



# PLACER COUNTY VETERANS SERVICE OFFICE

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

## Aid & Attendance Verification Form

### Surviving Spouse

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 DIC, Survivors Pension and/or Accrued Benefits (21P-534EZ)

- Income & Asset Statement (21P-0969) - If Assets are over \$10,000  
 Medical Expenses - Ongoing monthly expenses

- A&A Application Sheet (3 pages) \*       Marriage Certificate       Death 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 of Similar Facility (21P-534EZ)
- Worksheet for In-Home Attendant Expenses (21P-534EZ)
- Care and Expense Statement for Caregiver/Facility (2 pgs.) & Proof of Monthly Payment

**Verification of Gross Income from all Sources**

- 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**

- 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 Surviving Spouse and returned to our VSO. (Unless one has already been filed).

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

**Third Party Form:** Will need to be completed, signed & dated by the Surviving Spouse 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.

**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 Surviving Spouse does not have the income, medical expense, or asset, you must enter None or N/A in the spot provided for the Surviving Spouse.

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

**Page 3:** Is requesting prior marriages for the Veteran & Surviving Spouse. If you were married more than once, you must complete this page providing the date & location of the prior marriage(s) 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 IX**

**Medical Expenses (Section IX):** Enter the monthly amount of the Surviving 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.

**Signature Page**

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

**Claim Certification and Signature (Section XI):** Only Signature of Surviving Spouse is required in box 50A **(do not date).**

**Worksheets (Facility or In-Home Care) \***

**(Use the Worksheet that is applicable to the Surviving 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 Surviving 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: Add the Surviving Spouse's full name on first line, enter the care provider's name on the second line and the care provider must sign & date it.

**Care & Expense Statement (2 pages)**

**Complete & enter the information on behalf of the Surviving 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 Surviving Spouse must sign & date it.

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

**Cover Sheet, Page 1:**

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

**Box 4, 5 and 6:** Enter Surviving Spouse information

**Box 7:** Check the Surviving Spouse box only.

**Page 2-11:**

Answer all questions; if you check yes for any question, enter the Surviving 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 the Surviving 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

8. VETERAN'S SERVICE NUMBER (If applicable)

MALE  FEMALE

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?

YES  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](http://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)

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, 58VA21/22/28, 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](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.



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](http://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. Redislosure 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.

<b>VA USE ONLY</b>	COPY OF VA FORM 21-22 SENT TO: <input type="checkbox"/> VR&E FILE <input type="checkbox"/> EDU FILE	DATE SENT	ACKNOWLEDGED <i>(Date)</i>	REVOKED <i>(Reason and date)</i>
	<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.



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. Please print the information requested in ink, neatly, and legibly to help process the form.

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

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

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

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

### SECTION II - BENEFICIARY/CLAIMANT'S IDENTIFICATION INFORMATION

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

7. ADDRESS OF BENEFICIARY/CLAIMANT (*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. PREFERRED PHONE NUMBER (*Include Area Code*)

9. PREFERRED EMAIL ADDRESS (*Optional*)

### 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

**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

**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](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.



## 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 <b>is not</b> 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 <b>one person</b> or <b>one organization</b>. 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 <b>cannot</b> be used to disclose federal tax information to third parties.</p> <p><b>IMPORTANT:</b> The information provided in Item 6, "Name of Beneficiary/Claimant Who Is Not the Veteran," <b>cannot</b> 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
Department of Veterans Affairs Evidence Intake Center PO Box 4444 Janesville, WI 53547-4444	844-531-7818 (Toll Free) 248-524-4260 (Foreign claims)	<a href="http://www.ebenefits.gov">www.ebenefits.gov</a>

**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).



**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 X: 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 46, 47, and 48 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](http://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.

46. 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.: \_\_\_\_\_

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

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

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

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

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

I certify I have enclosed all 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 49, 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.

49. 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 box below **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.

50A. CLAIMANT'S SIGNATURE (REQUIRED)

50B. DATE SIGNED

**SECTION XII: WITNESSES TO SIGNATURE (COMPLETE ONLY IF CLAIMANT SIGNED ITEM 45A WITH AN "X")**

51A. SIGNATURE OF WITNESS (If claimant signed above using an "X")

51B. PRINTED NAME AND ADDRESS OF WITNESS

52A. SIGNATURE OF WITNESS (If claimant signed above using an "X")

52B. PRINTED NAME AND ADDRESS OF WITNESS

**PRIVACY ACT NOTICE:** The form will be used to determine allowance to compensation and/or 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](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.

## WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR A 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?

(If "NO," continue to Step 2)

YES  NO (If "YES," **all** payments to the facility qualify as medical expenses in Items 45A thru 45F. 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 claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

YES  NO (If "NO," skip to Step 6)

**STEP 4.** Did you claim special monthly pension or special monthly DIC in Item 37?

YES  NO (If "NO," payments to this facility for meals and lodging **do not** qualify as medical expenses. **Only** claim amount you pay the facility for **health care services or assistance with ADLs provided by a health care provider** in Items 45A thru 45F. 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 in Items 45A thru 45F **if** VA rates you as eligible for special monthly pension or special monthly DIC. Please report the amount you pay the facility for lodging and meals separate from the amount you pay the facility for **health care services or assistance with ADLs provided by a health care provider** as medical expenses in Items 45A thru 45F. Skip to Step 8)  
(If "NO," payments to this facility for meals and lodging **do not** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay the facility for: (1) **health care services or assistance with ADLs provided by a health care provider**, and (2) **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 45A thru 45F. 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 45A thru 45F)  
(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 45A thru 45F. 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 your 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 claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

YES  NO (If "NO," skip to Step 4)

**STEP 2.** Did you claim special monthly pension on Item 37?

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 45A thru 45F 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 45A thru 45F **if** VA rates you as eligible for special monthly pension. Please report separately in Items 45A thru 45F 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 45A thru 45F 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 45A thru 45F. 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 45A thru 45F)  
(If "NO," report payments to this in-home attendant for **health care and/or custodial care** as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs **do not** qualify as medical expenses)

**STEP 6.** Check all activities below that 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 provided or supervised by a licensed health professional (RN, LVN, LPN)  Yes  No

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

**Section 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 <i>(First, Middle Initial, Last)</i>		
2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER <i>(If applicable)</i>	4. DATE OF BIRTH <i>(MM/DD/YYYY)</i> Month      Day      Year
5. VETERAN'S SERVICE NUMBER <i>(If applicable)</i>	6. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
7. TELEPHONE NUMBER <i>(Include Area Code)</i>	8. PREFERRED E-MAIL ADDRESS <i>(Optional)</i>	
9. PREFERRED MAILING ADDRESS <i>(Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)</i>  No. & Street Apt./Unit Number      City State/Province      Country      ZIP Code/Postal Code		

**SECTION II: CLAIM INFORMATION**

10. CLAIMANT'S NAME <i>(First, Middle Initial, Last)</i>	11. CLAIMANT'S SOCIAL SECURITY NUMBER	12. RELATIONSHIP OF CLAIMANT TO VETERAN
13. BENEFIT YOU ARE APPLYING FOR <i>(Choose One)</i>  <input type="checkbox"/> <b>Special Monthly Compensation (SMC)</b> - 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"/> <b>Special Monthly Pension (SMP)</b> - 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 <i>(If "Yes," complete Items 16B and 16C)</i>	16B. DATE ADMITTED	16C. NAME AND ADDRESS OF HOSPITAL

<p><b>NOTE: EXAMINER PLEASE READ CAREFULLY</b></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	18B. WEIGHT ACTUAL: LBS.                      ESTIMATED: LBS.	18C. HEIGHT FEET:                      INCHES:	
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>			
29A. IS THE CLAIMANT LEGALLY BLIND? <i>(If "Yes," provide explanation)</i>		29B. CORRECTED VISION	
<p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p><input type="checkbox"/>    <input type="checkbox"/></p>		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)*  1 BLOCK  5 or 6 BLOCKS  1 MILE  OTHER *(Specify distance)* \_\_\_\_\_  
 NO *(Check applicable box or specify distance)*

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 <i>(Include Area Code)</i>
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**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(e)(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.



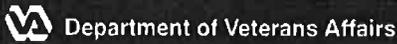
**Department of  
Veterans Affairs**

**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

<b>VETERAN/CLAIMANT PERSONAL INFORMATION</b>		
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		
<p style="text-align: center;"><b>IMPORTANT INFORMATION FOR CLAIMANTS</b></p> <p><b>NOTE</b> - The term "<b>assets</b>" 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 <b>Veteran</b>, you must report income and assets for:</p> <ul style="list-style-type: none"> <li>• yourself</li> <li>• 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)</li> <li>• 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)</li> </ul> <p>If you are a <b>Surviving Spouse</b>, you must report income and assets for:</p> <ul style="list-style-type: none"> <li>• yourself</li> <li>• any child of the veteran who is in your custody*</li> </ul> <p>If you are a <b>Surviving Child</b> or the <b>Custodian of a Surviving Child</b>, you must report income and assets for the:</p> <ul style="list-style-type: none"> <li>• child</li> <li>• child's custodian (unless the child's custodian is an institution)</li> <li>• custodian's spouse</li> </ul> <p>If you are a <b>Parent</b>, you must report income** for:</p> <ul style="list-style-type: none"> <li>• yourself</li> <li>• 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)</li> </ul> <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>		
<b>NOTICE</b>		
<p><b>IMPORTANT:</b> 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><b>PRIVACY ACT NOTICE:</b> VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e. civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation Records - VA, 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><b>RESPONDENT BURDEN:</b> 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: <a href="http://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. 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)
	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 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)

<b>A. INCOME RECIPIENT</b> (Veteran, Spouse, Child, Parent, Custodian, etc.)	<b>B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT OR EXPECTED INCOME FROM THIS SOURCE?</b> (Provide documentation of current income and expected income changes)	<b>C. WHAT KIND OF INCOME IS THIS?</b> (Check applicable box)	<b>D. WHAT IS THE VALUE OF YOUR PORTION OF THE PROPERTY, FARM, OR BUSINESS?</b> (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)
		<p>CURRENT MONTHLY GROSS INCOME      \$</p> <hr/> <p>DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT</p> <p align="center">\$</p>	
		<p>CURRENT MONTHLY GROSS INCOME      \$</p> <hr/> <p>DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT</p> <p align="center">\$</p>	
		<p>CURRENT MONTHLY GROSS INCOME      \$</p> <hr/> <p>DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT</p> <p align="center">\$</p>	
		<p>CURRENT MONTHLY GROSS INCOME      \$</p> <hr/> <p>DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <hr/> <p>DATE INCOME WILL CHANGE AND EXPECTED INCOME AMOUNT</p> <p align="center">\$</p>	

**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)

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

**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)

<b>A. INCOME RECIPIENT</b> (Veteran, Spouse, Child, Parent, Custodian, etc.)	<b>B. WHO WAS THE INCOME PAYER?</b> (Name of business, financial institution, etc.)	<b>C. WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?</b>	<b>D. WHEN DID THE INCOME STOP?</b> (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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) _____
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 _____ _____
10K. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

YES  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?

YES  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?

YES  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?

YES  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.**