NOTICE TO VETERAN OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR VETERANS PENSION BENEFITS

This notice provides information regarding the evidence necessary to substantiate a claim for:

- Veterans Pension (a needs-based income program for veterans)
- Special Monthly Pension
- Benefits Based on a Veteran's Seriously Disabled Child

If you are making a claim for:

Pension Benefits	Complete and submit VA Form 21P-527EZ, *Application for Veterans Pension*
Survivors Benefits	Complete and submit VA Form 21P-534EZ, *Application for D.I.C., Survivors Pension, and/or Accrued Benefits*
Higher-Level Review (HLR)	Complete and submit VA Form 20-0995, *Decision Review Request: Supplemental Claim*

If you are not ready to submit a claim for Veterans Pension, please complete a VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or D.I.C.*, to protect your date of claim. If you complete the VA Form 21P-527EZ within one year of filing the VA Form 21-0966, your completed application will be considered filed as of the date VA receives the VA Form 21-0966.

VA forms are available at www.va.gov/vaforms.

For more information on Veterans Pension see https://www.va.gov/pension/eligibility/.

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)
You may wish to contact an accredited Veterans Service Officer (VSO) to assist you with your application. For a list of accredited Veterans Service Organizations, go to https://www.benefits.va.gov/vso/. You may also contact your state office of Veteran's Affairs at https://www.va.gov/statedva.htm. To assign a VSO as your power of attorney for the claims process, submit VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents
Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veterans Affairs at https://www.va.gov/ogc/apps/accreditation/index.asp. To assign a private attorney for the claims process, submit VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims: Generally, an accredited attorney or claims agent can ONLY charge claimants a fee after the VA has issued a decision on a claim. 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.

WHEN TO USE THIS FORM

The attached application is needed to submit a claim for Veterans Pension. There are worksheets included to help verify care expenses if you claim them. Please leave items in a section blank if it does not apply to you.

THE APPLICATION HAS 13 SECTIONS			
SECTION I:	VETERAN'S IDENTIFICATION INFORMATION	SECTION IX:	QUESTIONS REGARDING INCOME AND ASSETS
SECTION II:	VETERAN'S CONTACT INFORMATION		
SECTION III:	VETERAN'S SERVICE INFORMATION	SECTION X:	INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES
SECTION IV:	PENSION INFORMATION		
SECTION V:	EMPLOYMENT HISTORY	SECTION XI:	DIRECT DEPOSIT INFORMATION
SECTION VI:	MARITAL STATUS	SECTION XII:	CLAIM CERTIFICATION AND SIGNATURE
SECTION VII:	PRIOR MARITAL HISTORY	SECTION XIII:	WITNESSES TO SIGNATURE
SECTION VIII:	DEPENDENT CHILDREN		

WHAT YOU NEED TO DO

Submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession. A substantially complete claim must contain: (1) The claimant's name; (2) Sufficient service information for VA to verify the claimed service, if applicable; (3) The benefit sought and any medical condition(s) on which it is based; (4) The claimant's signature; (5) A statement of income.

To get the quickest response, you must

1. Submit your claim on a signed and complete VA Form 21P-527EZ, *Application for Veterans Pension* (Attached)
2. Submit simultaneously with your claim (See special circumstances below):
   - All necessary income and asset information; AND
   - All, if any, relevant, private medical treatment records and an identification of any relevant treatment records available at a federal facility, such as a VA medical center.*******
   - Any additional forms and evidence as the situation requires. Special Circumstances below indicates the most common circumstances. The application and other VA Forms may require additional evidence.
3. Report for any VA medical examinations VA determines are necessary to decide your claim.

*****IMPORTANT:** If you are a veteran who is claiming pension and you are age 65 or older or determined to be disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application unless you are claiming Special Monthly Pension. Special Monthly Pension is an increased amount paid to individuals who, due to mental or physical disability, require the aid of another person to perform activities of daily living, are a patient in a nursing home, have severe visual problems, or are substantially confined to their home.

• If you are aware of evidence not in your possession and require VA's assistance to obtain it on your behalf; provide VA with enough information to request the evidence from the person or agency.

SPECIAL CIRCUMSTANCES (Additional Forms that may be needed to remain eligible)

VA Form 21P-0969, *Income and Asset Statement in Support Claim for Pension or Parents' D.I.C.*, may be required if you:

- Have multiple income sources
- Have more than $75,000 in Assets
- Additional forms as noted on the VA Form 21P-0969 may be required

If claiming Veterans Pension with Special Monthly Pension:

- Please have a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinic Nurse Specialist (CNS) complete VA Form 21-2680, *Examination for Household Status or Permanent Need for Regular Aid and Attendance*, **- OR -**
- If you are a patient in a nursing home, VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*.

If claiming a child:

- And they are in school between the ages of 18 and 23, a completed VA Form 21-674, *Request for Approval of School Attendance*
- If the child was adopted, please submit the adoption papers or amended birth certificate
- If claiming benefits for a child who became seriously disabled prior to reaching the age of 18, submit all, if any, relevant, private medical treatment records for the child's pertinent disabilities.

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

The VA will retrieve evidence on your behalf in some circumstances. If the VA is unable to retrieve the necessary evidence, we will notify you and provide you with an opportunity to submit the information or evidence. It is your responsibility to make sure we receive all requested records that are not in the possession of a federal department or agency.

VA will:

• Retrieve relevant records from a Federal facility such as a VA medical center, that you adequately identify and authorize VA to obtain.

• Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim.

• Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from State or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records from current or former employers.

WHEN YOU SHOULD SEND WHAT WE NEED

You must:

• Send the information and evidence simultaneously with your claim.

You are strongly encouraged to:

• Send any information or evidence as soon as you can.

You have up to one year from the date we received the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we receive the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See the evidence table titled...
Veterans Pension (a needs-based benefit)	• Military Service Verification
	• Veterans Pension
Special Monthly Pension	• Veterans Pension with Special Monthly Pension
Benefits because your child is severely disabled	• Child Permanently Incapable of self-support

EVIDENCE TABLES

Military Service Verification
To support your claim for Veterans Pension, your military service must be verified. The following evidence can be submitted to verify military service: • A photocopy of your DD Form 214 (or equivalent) for all periods of military service. You may request a copy of the DD Form 214 through the National Archives' National Personnel Records Center (NPRC) using SF180, *Request Pertaining to Military Records*, (available at https://www.archives.gov/veterans/military-service-records/standard-form-180.html) or through your local public custodian of records.
Fire Related Military Records As you may know, there was a fire at the National Archives and Records Administration on July 12, 1973, which destroyed approximately; • 80 percent of the records NPRC held for Veterans who were discharged from the Army between November 1, 1912, and January 1, 1960, and • 75 percent of the records NPRC held for Veterans with surnames beginning (alphabetically) with Hubbard and running through the end of the alphabet, and who were discharged from the Air Force between September 25, 1947, and January 1, 1964. If your military records were stored there on that date, they may have been destroyed in the fire. If you believe your military records may have been destroyed in the fire go to https:www.archives.gov/veterans/military-service-records for other methods to request military service records and to avoid delays in processing your claim. **Note**: The Veterans Benefits Administration (VBA) is no longer able to retrieve or return original documents submitted. Please **do not** submit original documents to the VA. They will not be returned.

Veterans Pension

To support a claim for Veterans Pension, the evidence must show:

1. You met certain minimum active service requirements during a period of war. Generally, those requirements are:
   - 90 days of service during a period of war; **OR**
   - 90 days of consecutive service at least one day of which was during a period of war; **OR**
   - 90 days of combined service during more than one period of war:
     (None: If your service began after September 7, 1980, additional length of service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligation), **OR**
   - any length of active service during a period of war with a discharge due to a service-connected disability

2. You are age 65 or older or are permanently and totally disabled. Your disability or disabilities do not have to be related to your military service. You are considered permanently and totally disabled if medical evidence shows you are:
   - A patient in a nursing home for long-term care or medical foster home; **OR**
   - Receiving Social Security disability benefits; **OR**
   - Unemployable due to a disability reasonably certain to continue throughout your lifetime; **OR**
   - Suffering from a disability that is reasonably certain to continue throughout your lifetime that would make it impossible for an average person to follow a substantially gainful occupation; **OR**
   - Suffering from a disease or disorder that VA determines causes persons who have that disease or disorder to be permanently and totally disabled

3. Your income and assets are within established limits. You must report income and assets for:
   - Yourself
   - Your spouse (unless you live apart and you are estranged, and you do not contribute to your spouse's support)
   - Your child/children (unless custody has been legally removed by a court and you do not contribute to your child's support or the child's income is not reasonably available to you).

   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 unless the additional acreage is not marketable) less the amount 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.

Veterans Pension with Special Monthly Pension

To support a claim for increased pension eligibility based on the need for aid and attendance, the evidence must show:

- You have corrected visual acuity of 5/200 or less in both eyes; **OR**
- You have concentric contraction of the visual field to 5 degrees or less; **OR**
- You are a patient in a nursing home due to mental or physical incapacity; **OR**
- You need the aid of another person to perform activities of daily living (ADLs), such as bathing or showing, dressing, eating, toileting, and transferring (e.g. getting in and out of bed); **OR**
- You require regular supervision because you are unsafe if you are left alone due to a mental disorder, **OR**
- You are bedridden, in that your disability requires that you remain in bed apart from any prescribed course of convalescence or treatment.

To support your claim for **increased pension eligibility based on being housebound**, the evidence must show:

- You have a single permanent disability evaluated as 100 percent disabling; **AND** due to such disability, you are permanently and substantially confined to your immediate premises; **OR**
- You have a single permanent disability evaluated as 100 percent disabled, **AND** you have an additional disability or disabilities rated 60 percent or higher.

Child Permanently Incapable of Self-Support

The information necessary to establish the extent of the child's disability includes;

- The extent to which the child is and was, prior to reaching their 18th birthday, physically or mentally deficient, as evidenced by factors such as their ability to perform self-care functions, and ordinary tasks expected of a child of that age
- Whether or not the child attended school and, if so, the maximum grade attended
- If any material improvement in the child's condition has occurred
- If the child has ever been employed and, if so, the nature and dates of such employment, and amount of pay received
- Whether or not the child has ever married, and
- A description of the child's present condition.

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 at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognized marriages is available at http://www.va.gov/opa/marriage/.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant your claim, the beginning date of your entitlement will generally be based on when we received your claim or when we received an intent to file (ITF) for pension, if received within a year of the ITF.

Special monthly pension may be assigned for disabilities that affect your ability to perform certain activities of daily living or the ability to leave your home. Special monthly pension may be effective from the date the medical evidence first shows entitlement.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

When you have completed this application, you can either submit it online or mail it to the Pension Intake Center listed below. Be sure to attach any materials that support and explain your claim. Make a photocopy of your application and all supporting material you submit to VA before submitting it.

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs Pension Intake Center P.O. Box 5365 Janesville, Wisconsin 53547-5365	VA gov: www.va.gov Direct Upload via: access.va.gov

TERMS AND CALCULATIONS FOR PENSION

Maximum Annual Pension Rate (MAPR)
This is the maximum payable amount of the benefit. Your MAPR is based on how many dependents you have, if you're married to another Veteran who qualifies for a pension, and if your disabilities qualify you for housebound or aid and attendance benefits. The MAPR is adjusted each year for cost-of-living increases.

Medical Deductible
The unreimbursed expenses must exceed 5 percent of the applicable **MAPR**. The deductible increases based on the number of dependents but is not adjusted for aid and attendance (A&A) or housebound benefits.

Countable Medical Expenses
Your countable medical expenses are only those medical expenses that exceed the **Medical Deductible**. Medical expenses are typically considered on a calendar year basis. Your initial year is considered separately, and we will count medical expenses which provide the greatest benefit.

- Recurring Medical Expenses
  - Examples include: Medicare Part B, medical related insurance, in-home care provider, or care provided by a care facility
- One-Time Medical Expenses
  - Examples include: medical co-payments, prescription medications, and durable medical equipment

Reported Annual Medical Expenses - Medical Deductible = Countable Medical Expenses (Min. Zero)

Countable Income
We count the **gross** income you receive as reported or the income we discover from data matching programs with other federal sources. If our data match shows a significant discrepancy, you will be asked to clarify the discrepancy. We count incomes in three ways:

- One-time income is income that you receive once. VA will count it for one year from the first of the following month from receipt date.
  - Examples include: lottery winnings, gifts, capital gains from property sales, irregular IRA (Individual Retirement Account) or stock disbursements.
- Irregular income is income that you receive at different times or in irregular amounts throughout the year. VA will count it for one year from the first of the following month from receipt date receipt date.
  - Examples include: odd jobs or contract work and interest income.
- Recurring income is counted continuously until we are informed that you are no longer in receipt of it.
  - Examples include: wages from employment, retirement payments, required minimal distributions from an IRA

Income for VA Purposes (IVAP)
VA counts all of your family income and considers any unreimbursed medical expenses reported when determining your IVAP. The following calculation is a way for you to estimate your IVAP.

Countable Annual Income - Countable Medical Expenses = IVAP

Pension Rate
Your maximum annual benefit is the difference of the current MAPR and what the VA calculates as your IVAP. To convert into a monthly benefit, take this amount and divide by 12 then rounded down to the nearest dollar.

MAPR - IVAP = Annual Pension Rate

Net Worth
The net worth limit is increased by the same percentage as the Social Security increase when there is a cost-of-living adjustment. For purposes of entitlement to VA Pension, net worth includes your and your spouse's assets and your and your dependent's annual income. VA considers children's net worth separately if their net worth would cause you to exceed the limit. VA won't consider them as a dependent when determining your pension entitlement.

Additional information about how VA calculates net worth, Income, and benefits rates can be found at:
https://www.va.gov/pension/veterans-pension-rates/

Veterans Pension Application Checklist

In addition to your application, VA may require some of the evidence described in this checklist. Information not provided will be requested, which will result in delaying your claim. Additional evidence may be needed beyond this checklist depending on your specific situation.

Service Verification (Requested in Section III and/or Page 4 of Instructions)

- ☐ Copy of your DD Form 214 (or equivalent) for all periods of military service. Must demonstrate military service dates, type of service and character of discharge.

Income and Net Worth (Requested in Section IX and/or Page 4 of Instructions)

- ☐ VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.)*, is required if instructed in Section IX of this application. If you have specific types of income or assets additional evidence may be required. If reporting:
  - ☐ Farm - VA Form 21P-4165, *Pension Claim Questionnaire for Farm Income*
  - ☐ Business - VA Form 21P-4185, *Report of Income from Property or Business*
  - ☐ Rental Property - VA Form 21P-4185, *Report of Income from Property or Business*
  - ☐ Royalties - VA Form 21-4138, *Statement in Support of Claim*
  - ☐ Trust - Submit complete Trust documents to include the Schedule of Assets

Special Circumstances Regarding Your Medical Care (Requested in Section IV, Section X and/or Page 4 of Instructions)

Claim for Special Monthly Pension (SMP) - Aid and Attendance or Housebound Status

- ☐ VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Claim for Medicare Nursing Home and/or $90.00 Rate Reduction Request

- ☐ VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

Claim for Fiduciary Assistance

- ☐ VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Statement of Medical Care

- ☐ Care Worksheets (found at the end of the application)
- ☐ Proof of Payment from care provided (Canceled checks, bank statements, etc.)
- ☐ Signed verification from care service provider

Dependent Children (Requested in Section VIII and/or Pages 4 and 5 of Instructions)

- ☐ If children are adopted, the adoption decree or a revised birth certificate is required.
- ☐ If your child is over 18 but under 23, please submit VA Form 21-674, *Request for Approval of School Attendance*.
- ☐ Medical records for each seriously disabled child.

Medical Expenses (Requested in Section X)

- ☐ If additional space is needed, submit VA Form 21P-8416, *Medical Expense Report*.

OMB Control No. 2900-0002
Respondent Burden: 30 minutes
Expiration Date: XX/XX/20XX

VA | U.S. Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME *(First, Middle Initial, Last)*

1B. VETERAN'S SOCIAL SECURITY NUMBER — —

1C. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* / /

1D. HAVE YOU EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO *(If "NO," skip question 1E)*

1E. VA FILE NUMBER *(If known)*

SECTION II: VETERAN'S CONTACT INFORMATION

2A. MAILING ADDRESS

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

2B. TELEPHONE NUMBER *(Include Area Code)* — —

International Phone Number *(If applicable)*

2C. VETERAN'S E-MAIL ADDRESS *(Optional)*

SECTION III: VETERAN'S SERVICE INFORMATION *(MUST COMPLETE)*

3A. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER *(If None, leave blank)*

3B. DATE INITIALLY ENTERED ACTIVE DUTY *(MM/DD/YYYY)* / /

3C. FINAL RELEASE DATE FROM ACTIVE DUTY *(MM/DD/YYYY)* / /

3D. YOUR SERVICE NUMBER

3E. BRANCH OF SERVICE

☐ ARMY ☐ NAVY ☐ AIR FORCE
☐ COAST GUARD ☐ MARINE CORPS
☐ SPACE FORCE ☐ USPHS ☐ NOAA

3F. PLACE OF YOUR LAST SEPARATION

3G. HAVE YOU EVER BEEN A PRISONER OF WAR? ☐ YES ☐ NO *(If "NO," skip to question 4A)*

3H. DATES CONFINEMENT STARTED *(MM/DD/YYYY)* / / / /

3I. DATES CONFINEMENT ENDED *(MM/DD/YYYY)* / / / /

SECTION IV: PENSION INFORMATION

4A. ARE YOU OVER THE AGE OF 65 OR HAVE YOU BEEN DETERMINED TO BE DISABLED BY SOCIAL SECURITY ADMINISTRATION?

☐ YES ☐ NO *(If "YES," skip question 4B and Section V)*

4B. ARE YOU MEDICALLY INCAPABLE OF WORKING?

☐ YES ☐ NO *(If "YES," you must submit medical evidence with this application)*

4C. DO YOU LIVE IN A NURSING HOME?

☐ YES *(If "YES," please have an official from your nursing home complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance)*

☐ NO *(If "NO," skip question 4D)*

4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED FOR MEDICAID?

☐ YES ☐ NO

4E. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL IMPAIRMENT OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

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

4F. HAVE YOU RECEIVED TREATMENT FROM A VA MEDICAL CENTER?

☐ YES ☐ NO Specify Facility:

4G. HAVE YOU RECENTLY RECEIVED TREATMENT FROM ANY FEDERAL MEDICAL FACILITIES *(Military base, etc.)*?

☐ YES ☐ NO Specify Facility:

SECTION V: EMPLOYMENT HISTORY

5A. ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO *(If "NO," skip questions 5B and 5C)*

5B. WHAT KIND OF WORK ARE YOU CURRENTLY DOING?

5C. HOW MANY HOURS PER WEEK DO YOU AVERAGE?

5D. WHEN DID YOU LAST WORK? *(MM/DD/YYYY)* / /

5E. HOW MANY HOURS PER WEEK DID YOU AVERAGE?

5F. WHAT WAS YOUR JOB TITLE?

5G. WHAT KIND OF WORK DID YOU DO?

SECTION VI: MARITAL STATUS *(MUST COMPLETE)*

NOTE: If reporting the United States as the place a marriage happened, you must report the City and State of the marriage.

6A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

☐ MARRIED ☐ SEPARATED ☐ NOT MARRIED *(If Widowed or Divorced - Skip to Section VII; If Never Married - Skip to Section VIII)*

6B. SPOUSE'S CURRENT LEGAL NAME *(First, Middle Initial, Last)*

6C. SPOUSE'S BIRTH DATE *(MM/DD/YYYY)* / /

6D. SPOUSE'S SOCIAL SECURITY NUMBER – –

6E. DATE OF MARRIAGE *(MM/DD/YYYY)* / /

6F. PLACE OF MARRIAGE

6G. STATE

6H. COUNTRY

6I. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, etc.)*

☐ CEREMONIAL ☐ OTHER *(Specify)*

6J. IS YOUR SPOUSE ALSO A VETERAN?

☐ YES ☐ NO *(If "NO," skip question 6H)*

6K. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? *(If any)*

6L. IF YOU ARE SEPARATED, PLEASE TELL US THE REASON YOU ARE SEPARATED *(Illness, work, etc.)*

☐ MEDICAL REASON ☐ MARITAL DISCORD ☐ WORK ☐ OTHER *(Specify)* _____

6M. SPOUSE'S MAILING ADDRESS *(If separated)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

6N. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? *(If separated)* $, .

SECTION VII: PRIOR MARITAL HISTORY

Tell us about your and your spouse's previous marriages. If you have never been married or your current marriage is yours and your spouse's only marriage skip to Section VIII.

NOTE: If reporting the United States as the place a marriage happened, you must report the City and State of the marriage.

VETERAN'S PRIOR MARRIAGES *(If None, skip to question 7L)*

7A. WHO WERE YOU MARRIED TO? *(First, Middle Initial, Last)*

7B. HOW DID YOUR PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*

☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)*

7C. WHAT IS THE START DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)* / /

7D. WHAT IS THE END DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)* / /

7E. PLACE OF MARRIAGE *(City and State or Country)*

7F. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7G. WHO WERE YOU MARRIED TO? *(First, Middle Initial, Last)*

VETERAN'S PRIOR MARRIAGES - CONTINUED *(If None, skip to question 7L)*

7H. HOW DID YOUR PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)*

7I. WHAT IS THE START DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7J. WHAT IS THE END DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7K. PLACE OF MARRIAGE *(City and State or Country)*

7L. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7M. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?
☐ YES ☐ NO *(If "YES," please submit a VA Form 21-686c, Application Request to Add and/or Remove Dependents , or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)*

SPOUSE'S PRIOR MARRIAGES *(If "None," skip to Section VIII)*

7N. WHO WAS YOUR SPOUSE MARRIED TO? *(First, Middle Initial, Last)*

7O. HOW DID THE PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)*

7P. WHAT IS THE START DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7Q. WHAT IS THE END DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7R. PLACE OF MARRIAGE *(City and State or Country)*

7S. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7T. WHO WAS YOUR SPOUSE MARRIED TO? *(First, Middle Initial, Last)*

7U. HOW DID THE PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)*

7V. WHAT IS THE START DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7W. WHAT IS THE END DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7X. PLACE OF MARRIAGE *(City and State or Country)*

7Y. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7Z. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR YOUR SPOUSE?
☐ YES ☐ NO *(If "YES", please submit a VA Form 21-686c, Application Request to Add and/or Remove Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history.)*

SECTION VIII: DEPENDENT CHILDREN

NOTE: Please refer to the Special Circumstances on the instructions page for information regarding dependents and the necessary forms if additional space is required to list all dependents. If None, skip to Section IX. **In most circumstances, children over the age of 23 are not considered dependent for VA purposes unless they have been rated incapable of self-support.** If reporting the United States as the place a marriage happened, you must report the City and State of the marriage.

8A. HOW MANY DEPENDENT CHILDREN LIVE WITH YOU? *(Please complete a VA Form 21-686c, Application Request to Add and/or Remove Dependents, if you need more space for additional dependents.)*

8B. CHILD'S NAME *(First, Middle Initial, Last)*

8C. CHILD'S BIRTH DATE *(MM/DD/YYYY)*

8D. CHILD'S SOCIAL SECURITY NUMBER

8E. PLACE OF BIRTH *(City and State or Country)*

8F. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*
☐ BIOLOGICAL ☐ STEPCHILD ☐ SERIOUSLY DISABLED ☐ 18-23 YEARS OLD *(in school)* ☐ MARRIED/PREVIOUSLY MARRIED ☐ ADOPTED
☐ CHILD DOES NOT LIVE WITH YOU BUT YOU ANNUALLY CONTRIBUTE $

8G. CHILD'S NAME *(First, Middle Initial, Last)*

8H. CHILD'S BIRTH DATE *(MM/DD/YYYY)*

8I. CHILD'S SOCIAL SECURITY NUMBER

8J. PLACE OF BIRTH *(City and State or Country)*

SECTION VIII: DEPENDENT CHILDREN *(CONTINUED)*

8K. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*

☐ BIOLOGICAL ☐ STEPCHILD ☐ SERIOUSLY DISABLED ☐ 18-23 YEARS OLD *(in school)* ☐ MARRIED/PREVIOUSLY MARRIED ☐ ADOPTED

☐ CHILD DOES NOT LIVE WITH YOU BUT YOU ANNUALLY CONTRIBUTE $

8L. CHILD'S NAME *(First, Middle Initial, Last)*

8M. CHILD'S BIRTH DATE *(MM/DD/YYYY)* / /

8N. CHILD'S SOCIAL SECURITY NUMBER – –

8O. PLACE OF BIRTH *(City and State or Country)*

8P. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*

☐ BIOLOGICAL ☐ STEPCHILD ☐ SERIOUSLY DISABLED ☐ 18-23 YEARS OLD *(in school)* ☐ MARRIED/PREVIOUSLY MARRIED ☐ ADOPTED

☐ CHILD DOES NOT LIVE WITH YOU BUT YOU ANNUALLY CONTRIBUTE $

8Q. DO ALL OF YOUR CHILDREN THAT ARE NOT LIVING WITH YOU AS ANSWERED ABOVE RESIDE AT THE SAME ADDRESS?

☐ YES ☐ NO *(If "NO," Please submit a VA Form 21-4138, Statement in Support of Claim, with the following information: Who the child is currently living with, and the full address of where the child resides.)*

8R. PLEASE PROVIDE THE NAME OF THE CUSTODIAN OF CHILDREN NOT LIVING WITH YOU *(First, Middle Initial, Last)*

8S. PLEASE PROVIDE THE ADDRESS OF THE CUSTODIAN OF CHILDREN NOT LIVING WITH YOU

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS

NOTE: Assets are all the money and property you or your dependents own. Assets do not include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

9A. DO YOU AND YOUR DEPENDENTS HAVE OVER $75,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?

☐ YES *(If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.))*

☐ NO *(If "NO," please estimate the total value of your assets)* $

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? *(Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)*

☐ YES ☐ NO *(If "YES," please submit VA Form 21P-0969)*

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

☐ YES ☐ NO *(If "NO," skip to Item 9G)*

9D. IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

☐ YES ☐ NO *(If "NO," skip to Item 9G)*

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES? *(Do not include the value of the residence or the first 2 acres.)*

$

9F. IS THE LAND OVER 2 ACRES (87, 120 SQ FT) REPORTED IN QUESTION 9E MARKETABLE?

☐ YES ☐ NO *(If "YES," please submit VA Form 21P-0969)*

9G. HOW MANY INCOME SOURCES DOES YOUR FAMILY HAVE?

☐ NO INCOME ☐ 1 - 4 SOURCES OF INCOME ☐ 5+ SOURCES OF INCOME *(If 5+, please submit VA Form 21P-0969)*

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, by questions 9A through 9G, we only require Social Security income reported below. All other income should be reported on VA Form 21P-0969. Income will be counted as reported, do not duplicate.

NOTE: If reporting income in 9H through 9K, any items skipped or left blank will be considered as an unspecified income and could require a request for further information, potentially delaying your claim. If you leave the entire question blank, we will assume you have no income to report.

9H(1) WHO IS THE INCOME RECIPIENT? *(Select one)*

☐ VETERAN
☐ SPOUSE
☐ CHILD *(Specify Name)*

9H(2) SPECIFY THE TYPE OF INCOME

☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS
☐ CIVIL SERVICE ☐ PENSION/RETIREMENT
☐ OTHER *(Specify type of income)*

9H(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*

9H(4) CURRENT GROSS MONTHLY INCOME

$

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS *(Continued)*

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9I(2) SPECIFY THE TYPE OF INCOME	9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9I(4) CURRENT GROSS MONTHLY INCOME $
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9J(2) SPECIFY THE TYPE OF INCOME	9J(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9J(4) CURRENT GROSS MONTHLY INCOME $
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9K(2) SPECIFY THE TYPE OF INCOME	9K(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)* _____	9K(4) CURRENT GROSS MONTHLY INCOME $

SECTION X: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

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

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?

☐ YES ☐ NO *(If "NO," skip to Section XI)*

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed in questions 10B through 10J. Do not include expenses paid by other family members, insurance, etc.

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or residential care, adult daycare, or similar care facility, you must also complete the applicable worksheet(s) on **pages 16 and 17** for each provider. **All in-home care fees or facility fees you pay must be reported on this form if you want VA to use them as a deductible expenses.**

10B(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10B(2). NAME OF PROVIDER	10B(4). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE HOURLY RATE?
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	10B(3). TYPE OF CARE *(Select one)* ☐ NURSING HOME ☐ RESIDENTIAL CARE FACILITY ☐ ADULT DAYCARE ☐ IN-HOME CARE ATTENDANT	$ 10B(5). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT ARE THE HOURS WORKED PER MONTH?
10B(6). PROVIDER START DATE *(MM/DD/YYYY)* 10B(7). PROVIDER END DATE *(MM/DD/YYYY)* ☐ CONTINUING	10B(8). PAYMENT FREQUENCY ☐ MONTHLY ☐ ANNUALLY	10B(9). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED $

10C(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10C(2). NAME OF PROVIDER	10C(4). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE HOURLY RATE?
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	10C(3). TYPE OF CARE *(Select one)* ☐ NURSING HOME ☐ RESIDENTIAL CARE FACILITY ☐ ADULT DAYCARE ☐ IN-HOME CARE ATTENDANT	$ 10C(5). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT ARE THE HOURS WORKED PER MONTH?
10C(6). PROVIDER START DATE *(MM/DD/YYYY)* 10C(7). PROVIDER END DATE *(MM/DD/YYYY)* ☐ CONTINUING	10C(8). PAYMENT FREQUENCY ☐ MONTHLY ☐ ANNUALLY	10C(9). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED $

IN-HOME CARE OR CARE FACILITY *(Continued)*

10D(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)* _____

10D(2). NAME OF PROVIDER

10D(4). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE HOURLY RATE?
$

10C(3). TYPE OF CARE *(Select one)*
- ☐ NURSING HOME
- ☐ RESIDENTIAL CARE FACILITY
- ☐ ADULT DAYCARE
- ☐ IN-HOME CARE ATTENDANT

10D(5). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT ARE THE HOURS WORKED PER MONTH?

10D(6). PROVIDER START DATE *(MM/DD/YYYY)*
__/__/____

10D(7). PROVIDER END DATE *(MM/DD/YYYY)*
__/__/____ ☐ CONTINUING

10D(8). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY

10D(9). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
$

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES

10E(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)* _____

10E(2) PAID TO *(Name of Provider)*

10E(4) DATE COSTS PAID *(MM/DD/YYYY)*
__/__/____

10E(5) PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

10E(3) PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10E(6) AMOUNT YOU PAID *(Based on Frequency selected)*
$

10F(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)* _____

10F(2) PAID TO *(Name of Provider)*

10F(4) DATE COSTS PAID *(MM/DD/YYYY)*
__/__/____

10F(5) PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

10F(3) PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10F(6) AMOUNT YOU PAID *(Based on Frequency selected)*
$

10G(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)* _____

10G(2) PAID TO *(Name of Provider)*

10G(4) DATE COSTS PAID *(MM/DD/YYYY)*
__/__/____

10G(5) PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

10G(3) PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10G(6) AMOUNT YOU PAID *(Based on Frequency selected)*
$

10H(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)* _____

10H(2) PAID TO *(Name of Provider)*

10H(4) DATE COSTS PAID *(MM/DD/YYYY)*
__/__/____

10H(5) PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

10H(3) PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10H(6) AMOUNT YOU PAID *(Based on Frequency selected)*
$

10I(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)* _____

10I(2) PAID TO *(Name of Provider)*

10I(4) DATE COSTS PAID *(MM/DD/YYYY)*
__/__/____

10I(5) PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

10I(3) PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10I(6) AMOUNT YOU PAID *(Based on Frequency selected)*
$

10J(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)* _____

10J(2) PAID TO *(Name of Provider)*

10J(4) DATE COSTS PAID *(MM/DD/YYYY)*
__/__/____

10J(5) PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

10J(3) PURPOSE *(Any medical insurance premium, medical supplies, etc.)*

10J(6) AMOUNT YOU PAID *(Based on Frequency selected)*
$

SECTION XI: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

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, 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 questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit sent)*

11B. TYPE OF ACCOUNT *(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 I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

11C. ROUTING NUMBER	11D. ACCOUNT NUMBER

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

I CERTIFY THAT 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 waive any privilege which makes the information confidential.

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA Medical Center; **OR**, I have no information or evidence to give VA to support my claim.

12A. SIGNATURE OR MARK	12B. DATE SIGNED *(MM/DD/YYYY)*
	/ /

SECTION XIII: WITNESSES TO SIGNATURE

(TWO (2) WITNESS SIGNATURES ARE REQUIRED IF THE CLAIMANT SIGNED ITEM 12B WITH AN "X")

13A. SIGNATURE OF THE FIRST WITNESS *(If claimant signed above using an "X")*	13B. PRINTED NAME OF FIRST WITNESS
	13C. PRINTED ADDRESS OF FIRST WITNESS
14C. SIGNATURE OF THE SECOND WITNESS *(If claimant signed above using an "X")*	14D. PRINTED NAME OF SECOND WITNESS
	14C. PRINTED ADDRESS OF FIRST WITNESS

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE *(NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)*

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED *(MM/DD/YYYY)*
	/ /

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside 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 Veteran Readiness 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, 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: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0002, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 30 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Please refer to OMB Control No. 2900-0002 in any correspondence. Do not send your completed VA Form 21P-527EZ to this email address.

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance,* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? *(Name of Care Recipient, either the Claimant or Dependent)*

2. WHO IS COMPLETING THIS WORKSHEET? *(Name of Provider, either an Administrator or Licensed Medical Professional)*

3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

4. WHAT IS THE NAME OF THE FACILITY? *(As shown on facility license or official website)*

5. WHAT IS THE FACILITY TELEPHONE NUMBER? – – International Phone Number *(If applicable)* _____

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY OR ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code – THE FACILITY IS RESIDENTIAL

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

8. SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

☐ A. EATING ☐ B. BATHING/SHOWERING ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
☐ D. DRESSING ☐ E. USING THE TOILET ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT, PLEASE CHECK THE BOX IF THE STATEMENT IS TRUE FOR THE FACILITY.

YES	NO	
☐	☐	THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
☐	☐	THE FACILITY IS LICENSED
☐	☐	THE FACILITY IS RESIDENTIAL
☐	☐	THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)

☐ YES ☐ NO, Care is being provided by a third-party provider. ☐ NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each in-home provider complete an In-Home Attendant Worksheet.

11. DATE THE CARE RECIPIENT WAS ADMITTED TO THE FACILITY. *(MM/DD/YYYY)* / /

12. DO YOU EXPECT THIS CARE TO END? *(If "Yes," provide the date the care is expected to end in question 13.)*
☐ YES ☐ NO

13. DATE YOU EXPECT CARE TO END. *(MM/DD/YYYY)* / /

14. MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.
$ PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the care recipient and the facility.

15. SIGNATURE OF PROVIDER *(From question 2)*

16. DATE SIGNED *(MM/DD/YYYY)* / /

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance,* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? *(Name of Care Recipient, either the Claimant or Dependent)*

2. WHO IS COMPLETING THIS WORKSHEET? *(In-Home Care Attendant or Agency Administrator, Provider)*

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)
☐ YES ☐ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?
☐ YES ☐ NO *(If "NO," skip to question 7)*

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

6. WHAT IS THE AGENCY TELEPHONE NUMBER?
___ – ___ – ____

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code –

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
☐ A. EATING ☐ B. BATHING/SHOWERING ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
☐ D. DRESSING ☐ E. USING THE TOILET ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
☐ A. SHOPPING ☐ B. FOOD PREPARATION ☐ C. NON-MEDICAL TRANSPORTATION
☐ D. LAUNDERING ☐ E. USING TELEPHONE ☐ F. MANAGING FINANCES
☐ G. HOUSEKEEPING ☐ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE?
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)
☐ YES ☐ NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. *(MM/DD/YYYY)*
__ / __ / ____

12. DO YOU EXPECT THIS CARE TO END? *(If "Yes," provide the date the care is expected to end in question 13.)*
☐ YES ☐ NO

13. DATE YOU EXPECT CARE TO END. *(MM/DD/YYYY)*
__ / __ / ____

14. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$ _____ PER HOUR

15. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.
___ HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

16. SIGNATURE OF PROVIDER *(From question 2)*

17. DATE SIGNED *(MM/DD/YYYY)*
__ / __ / ____