Department of Veterans Affairs

GENERAL INSTRUCTIONS

FOR APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION (DIC), SURVIVORS PENSION AND ACCRUED BENEFITS BY A SURVIVING SPOUSE OR CHILD (INCLUDING DEATH COMPENSATION IF APPLICABLE)
VA FORM 21P-534

Note: Read very carefully, detach, and keep these instructions for your reference.

A. How can I contact VA if I have questions?

If you have any questions about this form, how to fill it out, or about VA benefits, contact your nearest VA regional office.
You can locate the address of the nearest regional office in your telephone book blue pages under "United States Government, Veterans" or call 1-800-827-1000 (Hearing Impaired TDD line is 711). You may also contact VA by Internet at https://iris.custhelp.va.gov.

B. What is the purpose of VA Form 21P-534?

Use VA Form 21P-534 to apply for:

- VA benefits you may be entitled to receive as a surviving spouse or child of a deceased veteran, ***and***
- any money VA owes the veteran but did not pay prior to his or her death (accrued benefits).

NOTE: If you apply for any one of these benefits, the law requires that we also consider you for the others.

C. What is the purpose of the attached SSA-24 form?

You can apply for Social Security (SS) benefits by using the SSA-24 form attached to this VA Form (see pages 12 and 13). You don't have to apply if you don't want to or have already done so. If you do want to apply, fill it out and leave it attached. We will send it to the Social Security Administration for you. They will then contact you.

D. What are dependency and indemnity compensation (DIC) and Survivors Pension benefits, and how does VA decide what I will or will not receive?

1. Dependency and indemnity compensation may be payable when:
   - a veteran's death occurred while on active service, ***or***
   - a veteran dies of a service-connected disability or disabilities that was/were either the principal or contributory cause of death, ***or***
   - a veteran died from a non-service connected injury or disease AND was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling;
   - For at least 10 years immediately before death; ***or***
   - For at least 5 years after the veteran's release from active duty preceding death; ***or***
   - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999.
2. Survivors Pension may be payable when:
   - the death of a veteran with wartime service is not due to service, ***and***
   - income and assets are within applicable limits.

VA pays pension based on the amount of family income and assets and the number of dependent children. This is based on law. VA must include as income all sources that Federal law specifies. If there is no surviving spouse, pension may be payable on behalf of a child or children.

You must provide information about the Social Security benefits you and your dependents receive. Report the gross amount you and your dependents receive monthly before deductions are taken out. If you have a copy of your most recent Social Security award letter, please include a copy of the letter with your application.

You must tell us if you or your dependents receive or received income from sources other than Social Security. Please also report if you or your dependents own your primary residence and the value of your assets and your dependents' assets. Your assets **do** include your spouse's assets. Although your assets ***do not*** include your child's assets, you must tell us if your child has significant assets.

Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the primary residence including the residential lot area, not to exceed 2 acres) less the amount of mortgages or other encombrances 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.

Unless a claim for dependency and indemnity compensation or Survivors Pension is filed within 1 year from the date of the veteran's death, that benefit is not payable from a date earlier than the date the claim is received in the VA.

If it is determined that you are entitled to DIC and death pension, we will pay you whichever benefit entitles you to the most money. Benefit rates and income limits are frequently changed, so it is not possible to keep this information current in these instructions. You can find out what the current income limitations and rates of benefits are by contacting your nearest VA regional office.

E. How do I apply for special monthly pension or special monthly DIC?

VA may pay increased survivor benefits to a surviving spouse who is blind, a patient in a nursing home due to mental or physical incapacity, requires the aid of another person to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulations 3.352(a)); or who is permanently confined to his or her immediate premises because of a permanent disability. If you wish to apply for this benefit, check "Yes" for Item 34.

F. How do I complete my application?

Print all answers clearly. If an answer is "none" or "0," write that. Your answer to every question is important to help us complete your claim. If you do not know the answer, write "unknown." For additional space, use Item 51, "Remarks, " or attach a separate sheet, indicating the item number to which the answers apply. Make sure you print your name, sign and date this application in Items 48A, 48B and 48C.

Note: If the claim is being made on behalf of a minor or incompetent person, the application form should be completed and filed by the legal guardian. If no legal guardian has been appointed, it may be completed and filed by some person acting on behalf of the minor or incompetent person.

G. What do I do when I have completed my application?

When you have completed this application mail or fax it to the Pension Intake Center address shown below. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and everything that you submit to VA before mailing or faxing it.

MAIL: Department of Veterans Affairs
Pension Intake Center
P.O. Box 5365
Janesville, Wisconsin 53547-5365

FAX: Toll-Free (844) 655-1604

H. How can I assign someone to act as my representative?

You may wish to contact an accredited veterans service officer (vso) to assist with your application. For a list of accredited veterans service organizations go to https://www.va.gov/vso/.

You may also contact your state office of veterans affairs at https://www.va.gov/statedva.htm, should you need further assistance with the application process. Depending on the type of representative you want to designate, please submit one of the following forms:

- VA Form 21-22, *Appointment of a Veterans Service Organization as Claimant's Representative*, ***or***
- VA Form 21-22A, *Appointment of Individual as Claimant's Representative*.

You may download these forms at www.va.gov/vaforms.

I. What if I believe that VA has made an error in processing or deciding my benefits?

You can ask for a personal hearing at any time during the processing of your claim. That means you can ask for the hearing while VA is processing your claim or after VA has made a decision. You should contact the nearest VA office and tell them that you want a personal hearing on your case. Someone in the local VA office will arrange a time and place for your hearing. At this hearing, you can bring witnesses. VA will record whatever you and your witnesses say during the hearing and include it in the official record. VA will furnish the hearing room and officials, and prepare a transcript of the hearing. VA cannot pay your expenses or the expenses of anyone you want to bring with you to the hearing.

IMPORTANT: If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided when you filed your claim (or later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on VA recognized marriages is available at **http:www.va.gov/opa/marriage/**.

J. FEES FOR CLAIMS:

Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

PRIVACY ACT INFORMATION: 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, 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 SSN account information is mandatory. Applicants are required to provide their SSN under Title 38 USC 5101 (c) (1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by 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 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 eligibility for death benefits and accrued benefits under 38 U.S.C. 1310 through 1314, 1532 through 1543, and 5121. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 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.

OMB Approved No. 2900-0004
Respondent Burden: 1 hour 15 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION AND ACCRUED BENEFITS BY A SURVIVING SPOUSE OR CHILD
(Including Death Compensation if Applicable)

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

PART I - IDENTIFYING INFORMATION (Provide information about you and the deceased veteran)

NOTE: You may complete the form on-line or by hand. If completed by hand, print the information requested in ink, neatly and legibly, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle, Last Name of Veteran) (Suffix if applicable)

2. VETERAN'S SOCIAL SECURITY NUMBER?

3. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)
Month Day Year

4. VETERAN'S DATE OF DEATH (MM, DD, YYYY)
Month Day Year
*(**NOTE:** Attach a copy of the death certificate unless the veteran died in active service of the Army, Navy, Air Force, Marine Corps, or Coast Guard, or in a U.S. government institution)*

5A. DID THE VETERAN SERVE UNDER ANOTHER NAME?
◯ YES ◯ NO (If "Yes," answer Item 5B)

5B. LIST THE OTHER NAME(S) THE VETERAN SERVED UNDER (If known)

6A. WAS THE VETERAN A FORMER PRISONER OF WAR?
◯ YES ◯ NO (If "Yes," answer Item 6B)

6B. DATES OF CONFINEMENT (If known)
FROM: TO:

7. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)
◯ SURVIVING SPOUSE ◯ CHILD

8. WHAT IS THE YOUR DATE OF BIRTH (MM, DD, YYYY)
Month Day Year

9. WHAT IS YOUR SOCIAL SECURITY NUMBER?

10. SURVIVING SPOUSE OR CHILD'S NAME (First, Middle Initial, Last Name)

11. CURRENT MAILING ADDRESS OF SURVIVING SPOUSE OR CHILD (Number and street or rural route, city or P.O., State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

12. SURVIVING SPOUSE'S OR CHILD'S TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

13. SURVIVING SPOUSE OR CHILD'S E-MAIL ADDRESS (If applicable)

PART II - CLAIM INFORMATION (Tell us what you are applying for and what you and the deceased veteran have applied for)

14. DID THE VETERAN EVER FILE A CLAIM WITH VA ?
◯ YES ◯ NO (If "Yes," answer Item 15)

15. WHAT IS THE VA FILE NUMBER? (If known)

16. HAS THE SURVIVING SPOUSE OR CHILD EVER FILED A CLAIM WITH VA?
◯ YES ◯ NO (If "Yes," answer Items 17, 18 & 19)

17. WHAT IS THE VA FILE NUMBER? (If known)

18. WHAT IS THE NAME OF THE PERSON ON WHOSE SERVICE THE CLAIM WAS FILED? (First, Middle, Last Name of Veteran)

19. DESCRIBE YOUR RELATIONSHIP TO THE PERSON NAMED IN ITEM 18

20. ARE YOU CLAIMING SERVICE CONNECTION FOR CAUSE OF DEATH?
◯ YES
◯ NO

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

PART III - VETERAN'S ACTIVE DUTY SERVICE

IMPORTANT: Enter complete information for ***all*** periods of service. If more space is needed use Item 51 "Remarks". If the veteran never filed a claim with VA, attach the original DD214 or a certified copy for each period of service listed. We will return original documents to you.

21A. ENTERED ACTIVE SERVICE - First Period (Month, Day, Year)	21B. PLACE ENTERED ACTIVE SERVICE - First Period	
Month – Day – Year		
21C. DATE LEFT ACTIVE SERVICE - First Period (Month, Day, Year)	21D. PLACE LEFT ACTIVE SERVICE - First Period	
Month – Day – Year		
21E. SERVICE NUMBER	21F. BRANCH OF SERVICE	21G. GRADE, RANK, OR RATING
	◯ ARMY ◯ NAVY ◯ MARINE CORPS ◯ AIR FORCE ◯ COAST GUARD	
22A. ENTERED ACTIVE SERVICE - Second Period (Month, Day, Year)	22B. PLACE ENTERED ACTIVE SERVICE - Second Period	
Month – Day – Year		
22C. DATE LEFT ACTIVE SERVICE - Second Period (Month, Day, Year)	22D. PLACE LEFT ACTIVE SERVICE - Second Period	
Month – Day – Year		
22E. SERVICE NUMBER	22F. BRANCH OF SERVICE	22G. GRADE, RANK, OR RATING
	◯ ARMY ◯ NAVY ◯ MARINE CORPS ◯ AIR FORCE ◯ COAST GUARD	
23A. ENTERED ACTIVE SERVICE - Third Period (Month, Day, Year)	23B. PLACE ENTERED ACTIVE SERVICE - Third Period	
Month – Day – Year		
23C. DATE LEFT ACTIVE SERVICE - Third Period (Month, Day, Year)	23D. PLACE LEFT ACTIVE SERVICE - Third Period	
Month – Day – Year		
23E. SERVICE NUMBER	23F. BRANCH OF SERVICE	23G. GRADE, RANK, OR RATING
	◯ ARMY ◯ NAVY ◯ MARINE CORPS ◯ AIR FORCE ◯ COAST GUARD	
24A. ENTERED ACTIVE SERVICE - Fourth Period (Month, Day, Year)	24B. PLACE ENTERED ACTIVE SERVICE - Fourth Period	
Month – Day – Year		
24C. DATE LEFT ACTIVE SERVICE - Fourth Period (Month, Day, Year)	24D. PLACE LEFT ACTIVE SERVICE - Fourth Period	
Month – Day – Year		
24E. SERVICE NUMBER	24F. BRANCH OF SERVICE	24G. GRADE, RANK, OR RATING
	◯ ARMY ◯ NAVY ◯ MARINE CORPS ◯ AIR FORCE ◯ COAST GUARD	

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

PART IV - MARITAL INFORMATION

(Attach a copy of your marriage certificate showing your marriage to the veteran)

NOTE: You must furnish complete information about ***all*** marriages of the surviving spouse and the veteran. If you need additional space, please attach a separate VA Form 21-686c, *Declaration of Status of Dependents*, providing the requested information.

If you are claiming benefits as the surviving spouse of the veteran you should complete Items 25A through 31. If you are not the surviving spouse, skip to Section V.

TELL US ABOUT THE VETERAN'S MARRIAGES

25A. HOW MANY TIMES WAS THE VETERAN MARRIED? (Include marriage to you)

25B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country)	25C. TO WHOM MARRIED (first, middle, last name)	25D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	25E. HOW MARRIAGE TERMINATED (death, divorce)	25F. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)

25G. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 25D, PLEASE EXPLAIN:

TELL US ABOUT YOUR MARRIAGES

26A. HOW MANY TIMES HAVE YOU BEEN MARRIED? (Include your marriage to the veteran)

Provide information in Items 26c through 26G for all of your marriages)

26B. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN? ◯ YES ◯ NO

26C. DATE (month, day, year) and PLACE OF MARRIAGE (city/state or country)	26D. TO WHOM MARRIED (first, middle, last name)	26E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	26F. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	26G. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)

26H. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 26E, PLEASE EXPLAIN:

27. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

◯ YES ◯ NO (Answer Item 28 only if you were married to the veteran less than one year)

28. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

◯ YES ◯ NO

29. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?

◯ YES ◯ NO (If "No," complete Item 30)

30. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)*

31. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

◯ YES ◯ NO (If "Yes," provide explanation):_____

PART V - DEPENDENT CHILDREN *(Complete ONLY if claiming benefits for a child(ren) of the veteran)*

*(Skip to Section VI if you are **NOT** claiming benefits for a child(ren) of the veteran)*

TELL US ABOUT THE UNMARRIED CHILDREN OF THE VETERAN

NOTE: You should provide a copy of the public record of birth or a copy of the court record of adoption for each child listed in Item 32A ***unless*** the veteran was receiving additional VA benefits for the child.

If you need additional space, please attach a separate VA Form 21-686c, *Declaration of Status of Dependents*, providing the requested information about each child.

IMPORTANT: **Skip to Part VI if you are not claiming benefits for any children that meet the following criteria.**

VA recognizes the veteran's biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:

- under age 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- of any age if they became permanently unable to support themselves before reaching at 18.

"Seriously disabled" (Item 32H) means that the child became permanently unable to support himself/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

Note to surviving spouse: If entitlement to DIC is established, a "seriously disabled" child over age 18 is entitled to receive DIC benefits in his or her own right. A veteran's child who is seriously disabled and over age 18 must submit a separate VA Form 21P-534 to apply for benefits.

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

PART V - DEPENDENT CHILDREN ***(Complete ONLY if claiming benefits for a child(ren) of the veteran)***
*(Skip to Section VI if you are **NOT** claiming benefits for a child(ren) of the veteran)* **(Continued)**

32A. NAME OF CHILD (First, middle initial, last name)	32B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	32C. SOCIAL SECURITY NUMBER	(Check all that apply) 32D. BIOLOGICAL	32E. ADOPTED	32F. STEPCHILD	32G. 18-23 YEARS OLD (in school)	32H. SERIOUSLY DISABLED	32I. CHILD MARRIED	32J. CHILD PREVIOUSLY MARRIED
			◯	◯	◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯	◯	◯
			◯	◯	◯	◯	◯	◯	◯

Tell us about the child(ren) listed in Item 32A that ***do not*** live with you in Items 33A through 33D.

33A. NAME OF CHILD (First, middle initial, last name)	33B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	33C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	33D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$ ____ .00
			$ ____ .00
			$ ____ .00

PART VI - HOUSEBOUND, IN A NURSING HOME OR REQUIRE AID AND ATTENDANCE

NOTE: If you are claiming aid and attendance allowance and/or housebound benefits because you need the regular assistance of another person, are having severe visual problems, or are housebound and not in a nursing home, submit a statement from your doctor showing the extent of your disabilities. If you are in a nursing home, attach a statement signed by an official of the nursing home showing the date you were admitted, the level of care you receive, the amount you pay out-of-pocket for your care, and whether Medicaid covers all or part of your nursing home costs.

34. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE CONFINED TO YOUR IMMEDIATE PREMISES?

◯ YES ◯ NO *(If "Yes," please complete and attach with this application VA Form 21-2680, Exam for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistance (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS))*

35A. ARE YOU NOW IN A NURSING HOME?

◯ YES ◯ NO *(If "Yes," answer Items 35B and 35C and submit a statement from an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care)*

35B. PROVIDE THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY

35C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?

◯ YES ◯ NO *(If "No," answer Item 35D)*

35D. HAVE YOU APPLIED FOR MEDICAID?

◯ YES ◯ NO

PART VII - INCOME AND ASSETS

36A. HAVE YOU CLAIMED OR ARE YOU RECEIVING BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION ON YOUR OWN BEHALF OR ON BEHALF OF A CHILD OR CHILDREN IN YOUR CUSTODY?

◯ YES ◯ NO (If "Yes," answer Item 43B)

36B. IS SOCIAL SECURITY BASED ON YOUR OWN EMPLOYMENT?

◯ YES ◯ NO

37. HAS A SURVIVING SPOUSE OR CHILD FILED A CLAIM FOR COMPENSATION FROM THE *OFFICE OF WORKER'S COMPENSATION PROGRAMS* BASED ON THE DEATH OF THE VETERAN?

◯ YES ◯ NO

38. HAS A COURT AWARDED DAMAGES BASED ON THE DEATH OF THE VETERAN OR IS A CLAIM OR LEGAL ACTION FOR DAMAGES PENDING?

◯ YES ◯ NO

39. HAVE YOU CLAIMED OR ARE YOU RECEIVING *SURVIVOR BENEFIT PLAN (SBP) ANNUITY* FROM A SERVICE DEPARTMENT BASED ON THE DEATH OF THE VETERAN?

◯ YES ◯ NO

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

PART VIII - INCOME AND ASSETS

IMPORTANT: Tell us about the income and assets of you and your dependents.

40A. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

◯ YES ◯ NO (If "Yes," complete Item 40B) (If "No," skip to Item 41)

40B. GROSS MONTHLY INCOME (Attach a separate sheet if necessary)

SOCIAL SECURITY RECIPIENT	GROSS MONTHLY AMOUNT
	$ .00
	$ .00
	$ .00
	$ .00
	$ .00
	$ .00
	$ .00
	$ .00

41. DO YOU OWN YOUR PRIMARY RESIDENCE?

◯ YES ◯ NO (If "No," skip to Item 43A)

42A. IS THE SIZE OF THE LOT ON WHICH YOUR PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 Square Feet)?
(If over 2 acres enter square feet)_____

◯ YES ◯ NO (If "Yes," complete 42B and 42C, if "No" skip to Item 43A)

42B. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 Square Feet) WHAT IS THE VALUE OF THE LAND OVER 2 ACRES?

Value of land $ _____.00
(Do not include the value of the residence or the first 2 acres)

42C. IS THE LAND OVER 2 ACRES (87,120 Square Feet) LISTED IN 42B MARKETABLE?

◯ YES ◯ NO

(If "Yes," complete and attach VA Form, 21P-0969, *Income and Asset Statement*)

IMPORTANT: VA matches income information reported with Federal tax information. Report ALL income you and your dependents receive on the appropriate sections of this form and VA Form 21P-0969, Income and Asset Statement, if appropriate.

43A. **OTHER THAN SOCIAL SECURITY**, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?

◯ YES ◯ NO

43B. **OTHER THAN SOCIAL SECURITY**, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?

◯ YES ◯ NO

43C. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN $10,000 IN ASSETS? (NOTE: Assets are all the money and property you or your dependents own. Assets ***do not*** include your primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation)

◯ YES ◯ NO

43D. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving them away, selling them, purchasing an annuity, or using them to establish a trust)

◯ YES ◯ NO

43E. DID YOU ANSWER "YES," TO ***ANY*** OF THE QUESTIONS IN ITEMS 43A THRU 43D?

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

PART IX - DIRECT DEPOSIT INFORMATION

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, please attach a voided personal check, deposit slip, or provide the information requested below. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

44. ◯ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITION OR CERTIFIED PAYMENT AGENT.

45A. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

Account No.: _____ ◯ CHECKING ◯ SAVINGS

45B. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)

45C. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

PART X - MEDICAL, LAST ILLNESS, BURIAL OR OTHER UNREIMBURSED EXPENSES

IMPORTANT: Tell us about medical, last illness, burial or other unreimbursed expenses.

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of any unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself 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 paid by you for the veteran's or his/her child's last illness and burial and the veteran's just debts. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. **Do not** include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim. If more space is needed 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 10 and 11.

46. ARE YOU CLAIMING UNREIMBURSED MEDICAL EXPENSES?

◯ YES ◯ NO (If "No," skip to Section XI)

47A. WHOSE MEDICAL, BURIAL, OR OTHER EXPENSES WERE PAID?	47B. PAID TO (Name of provider, Insurance company, nursing home, etc.)	47C. PURPOSE (Medicare premiums, nursing home, etc.)	47D. DATE PAID (mm/dd/yyyy)	47E. HOURLY RATE/HOURS (In-home Provider only)	47F. AMOUNT YOU PAY
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00
					$ .00

PART XI - CERTIFICATION AND SIGNATURE

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.

48A. PRINTED NAME OF PERSON SIGNING (First, Middle Initial, Last)

48B. SIGNATURE OF CLAIMANT (Provide your signature in the box) (If you sign with an "X," then you must have 2 people you know witness as you sign. They must then sign the form and print their names and addresses)

48C. TODAY'S DATE (MM,DD,YYYY)

49A. SIGNATURE OF WITNESS (If claimant signed above using an "X")

49B. PRINTED NAME AND ADDRESS OF WITNESS

50A. SIGNATURE OF WITNESS (If claimant signed above using an "X")

50B. PRINTED NAME AND ADDRESS OF WITNESS

VETERAN'S SOCIAL SECURITY NUMBER

PART XII - REMARKS

51. REMARKS (If any) (Use this space for any additional information or statements that you would like to make concerning your application)

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?

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

(If "YES," ***all*** payments to the facility qualify as medical expenses in Items 47A thru 47F. 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 in Item 34?

◯ 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 47A thru 47F. 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 47A thru 47F ***if*** VA rates you as eligible for special monthly pension or special monthly DIC. Please report separately in Items 47A - 47F 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)

(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 47A thru 47F 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 disabilty)

(If "NO," claim only amounts you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 47A thru 47F. 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)?

(If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 47A thru 47F)

◯ 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 custodial care*** in Items 47A thru 47F)

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 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 individual staying at your facility)

and his/her care at this facility (_____).

(Name and address of facility)

_____ _____

(Name, Signature, Title at Facility) (Date)

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 Parents' DIC claimant?

◯ YES ◯ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension in Item 34?

◯ YES ◯ NO (If "NO," the in-home attendant ***must be a health care provider*** and payments for assistance with IADLs ***do not*** qualify as medical expenses. Payments for ***health care services or custodial care*** qualify as medical expenses. You may claim these expenses in Items 47A thru 47F. 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 ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 47A - 47F 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 47A thru 47F 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 the disabled person because of the disabled person's 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 47A thru 47F. 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 47A thru 47F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 47A thru 47F. Payment for assistance with IADLs ***do not*** qualify as medical expense)

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

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 breakdown of the time the attendant spends assisting the disabled person with health care services, ADLs, and IADLs.)

I CERTIFY the information within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment

pertaining to _____ and his/her care
(Name of Individual Requiring Care)

from _____.
(Name of Attendant)

_____ _____
(Name, Signature, Title) (Date)

Form Approved
OMB Approved No. 0960-0062

SOCIAL SECURITY ADMINISTRATION

APPLICATION FOR SURVIVORS BENEFITS

(PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT)

IMPORTANT - Read instructions before completing form. Detach and retain ONLY the instruction sheet.

(DO NOT WRITE IN THIS SPACE)
VA DATE STAMP

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	2. DATE OF DEATH

NOTE: If the veteran's Social Security No. is unknown, complete Items 4, 5, 6 and 7 about veteran.

3. SOCIAL SECURITY NO. OF VETERAN	4. DATE OF BIRTH	5. PLACE OF BIRTH

6. NAME OF FATHER	7. MAIDEN NAME OF MOTHER	8. DID THE VETERAN WORK IN THE RAILROAD INDUSTRY AT ANY TIME AFTER 1936? ◯ YES ◯ NO

NOTE: The following information should be furnished for each period of the veteran's active service (regular or reserves) after September 7, 1939, in the military service of the United States or service as a commissioned officer in the Public Health Service or the National Oceanic and Atmospheric Administration or during WWII, Philippine or Filipino or Allied country military service. If additional space is needed, attach a separate sheet.

9A. DATE ENTERED ACTIVE SERVICE	9B. SERVICE NO.	9C. DATE SEPARATED FROM ACTIVE SERVICE	9D. GRADE, RANK, OR RATING, ORGANIZATION AND BRANCH OF SERVICE

10. RELATIONSHIP OF APPLICANT TO VETERAN ◯ SURVIVING SPOUSE ◯ CHILD ◯ PARENT	11. DATE OF BIRTH OF APPLICANT	12. VA FILE NO.

CHILDREN: Show names of surviving children (including natural children, adopted children and stepchildren) or dependent grandchildren (including step grandchildren) who at any time since the veteran died, were unmarried and (a) under age 18; (b) age 18 to 19 and attending secondary school; (c) disabled or handicapped (18 or over and disability began before age 22).

13A.	13B.
13C.	13D.

I know that anyone who makes or causes to be made a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both. I affirm that all information I have given in this document is true.

14. DATE *(Month, day, year)*	15. SIGNATURE OF APPLICANT *(First name, middle initial, last name) (Sign in ink)*

16. MAILING ADDRESS OF APPLICANT *(No. and street or rural route, city or P.O., State and ZIP Code)*	17. TELEPHONE NO. *(Include Area Code)*

WITNESSES REQUIRED ONLY IF SIGNATURE OF APPLICANT IS MADE BY "X" MARK ABOVE

18A. SIGNATURE OF WITNESS	18B. ADDRESS OF WITNESS *(No. and street, city, State and ZIP Code)*
19A. SIGNATURE OF WITNESS	**19B. ADDRESS OF WITNESS *(No. and street, city, State and ZIP Code)***

ITEMS BELOW TO BE COMPLETED BY THE DEPARTMENT OF VETERANS AFFAIRS Use reverse for "Remarks"

20. PROOFS RECEIVED	21. PROOFS REQUESTED FROM CLAIMANT OR OTHER *(Specify)*
☐ DEATH ☐ MARRIAGE	☐ DEATH ☐ MARRIAGE
☐ AGE _____ (NAME)	☐ AGE _____ (NAME)
☐ OTHER *(Specify)* _____ (NAME)	☐ OTHER *(Specify)* _____ (NAME)
_____ (NAME)	_____ (NAME)

22. DATE	23. NAME AND ADDRESS OF TRANSMITTING VA OFFICE

IMPORTANT: PLEASE READ THE FOLLOWING BEFORE YOU COMPLETE THE SSA-24.
INSTRUCTIONS FOR COMPLETING FORM SSA-24, APPLICATION FOR SURVIVORS BENEFITS
(Payable Under Title II of the Social Security Act)

This application form, SSA-24, is an Application for Survivors Benefits Payable under Title II of the Social Security Act, as amended. Under authority of section 202(o) of the Social Security Act, the application requests information in order to determine eligibility to social security benefits.

You **do not** have to complete this application; there are no penalties under the law if you do not complete part or all of the SSA-24. However, it is usually to your advantage to provide the information because not providing it could prevent an accurate and timely decision on your claim or could result in the loss of some benefits or insurance coverage.

If you **do** wish to supply the information requested on the SSA-24, this information will be forwarded to the Social Security Administration and used by them to determine whether social security benefits may be payable to surviving dependent(s) of the veteran. Social Security will then contact you regarding any social security benefits payable based on information given on this form.

Please understand that Social Security may, in certain instances, disclose the information on this form to another Federal, State or local agency or individual without your written consent. This would be done in order to:

- enable a third party or an agency to assist Social Security in establishing an individual's right to benefits or coverage;
- comply with Federal laws which require or authorize the release of information from social security records; and
- facilitate statistical research and audit activities necessary to assure the integrity and improvement of the social security programs.

If you should have any question about entitlement to social security benefits or the information you have provided on this form, please contact your local social security office.

Complete each item of the attached application, Form SSA-24, (except Items 20 through 23). When signed and dated the form SHOULD BE LEFT ATTACHED to your completed

- VA Form 21P-534, Application for Dependency and Indemnity Compensation, Death Pension a and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable) or
- VA Form 21P-535, Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation When Applicable).

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 15 minutes to read the instructions, gather the necessary facts, and answer the questions.