement (21P-0969)

Income & Asset Statement (11 Pages): Complete only if,

- The Veteran or Spouse have combined income & assets over \$10,000.
- If, other than Social Security, you or your dependent(s) receive any income.
- If, in the 3 calendar years before this year, you or your dependent(s) transferred any assets.
- If, other than Social Security, you or your dependent(s) received any income last year.
- If the Veteran or Spouse have interest bearing accounts.

Cover Sheet, Page 1:

Box 1, 2 and 3: Enter Veteran's information.

Box 4, 5 and 6: Enter Spouse's information.

Box 7: Check the Veteran box only.

Page 2-11:

Answer all questions; if you check yes for any question, enter the Veteran & Spouse's name and their income & asset amounts.

➤ **Section V: Interest, Royalties, and Dividends**

Page 6: This page is where interest earned/gained is entered from any asset owned by either the Veteran or Spouse.



Department of Veterans Affairs

**VA DATE STAMP
 (DO NOT WRITE IN THIS SPACE)**

**INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION,
 OR SURVIVORS PENSION AND/OR DIC**
 (This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)

NOTE: Please read the Privacy Act and Respondent Burden below before completing the form.

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

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. CLAIMANT'S NAME (First, Middle Initial, Last)		
2. CLAIMANT'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)	4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY) Month Day Year 08/26/1930
5. VETERAN'S NAME (First, Middle Initial, Last) (If different from claimant)		
6. VETERAN'S SOCIAL SECURITY NUMBER	7. VETERAN'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	8. VETERAN'S SERVICE NUMBER (If applicable)
9. CURRENT 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		
10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. TELEPHONE NUMBER (Include Area Code)	12. EMAIL ADDRESS (If applicable)

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: VA may not be able to use this form to establish an effective date for benefits if you do not select one or more of the general benefits listed below.

13. I intend to file for the general benefit(s) checked below: (Choose all that apply)

COMPENSATION PENSION

NOTE: Only check the box below if you are a surviving dependent of the veteran.

SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at www.va.gov. If you give VA a completed application for the selected general benefit within **one** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the **first** completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is **not a claim for benefits**; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE	14B. DATE SIGNED (MM,DD,YYYY)
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15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION (Please Print)
 (NOTE: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

CDVA

PRIVACY ACT NOTICE: 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 benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/23, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by 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 the appropriate application and provide it to the claimant.

RESPONDENT BURDEN: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102), Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



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 21-22, *Appointment of Individual as Claimant's Representative*. When completed you can mail **or** fax this form to the appropriate intake center address shown on Page 4. 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 **USA**

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

State/Province

Country **USA**

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*)

California Department of Veterans Affairs

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

CVSO

veterans@placer.ca.gov

(916) 780-3290

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

Oakland: Oakland.oakland@calvet.ca.gov

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

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:

- | | |
|--|--|
| <input type="checkbox"/> DRUG ABUSE | <input type="checkbox"/> INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) |
| <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE | <input type="checkbox"/> 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 20.608. *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 <i>(Do Not Print)</i>	22B. DATE SIGNED <i>(MM/DD/YYYY)</i>
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A <i>(Do Not Print)</i>	23B. DATE SIGNED <i>(MM/DD/YYYY)</i>

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 <i>(Date)</i>	REVOKED <i>(Reason and date)</i>
	<input type="checkbox"/> VR&E FILE	<input type="checkbox"/> EDU FILE			
	<input type="checkbox"/> LG FILE	<input type="checkbox"/> 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.

**INFORMATION AND INSTRUCTIONS TO HELP YOU COMPLETE THE AUTHORIZATION TO
DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY**

GENERAL INFORMATION

At VA, we recognize and respect the importance of privacy. Personal information that we collect is kept confidential to the extent provided by law. In accordance with the Privacy Act and applicable confidentiality statutes, VA will only disclose the information in its custody or control in the following circumstances: where the individual identifies the particular information and consents to its use; where disclosure of the information is required by law; or where the disclosure is otherwise legally permitted, including release for a purpose compatible with the purpose for which it was collected.

By law, VA must have your written permission (an "authorization") to use or give out your claim or benefit information for any purpose that is not permitted by all applicable legal authorities. You may revoke your written permission at any time, except if VA has already acted based on your permission.

QUESTIONS	SPECIFIC INSTRUCTIONS
1-5	In this section, give us the veteran's identification information to include name, social security number, VA file number, date of birth and the veteran's service number, if applicable.
6-9	In this section, provide the beneficiary/claimant's identification information, who is not the veteran.
10-13	<p>In Item 10 VA will give your personal benefit or claim information to the person or organization you enter in this box. You may select only one person or one organization. If you designate an organization, you must also identify one or more individuals in that organization to whom VA may disclose your benefit or claim information. This form cannot be used to disclose federal tax information to third parties.</p> <p>IMPORTANT: The information provided in Item 6, "Name of Beneficiary/Claimant Who Is Not the Veteran," cannot be the same information provided in Item 10.</p> <p>Item 13 tells VA the duration of your consent. If you do not want your authorization to be effective indefinitely, tell us when to stop releasing your personal benefit or claim information to your authorized third party in Item 13. Check the box that applies and fill in dates, if applicable.</p>
14	Select the security question you would like us to ask your designated third party and provide the answer. This question will be asked each time your designated third party contacts the VA.

WHERE DO I SEND MY COMPLETED WORK?

Send your signed authorization in by utilizing any of the following methods:

MAIL TO	FAX TO	ONLINE
<p align="center">Department of Veterans Affairs Evidence Intake Center PO Box 4444 Janesville, WI 53547-4444</p>	<p align="center">844-531-7818 (Toll Free) 248-524-4260 (Foreign claims)</p>	<p align="center">www.ebenefits.gov</p>

NOTE: You should make a copy of your signed authorization for your records before mailing it to VA. You can only have one VA Form 21-0845, *Authorization to Disclose Personal Information to a Third Party*, on file with VA at a time.

WHAT IF I CHANGE MY MIND?

If you change your mind and do not want VA to give out your personal benefit or claim information, you may notify us in writing, or by telephone at 1-800-827-1000 or electronically via the Internet at <https://iris.custhelp.com/>. Upon notification from you VA will no longer give out benefit or claim information (except for the information VA has already given out based on your permission).



Department of Veterans Affairs

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs permission to release your personal beneficiary or claim information to a third party. This form **may not be executed** by any beneficiary recognized as incompetent for VA purposes, nor can VA **accept** this form from any beneficiary recognized as incompetent for VA purposes.

SECTION I - VETERAN'S IDENTIFICATION 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 the form.

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

[Grid for name entry]

2. VETERAN'S SOCIAL SECURITY NUMBER

[Grid for Social Security Number]

3. VA FILE NUMBER

[Grid for VA File Number]

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

[Grid for date of birth with Month, Day, Year labels]

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

[Grid for service number]

SECTION II - BENEFICIARY/CLAIMANT'S IDENTIFICATION INFORMATION

6. NAME OF BENEFICIARY/CLAIMANT WHO IS NOT THE VETERAN (*First, Middle Initial, Last*)

[Grid for beneficiary name]

7. ADDRESS OF BENEFICIARY/CLAIMANT (*Number and Street or rural route, P.O. Box, City, State, ZIP Code and Country*)

[Grid for address with labels: No. & Street, Apt./Unit Number, City, State/Province, Country, ZIP Code/Postal Code]

NOTE: If you **do not** want VA to contact you by email please check box:

8. EMAIL ADDRESS (*Optional*)

9. PHONE NUMBER (*Include Area Code*)

SECTION III - CONTACT INFORMATION

10. I (beneficiary/claimant) authorize the Department of Veterans Affairs (VA) to contact the person or organization listed below for the purposes of providing the following information pertaining to my VA record. (*Check only one box below to tell VA the specific benefit or claim information you want disclosed*)

- Any Information (*Go to Item 12*) Limited Information (*Go to Item 11*)

11. IF YOU SELECTED "LIMITED INFORMATION", CHECK ALL THAT APPLY

- Status of pending claim or appeal Amount of money owed VA Other
 Current benefit and rate Request a benefit payment letter
 Payment history Change of address or direct deposit

12. IF YOU SELECTED "ANY INFORMATION", THE TERMS OF SUCH RELEASE OF INFORMATION WILL BE:

- One time only From the date of signing below until _____
(Specify date - month, day, year)
 Ongoing until written notice is given to VA to terminate

13. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION AS SPECIFIED ABOVE TO THE PERSON OR ORGANIZATION LISTED BELOW.
NOTE: IF AUTHORIZATION IS FOR AN ORGANIZATION, PLEASE PROVIDE THE FIRST AND LAST NAME OF THE ORGANIZATION'S REPRESENTATIVE.

A. NAME OF PERSON OR ORGANIZATION

B. ADDRESS OF PERSON OR ORGANIZATION

VETERAN'S SSN

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SECTION III - CONTACT INFORMATION (Continued)

14. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY **ONE** SECURITY QUESTION BOX IN 14A AND PROVIDE THE ANSWER IN 14B.

A. SECURITY QUESTION	B. ANSWER
<input type="checkbox"/> The city and state your mother was born in	
<input type="checkbox"/> The name of the high school you attended	
<input type="checkbox"/> Your first pet's name	
<input type="checkbox"/> Your favorite teacher's name	
<input type="checkbox"/> Your father's middle name	

SECTION IV - DECLARATION OF INTENT

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

15A. SIGNATURE (*Do NOT print*)

15B. DATE SIGNED (*MM,DD,YYYY*)

WHERE TO SEND YOUR VA FORM 21-0845	MAIL TO	FAX TO
	Department of Veterans Affairs Evidence Intake Center PO Box 4444 Janesville, WI 53547-4444	844-531-7818 (Toll Free) <i>OR</i> Local: 248-524-4260

PRIVACY ACT INFORMATION: 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 and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. 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 Federal Statute of law in effect prior to January 1, 1975, and still in effect.

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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 MINIMUM 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 <input checked="" type="checkbox"/> DIVORCE <input type="checkbox"/>	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACE ENDED	
WHO MARRIED	NAME	WHY ENDED: DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/>	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACE ENDED	
WHO MARRIED	NAME	WHY ENDED: DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/>	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACE ENDED	

PRIOR MARRIAGE INFORMATION FOR SPOUSE			
WHO MARRIED	NAME	WHY ENDED: DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/>	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACE ENDED	
WHO MARRIED	NAME	WHY ENDED: DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/>	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACE ENDED	
WHO MARRIED	NAME	WHY ENDED: DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/>	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACE ENDED	

SECTION VII: QUESTIONS REGARDING INCOME AND ASSETS (If you need more space, attach a separate sheet) CONTINUED

29E. DID YOU ANSWER "YES" TO ANY OF THE ITEMS IN 29A - 29D?

YES NO (If "Yes," you **must** also complete VA Form 21P-0969, *Income and Asset Statement*)

SECTION VIII: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself, dependents you are under obligation to support, or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you or your dependents were/will be reimbursed. Please make sure to complete all 6 criteria below (if applicable). If more space is needed, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 11 and 12.

30. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?

YES NO (If "No," skip to Section IX)

A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	B. PAID TO (Name of Provider, Insurance company, Nursing home, etc.)	C. PURPOSE (Medicare premiums, Nursing Home, etc.)	D. DATE PAID (Month, Day, Year)	E. HOURLY RATE/ HOURS (In-home Provider Only)	F. AMOUNT YOU PAY
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$

SECTION IX: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 31, 32, and 33 to enroll in direct deposit. If you **do not** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

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

CHECKING SAVINGS

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

Account No.: _____ Account No.: _____

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

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

SECTION X: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

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

I certify I have received the notice attached to this application titled *Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected Pension Benefits*.

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 34, indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

34. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

I **DO NOT** want my claim considered for rapid processing under the FDC Program because I plan to submit further evidence in support of my claim.

35A. VETERAN'S SIGNATURE (REQUIRED)

35B. DATE SIGNED

SECTION XI: WITNESSES TO SIGNATURE (MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 35A WITH AN "X")

36A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

36B. PRINTED NAME AND ADDRESS OF WITNESS

37A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

37B. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. 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. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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 5, 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 and address of facility)

(Name, Signature and Title of Person Certifying for the Facility)

(Date Certified)

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 5, 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 and address of facility)

(Name, Signature and Title of Person Certifying for the Facility)

(Date Certified)

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 5, 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, Signature and Title of Certifying Official)

(Date Certified)

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 5, 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, Signature and Title of Certifying Official)

(Date Certified)

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. Please indicate the activities of daily life (ADLs) with which you assist the veteran:
 Help with getting out of bed Help with dressing Help with incontinence
 Help with bathing Help with feeding Help with toileting
 Help with ambulating (walking, movement, etc.)
 Other assistance: _____

C. Are you a licensed health professional? (RN, LVN or LPN) Yes No
If Yes, provide your license number: _____

Section 3: 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 Yes No
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): \$ _____ per month:
2. Medical and Nursing Services: \$ _____ per month:

Section 4: 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

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. Please indicate the activities of daily life (ADLs) with which you assist the veteran:
 Help with getting out of bed Help with dressing Help with incontinence
 Help with bathing Help with feeding Help with toileting
 Help with ambulating (walking, movement, etc.)
 Other assistance: _____

C. Are you a licensed health professional? (RN, LVN or LPN) Yes No
If Yes, provide your license number: _____

Section 3: 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 Yes No
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): \$ _____ per month:
2. Medical and Nursing Services: \$ _____ per month:

Section 4: 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



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

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/BENEFICIARY NAME (First, Middle Initial, Last)		
2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)	4. DATE OF BIRTH (MM/DD/YYYY) Month Day Year
5. VETERAN'S SERVICE NUMBER (If applicable)	6. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
7. TELEPHONE NUMBER (Include Area Code)	8. PREFERRED 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)	11. CLAIMANT'S SOCIAL SECURITY NUMBER	12. RELATIONSHIP OF CLAIMANT TO VETERAN
13. BENEFIT YOU ARE APPLYING FOR (Choose One) <input type="checkbox"/> 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 <u>without</u> eligibility to compensation. <input type="checkbox"/> 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

14. DATE OF EXAMINATION	15. HOME ADDRESS	
16A. IS CLAIMANT HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 16B and 16C)	16B. DATE ADMITTED	16C. NAME AND ADDRESS OF HOSPITAL

<p>NOTE: EXAMINER PLEASE READ CAREFULLY</p> <p>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.</p>							
<p>17. COMPLETE DIAGNOSIS <i>(Diagnosis needs to equate to the level of assistance described in questions 25 through 39)</i></p>							
18A. AGE	<p>18B. WEIGHT</p> <p>ACTUAL: LBS. ESTIMATED: LBS.</p>		<p>18C. HEIGHT</p> <p>FEET: INCHES:</p>				
19. NUTRITION			20. GAIT				
21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?				
<p>25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED</p> <p>From 9 PM to 9 AM: From 9 AM to 9 PM:</p>							
<p>26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? <i>(If "No," provide explanation)</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>							
<p>27. IS CLAIMANT ABLE TO PREPARE OWN MEALS? <i>(If "No," provide explanation)</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>							
<p>28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? <i>(If "Yes," provide explanation)</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>							
<p>29A. IS THE CLAIMANT LEGALLY BLIND? <i>(If "Yes," provide explanation)</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>29B. CORRECTED VISION</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">LEFT EYE</td> <td style="width: 50%; padding: 5px;">RIGHT EYE</td> </tr> <tr> <td style="height: 50px;"></td> <td style="height: 50px;"></td> </tr> </table>		LEFT EYE	RIGHT EYE		
LEFT EYE	RIGHT EYE						
<p>30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? <i>(If "Yes," provide explanation)</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>							
<p>31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? <i>(If "Yes," provide explanation)</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>							
<p>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? <i>(If "No," provide examples and rationale to support your conclusion.)</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>							

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

34. 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)*

35. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE 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 EXTREMITY.

36. DESCRIBE RESTRICTION OF THE 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 32 above)*

- YES *(If "YES," give distance) (Check applicable box or specify distance)*
 1 BLOCK
 5 or 6 BLOCKS
 1 MILE
 OTHER *(Specify distance)* _____
- NO

40A. PRINTED NAME OF EXAMINING PHYSICIAN

40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN

40C. DATE SIGNED

41A. NAME AND ADDRESS OF MEDICAL FACILITY

41B. 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 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 page 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.

**INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR
PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Attachment to VA Forms 21P-527, 21P-527EZ, 21P-534, 21P-534EZ, and 21-526)**

IMPORTANT: This is *not* a stand-alone form. Only complete this attachment if you are directed to do so when you complete *one* of the following:

1. Section VI on VA Form 21P-527 or Section VII on VA Form 21P-527EZ
2. Section VII on VA Form 21P-534 or Section VIII on VA Form 21P-534EZ
3. Section VIII on VA Form 21-526

VETERAN/CLAIMANT PERSONAL INFORMATION		
1. VETERAN'S NAME (Last, First, Middle)	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S FILE NUMBER (if known)
4. CLAIMANT'S NAME (Last, First, Middle)	5. CLAIMANT'S SOCIAL SECURITY NUMBER	6. CLAIMANT'S TELEPHONE NUMBER
7. TYPE OF CLAIMANT (Check only one box)		
<input type="checkbox"/> VETERAN <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> SURVIVING CHILD <input type="checkbox"/> PARENT		
IMPORTANT INFORMATION FOR CLAIMANTS		
<p>NOTE - The term "assets" means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of your or your dependent's primary residence including the residential lot area, not to exceed 2 acres) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.</p> <p>If you are a Veteran, you must report income and assets for:</p> <ul style="list-style-type: none"> • yourself • your spouse (<i>unless</i> you live apart <i>and</i> you are estranged <i>and</i> you do not contribute to your spouse's support) • your child or children (<i>unless</i> you do not have custody* <i>and</i> you do not contribute to your child's or children's support) <p>If you are a Surviving Spouse, you must report income and assets for:</p> <ul style="list-style-type: none"> • yourself • any child of the veteran who is in your custody* <p>If you are a Surviving Child or the Custodian of a Surviving Child, you must report income and assets for the:</p> <ul style="list-style-type: none"> • child • child's custodian (unless the child's custodian is an institution) • custodian's spouse <p>If you are a Parent, you must report income** for:</p> <ul style="list-style-type: none"> • yourself • your spouse (even if your spouse is the veteran's other parent. If your spouse is the veteran's other parent, you must <i>both</i> file claims) <p>*Child custody for pension purposes is defined in 38 C.F.R. § 3.57(d). A natural or adoptive parent has custody of a child unless custody is legally removed. For pension purposes, a child who has attained age 18 remains in the custody of the person who had custody before the child turned age 18 unless custody is legally removed.</p> <p>** Parent's DIC claimants do <i>not</i> need to <i>report</i> or <i>provide</i> documentation of their assets.</p>		
NOTICE		
<p>IMPORTANT: VA will compare the information you report on this form to Internal Revenue Service (IRS) and Social Security Administration (SSA) records to verify your income for the past three tax years for which information is available. Information from the IRS or SSA that conflicts with the income information you provide with your application may delay your claim and/or reduce your benefit amount.</p>		
<p><small>PRIVACY ACT NOTICE: 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, 58VA2122/28, Compensation, Pension, Education, and Vocational Rehabilitation Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. 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 responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.</small></p> <p><small>RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.</small></p>		

**INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR
 PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
 (Attachment to VA Forms 21P- 527, 21P-527EZ, 21P-534, 21P-534EZ, and 21-526)**

SECTION I: RETIREMENT INCOME AND DISTRIBUTIONS (If additional space is needed attach a separate sheet)

1. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS INCLUDING, BUT NOT LIMITED TO, DISTRIBUTIONS FROM A RETIREMENT PLAN, SUCH AS:

- Military Retirement
- Civil Service Retirement
- IRA
- SEP
- Qualified Plans
- Pensions
- Annuities
- Black Lung

YES NO (If "No," skip to Section II)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHO IS THE INCOME PAYER? (Name of business, financial institution, etc.)	C. WHAT IS YOUR CURRENT AND/OR EXPECTED INCOME? (Provide documentation of current income and expected income changes)	D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME? (Provide documentation of assets)
		CURRENT MONTHLY GROSS INCOME \$ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	
		CURRENT MONTHLY GROSS INCOME \$ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	
		CURRENT MONTHLY GROSS INCOME \$ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	
		CURRENT MONTHLY GROSS INCOME \$ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	

SECTION II - UNEMPLOYMENT INCOME (If additional space is needed attach a separate sheet)

2. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE UNEMPLOYMENT INCOME IN THE NEXT 12 MONTHS?

YES NO (If "No," skip to Section III)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED UNEMPLOYMENT INCOME? (Provide documentation of current income and expected income changes)
	<p>CURRENT MONTHLY GROSS INCOME \$</p> <hr/> <p>DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$</p>
	<p>CURRENT MONTHLY GROSS INCOME \$</p> <hr/> <p>DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$</p>
	<p>CURRENT MONTHLY GROSS INCOME \$</p> <hr/> <p>DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$</p>
	<p>CURRENT MONTHLY GROSS INCOME \$</p> <hr/> <p>DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$</p>

SECTION III - SAVINGS BONDS (If additional space is needed attach a separate sheet)

3. DO YOU OR YOUR DEPENDENTS OWN A SAVINGS BOND OR RECEIVE OR EXPECT TO RECEIVE INTEREST FROM A SAVINGS BOND WITHIN THE NEXT 12 MONTHS?

YES NO (If "No," skip to Section IV)

A. WHO OWNS THE SAVINGS BOND? (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED ANNUAL INCOME (interest earned)? (Attach a copy of the savings bond)	C. WHAT IS THE CURRENT FACE VALUE OF THE SAVINGS BOND?
	WHAT IS THE GROSS ANNUAL INCOME? \$ _____ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$ _____	\$ _____
	WHAT IS THE GROSS ANNUAL INCOME? \$ _____ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$ _____	\$ _____
	WHAT IS THE GROSS ANNUAL INCOME? \$ _____ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$ _____	\$ _____
	WHAT IS THE GROSS ANNUAL INCOME? \$ _____ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$ _____	\$ _____

SECTION IV - RENTAL PROPERTY, FARM OR BUSINESS INCOME (If additional space is needed attach a separate sheet)

4. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INCOME FROM RENTAL PROPERTY, FARM OR BUSINESS WITHIN THE NEXT 12 MONTHS?

YES NO (If "No," skip to Section V)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT OR EXPECTED INCOME FROM THIS SOURCE? (Provide documentation of current income and expected income changes)	C. WHAT KIND OF INCOME IS THIS? (Check applicable box)	D. WHAT IS THE VALUE OF YOUR PORTION OF THE PROPERTY, FARM, OR BUSINESS? (Note: Subtract the amount of Mortgages or other encumbrances specific to the property. Provide available documentation)
	CURRENT MONTHLY GROSS INCOME \$ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	<input type="checkbox"/> Farm - Submit a completed VA Form 21P-4165 with this application <input type="checkbox"/> Rental Property - Submit a completed VA Form 21P-4185 with this application <input type="checkbox"/> Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME \$ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	<input type="checkbox"/> Farm - Submit a completed VA Form 21P-4165 with this application <input type="checkbox"/> Rental Property - Submit a completed VA Form 21P-4185 with this application <input type="checkbox"/> Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME \$ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	<input type="checkbox"/> Farm - Submit a completed VA Form 21P-4165 with this application <input type="checkbox"/> Rental Property - Submit a completed VA Form 21P-4185 with this application <input type="checkbox"/> Business - Submit a completed VA Form 21P-4185 with this application	
	CURRENT MONTHLY GROSS INCOME \$ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	<input type="checkbox"/> Farm - Submit a completed VA Form 21P-4165 with this application <input type="checkbox"/> Rental Property - Submit a completed VA Form 21P-4185 with this application <input type="checkbox"/> Business - Submit a completed VA Form 21P-4185 with this application	

SECTION V - INTEREST, ROYALTIES, AND DIVIDENDS (If additional space is needed attach a separate sheet)

5. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INTEREST, DIVIDENDS, OR ROYALTIES WITHIN THE NEXT 12 MONTHS?

YES NO (If "No," skip to Section VI)

IMPORTANT: Do *not* report income you have already reported in Section III (Savings Bonds) or Section IV (Rental Property, Farm or Business Income).

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHO IS THE INCOME PAYER? (Name of business, financial institution, etc.)	C. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED INCOME? (Provide documentation of current income and expected income changes)	D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME? (Provide documentation of assets)
		CURRENT MONTHLY GROSS INCOME \$	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	
		CURRENT MONTHLY GROSS INCOME \$	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	
		CURRENT MONTHLY GROSS INCOME \$	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	
		CURRENT MONTHLY GROSS INCOME \$	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT \$	

SECTION VI - WAGES - INCLUDING SELF-EMPLOYMENT (If additional space is needed attach a separate sheet)

6. ARE YOU OR YOUR DEPENDENTS RECEIVING WAGES OR EXPECTING TO RECEIVE WAGES WITHIN THE NEXT 12 MONTHS?

YES NO (If "No," skip to Section VII)

A. WAGE RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT ARE YOUR OR YOUR DEPENDENTS CURRENT WAGES AND/OR EXPECTED WAGES? (Provide documentation of current wages and expected wage changes)
	<p>CURRENT MONTHLY GROSS WAGE \$</p> <hr/> <p>DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT \$</p>
	<p>CURRENT MONTHLY GROSS WAGE \$</p> <hr/> <p>DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT \$</p>
	<p>CURRENT MONTHLY GROSS WAGE \$</p> <hr/> <p>DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT \$</p>
	<p>CURRENT MONTHLY GROSS WAGE \$</p> <hr/> <p>DO YOU EXPECT THIS WAGE INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE WAGE INCOME WILL CHANGE AND EXPECTED WAGE AMOUNT \$</p>

SECTION VII - DISCONTINUED INCOME IN THE PRIOR TAX YEAR (If additional space is needed attach a separate sheet)

7. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME *LAST YEAR* THAT IS NO LONGER BEING RECEIVED OR WAS A ONE-TIME PAYMENT?

YES NO (If "No," skip to Section VIII)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHO WAS THE INCOME PAYER? (Name of business, financial institution, etc.)	C. WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?	D. WHEN DID THE INCOME STOP? (MM,DD,YYYY)
		\$	
		\$	
		\$	
		\$	

NOTE: Parent's DIC Claimants Only - You *do not* have to complete Sections VIII thru XI. Return to the application form. Your certification, signature and date on the application form applies to this attachment.

Pension Claimants - Continue to complete the attachment.

SECTION VIII - ASSETS PREVIOUSLY NOT REPORTED (If additional space is needed attach a separate sheet)

8. DO YOU OR YOUR DEPENDENTS HAVE ASSETS **NOT** ALREADY REPORTED, SUCH AS NON-INTEREST-BEARING ACCOUNTS, CASH, STOCKS, BONDS, OR REAL ESTATE?

YES NO (If "No," skip to Section IX)

A. ASSET OWNER (Veteran, Spouse, Child, Parent, Custodial, etc.)	B. WHAT IS THE CURRENT CASH VALUE OF THE ASSET? (Provide a bank or other official statement showing the current value. Do not report assets you have already reported in Sections I through VII)	C. AMOUNT OWED ON THE ASSET OR AMOUNT MORTGAGED OR OTHERWISE ENCUMBERED? (Provide documentation of mortgages or other encumbrances)
	\$	\$
	\$	\$
	\$	\$
	\$	\$

SECTION IX - ASSET TRANSFERS (If additional space is needed attach a separate sheet)

9. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ASSETS?

YES NO (If "No," skip to Section X)

A. WHO OWNED THE ASSET? (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER (Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)
	<input type="checkbox"/> SOLD <input type="checkbox"/> CONVEYED <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an asset reported to the IRS sold? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the original purchase price? _____ What was the sale price? _____ What date was the asset sold? (MM,DD,YYYY) _____ What was the gain (capital gain, etc.)? _____
	<input type="checkbox"/> SOLD <input type="checkbox"/> CONVEYED <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an asset reported to the IRS sold? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the original purchase price? _____ What was the sale price? _____ What date was the asset sold? (MM,DD,YYYY) _____ What was the gain (capital gain, etc.)? _____

SECTION IX: ASSET TRANSFERS (Continued)

A. WHO OWNED THE ASSET? (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER (Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)
	<input type="checkbox"/> SOLD <input type="checkbox"/> CONVEYED <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an asset that was reported to the IRS sold? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the original purchase price? _____ What was the sale price? _____ What date was the asset sold? (MM,DD,YYYY) _____ What was the gain (capital gain, etc.)? _____
	<input type="checkbox"/> SOLD <input type="checkbox"/> CONVEYED <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Explain below)	Name: _____ Relationship: _____	Was the asset transferred for less than fair market value? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an asset that was reported to the IRS sold? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the original purchase price? _____ What was the sale price? _____ What date was the asset sold? (MM,DD,YYYY) _____ What was the gain (capital gain, etc.)? _____

SECTION X: ANNUITIES AND TRUSTS (Attach a separate sheet if more than one annuity or trust is involved)

10A. IN THE CURRENT YEAR OR THE PRIOR THREE TAX YEARS, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS TO A TRUST OR PURCHASE AN ANNUITY?
 Yes No (If "No," skip to Section XI)

10B. WHAT WAS THE MARKET VALUE OF THE ASSET AT THE TIME OF TRANSFER OR ANNUITY PURCHASE? \$ _____

10C. WHAT WAS THE DATE THE ASSET WAS TRANSFERRED?
 (MM,DD,YYYY)

10D. DID YOU PURCHASE AN ANNUITY WITH THE ASSETS? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," complete Items 10E through 10G)	10E. PROVIDE DATE OF PURCHASE	10F. PROVIDE NAME OF PERSON THE ASSET WAS PURCHASED FROM (First-Middle-Last)
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10G. PROVIDE TYPE OF ANNUITY PURCHASED (Give details and attach documentation)

10H. WERE THE ASSETS USED TO ESTABLISH A TRUST? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," complete Items 10I through 10J)	10I. PROVIDE TAX NUMBER	10J. PROVIDE DETAILS AND ATTACH DOCUMENTATION
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10K. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?
 Yes No

SECTION XI - WAIVER OF RECEIPT OF INCOME *(If additional space is needed attach a separate sheet)*

11. DID YOU OR YOUR DEPENDENTS WAIVE OR EXPECT TO WAIVE ANY RECEIPT OF INCOME IN THE NEXT 12 MONTHS?

YES NO

(If "NO," skip this section. This attachment is complete. Return to the application. Your certification, signature and date on the application form applies to this attachment)

A. INCOME RECIPIENT (Veteran, Spouse, Child, Parent, Custodian, etc.)	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED WAIVED INCOME? (Provide documentation of income and expected income changes)
	CURRENT MONTHLY GROSS WAIVED INCOME \$ DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT \$
	CURRENT MONTHLY GROSS WAIVED INCOME \$ DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT \$
	CURRENT MONTHLY GROSS WAIVED INCOME \$ DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT \$
	CURRENT MONTHLY GROSS WAIVED INCOME \$ DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE WAIVED INCOME WILL CHANGE AND EXPECTED WAIVED INCOME AMOUNT \$

THIS ATTACHMENT FORM IS COMPLETE. RETURN TO THE APPLICATION FORM. YOUR CERTIFICATION, SIGNATURE AND DATE ON THE APPLICATION FORM APPLIES TO THIS ATTACHMENT.