Department of Veterans Affairs

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

(This notice is applicable to veterans claims for: Veterans Pension (a needs based benefit) • Special Monthly Pension • Benefits Based on a Veteran's Seriously Disabled Child)

Use this notice and the attached application to submit a claim for veterans pension.
This notice informs you of the evidence necessary to substantiate your claim.

Want your claim processed faster? The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed and there is no risk to participate! To participate in the FDC Program, if you are making a claim for veterans pension, simply submit your claim in accordance with the "FDC Criteria" shown below. If you are making a claim for veterans disability compensation or related compensation benefits, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. If you are making a claim for survivor benefits, use VA Form 21P-534EZ, *Application for DIC, Survivors Pension, and/or Accrued Benefits*.
VA forms are available at www.va.gov/vaforms.

FDC Criteria (Claim(s) for Veterans Pension Benefits

1. Submit your claim on a signed and completed VA Form 21P-527EZ, *Application for Veterans Pensio*n (attached).

2. Submit simultaneously with your claim:

   - 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.

   Note: Read the Important note below and attach current medical evidence showing that you are permanently and totally disabled, if necessary.

   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 his or her home.

   Special Circumstances

   Under the special circumstances shown below, you must also submit simultaneously with your claim:

   - **If claiming veterans pension with special monthly pension**, a completed VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*, or (if a patient in a nursing home) a completed VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance;*
   - **If claiming a child in school between the ages of 18 and 23**, a completed VA Form 21-674, *Request for Approval of School Attendance;*
   - **If claiming benefits for a seriously disabled child,** all, if any, relevant, private medical treatment records for the child's pertinent disabilities.

3. Report for any VA medical examinations VA determines are necessary to decide your claim.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

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

MAIL TO

Department of Veterans Affairs
Pension Intake Center
PO Box 5365
Janesville, WI 53547-5365

The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed, and there is no risk to participate! Participation in the FDC Program is optional and will not affect the quality of care you receive or the benefits to which you are entitled. If you file a claim in the FDC Program and it is determined that other records exist and VA needs the records to decide your claim, then VA will simply remove the claim from the FDC Program (Optional Expedited Process) and process it in the Standard Claim Process. See below for more information. If you wish to file your claim in the FDC Program, see FDC Program (Optional Expedited Process). If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process.

WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession.

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Submit your claim in accordance with the "FDC Criteria" (see page 1)	You must: • If you know of evidence not in your possession and want VA to try to get it for you, give VA enough information about the evidence so that we can request it from the person or agency that has it If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA 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.***

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

FDC Program (Optional Expedited Process)	Standard Claim Process
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	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 or records from current or former employers

WHEN YOU SHOULD SEND WHAT WE NEED

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Send the information and evidence simultaneously with your claim If you submit additional information or evidence after you submit your "fully developed" claim, then VA will remove the claim from the FDC Program Expedited Process and process it in the Standard Claim Process. If we decide your 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.	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 receive 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)	Veterans Pension
Special Monthly Pension	Veterans Pension with Special Monthly Pension
Benefits because your child is severely disabled	Child Incapable of self-support

EVIDENCE TABLES

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:

   (Note: 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 (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) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property). Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

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 showering, 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 Incapable of Self-Support

To support a claim for **benefits based on a veteran's child being incapable of self-support**, the evidence must show that the child, before his or her 18th birthday, became permanently incapable of self-support due to a mental or physical disability.

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.

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.

For more information on the FDC Program, visit our web site at http://benefits.va.gov/transformation/fastclaims/.
For more information on VA benefits, visit our web site at www.va.gov, contact us at https://iris.custhelp.va.gov or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.
VA forms are available at www.va.gov/vaforms.

IMPORTANT

If you wish to make a claim for veterans **disability compensation and/or related compensation benefits**, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. VA forms are available at *www.va.gov/vaforms*. If you cannot access this form, write the words "Will claim compensation - send VA Form 21-526EZ" in Item 8 ***or*** at the top of the attached application and VA will send you the form.

OMB Control No. 2900-0002
Respondent Burden: 25 minutes
Expiration Date: 10/31/2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.

SECTION I: VETERAN'S PERSONAL INFORMATION *(MUST COMPLETE)*

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

2. SOCIAL SECURITY NUMBER — – –

3. DATE OF BIRTH *(MM-DD-YYYY)* — – –

4. HAVE YOU EVER FILED A CLAIM WITH VA?
- ◯ YES *(If "Yes," provide your file number in Item 5)*
- ◯ NO

5. VA FILE NUMBER *(If applicable)*

6A. MAILING ADDRESS

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

6B. TELEPHONE NUMBERS *(Include Area Code)*

DAYTIME – –

EVENING – –

CELL PHONE – –

7. PREFERRED E-MAIL ADDRESS *(If applicable)*

8. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING?

A. DISABILITY(IES)	B. DATE DISABILITY(IES) BEGAN
	– –
	– –

9. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT
	– –
	– –
	– –
	– –
	– –
	– –

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

10A. DID YOU SERVE UNDER ANOTHER NAME?
- ◯ YES *(If "Yes," complete Item 10B)*
- ◯ NO *(If "No," skip to Item 11A)*

10B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

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

11A. I ENTERED ACTIVE SERVICE ON *(MM-DD-YYYY)*

11B. BRANCH OF SERVICE

◯ ARMY ◯ NAVY ◯ MARINE CORPS ◯ AIR FORCE ◯ COAST GUARD

11C. RELEASE DATE FROM ACTIVE SERVICE *(MM-DD-YYYY)*

11D. SERVICE NUMBER

11E. PLACE OF LAST SEPARATION

12A. HAVE YOU EVER BEEN A PRISONER OF WAR?

◯ YES *(If "Yes," complete Item 12B)*

◯ NO *(If "No," skip to Item 13A)*

12B. DATES OF CONFINEMENT ON *(MM-DD-YYYY)*

From:

To:

SECTION III: VETERAN'S DISABILITY(IES) AND BACKGROUND *(MUST COMPLETE)*

NOTE: You do not have to submit medical evidence or list disabilities if you are age 65 or older, unless you are housebound, or require the regular assistance of another person.

13A. WHAT DISABILITY(IES) PREVENT YOU FROM WORKING?

13B. WHEN DID THE DISABILITY(IES) BEGIN? *(MM-DD-YYYY)*

14A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

◯ YES ◯ NO *(If "Yes," 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 Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS.))*

14B. ARE YOU NOW OR HAVE YOU RECENTLY BEEN HOSPITALIZED OR GIVEN OUTPATIENT OR HOME CARE DUE TO THE DISABILITY(IES) LISTED IN ITEM 13A?

◯ YES ◯ NO

15A. DATE(S) OF RECENT HOSPITALIZATION OR CARE *(MM-DD-YYYY)*

15B. NAME AND MAILING ADDRESS OF FACILITY OR DOCTOR

NOTE: In the table below, tell us about all of your employment, including self-employment, for **one** year before you became disabled to the present.

16A. ARE YOU NOW EMPLOYED?

◯ YES ◯ NO

16B. WHEN DID YOU LAST WORK? *(MM-DD-YYYY)*

16C. WERE YOU SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED?

◯ YES ◯ NO *(If "Yes," complete Items 16D and 16E)*

16D. WHAT KIND OF WORK DID YOU DO?

16E. ARE YOU STILL SELF-EMPLOYED?

◯ YES ◯ NO

(If "Yes," complete Item 16F)

16F. WHAT KIND OF WORK DO YOU DO NOW?

17A. ARE YOU NOW IN A NURSING HOME?

◯ YES ◯ NO

(If "Yes," complete Items 17B and 17C 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.)

17B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY?

17C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?

◯ YES ◯ NO *(If "No," complete Item 17D)*

17D. HAVE YOU APPLIED FOR MEDICAID?

◯ YES ◯ NO

SECTION III: VETERAN'S DISABILITY(IES) AND BACKGROUND *(MUST COMPLETE) (CONTINUED)*

18A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?			
18B. WHAT WAS YOUR JOB TITLE?			
18C. WHEN DID YOUR JOB BEGIN?	– –	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	
18D. WHEN DID YOUR JOB END?	– –	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?	$, .00

18A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?			
18B. WHAT WAS YOUR JOB TITLE?			
18C. WHEN DID YOUR JOB BEGIN?	– –	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	
18D. WHEN DID YOUR JOB END?	– –	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?	$, .00

SECTION IV: MARITAL STATUS *(MUST COMPLETE)*

19A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ NEVER MARRIED *(Skip to Section VI if never married)*

TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

19B. HOW MANY TIMES HAVE ***YOU*** BEEN MARRIED *(Including current marriage)*?

20A. DATE *(MM-DD-YYYY)* AND PLACE OF MARRIAGE *(City and State or Country)*	– –
20B. TO WHOM MARRIED *(First, Middle, Last Name)*	
20C. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, or Other)*	
20D. HOW MARRIAGE ENDED *(Death, Divorce, Marriage Has Not Ended)*	
20E. DATE *(MM-DD-YYYY)* AND PLACE MARRIAGE ENDED *(City and State or Country)*	– –

20A. DATE *(MM-DD-YYYY)* AND PLACE OF MARRIAGE *(City and State or Country)*	– –
20B. TO WHOM MARRIED *(First, Middle, Last Name)*	
20C. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, or Other)*	
20D. HOW MARRIAGE ENDED *(Death, Divorce, Marriage Has Not Ended)*	
20E. DATE *(MM-DD-YYYY)* AND PLACE MARRIAGE ENDED *(City and State or Country)*	– –

20F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 20C, PLEASE EXPLAIN:

SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)*

Note - Skip to Section VI if not currently married.

TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

21. HOW MANY TIMES HAS ***YOUR SPOUSE*** BEEN MARRIED *(Including current marriage)*?

22A. DATE *(MM-DD-YYYY)* AND PLACE OF MARRIAGE *(City and State or Country)*	– –
22B. TO WHOM MARRIED *(First, Middle, Last Name)*	
22C. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, or Other)*	
22D. HOW MARRIAGE ENDED *(Death, Divorce, Marriage Has Not Ended)*	
22E. DATE *(MM-DD-YYYY)* AND PLACE MARRIAGE ENDED *(City and State or Country)*	– –

22A. DATE *(MM-DD-YYYY)* AND PLACE OF MARRIAGE *(City and State or Country)*	– –
22B. TO WHOM MARRIED *(First, Middle, Last Name)*	
22C. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, or Other)*	
22D. HOW MARRIAGE ENDED *(Death, Divorce, Marriage Has Not Ended)*	
22E. DATE *(MM-DD-YYYY)* AND PLACE MARRIAGE ENDED *(City and State or Country)*	– –

22F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22C, PLEASE EXPLAIN:

23A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? *(MM-DD-YYYY)* – –	23B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER? – –	23C. IS YOUR SPOUSE ALSO A VETERAN? ◯ YES ◯ NO *(If "Yes," complete Item 23D)*
23D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER *(If any)*?	23E. DO YOU LIVE WITH YOUR SPOUSE? ◯ YES ◯ NO *(If "Yes," skip to Section VI)* *(If "No," complete Items 23F, 23G and 23H)*	

23F. WHAT IS YOUR SPOUSE'S ADDRESS? *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

23G. TELL US THE REASON YOU ARE NOT LIVING WITH YOUR SPOUSE *(i.e.; illness, work, etc.)*	23H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? $, .00

SECTION VI: DEPENDENT CHILDREN *(COMPLETE IF YOU HAVE DEPENDENT CHILDREN)*

Note - Skip to Section VII if you have no dependent children.

24A. NAME OF DEPENDENT CHILD *(First, Middle initial, Last)*	
24B. DATE AND PLACE OF BIRTH *(City and State or Country)*	– –
24C. SOCIAL SECURITY NUMBER	– –
(Check all that apply)	○ 24D. BIOLOGICAL ○ 24E. ADOPTED ○ 24F. STEPCHILD ○ 24G. 18-23 YEARS OLD (in school) ○ 24H. SERIOUSLY DISABLED ○ 24I. CHILD MARRIED ○ 24J. CHILD PREVIOUSLY MARRIED

24A. NAME OF DEPENDENT CHILD *(First, Middle initial, Last)*	
24B. DATE AND PLACE OF BIRTH *(City and State or Country)*	– –
24C. SOCIAL SECURITY NUMBER	– –
(Check all that apply)	○ 24D. BIOLOGICAL ○ 24E. ADOPTED ○ 24F. STEPCHILD ○ 24G. 18-23 YEARS OLD (in school) ○ 24H. SERIOUSLY DISABLED ○ 24I. CHILD MARRIED ○ 24J. CHILD PREVIOUSLY MARRIED

24A. NAME OF DEPENDENT CHILD *(First, Middle initial, Last)*	
24B. DATE AND PLACE OF BIRTH *(City and State or Country)*	– –
24C. SOCIAL SECURITY NUMBER	– –
(Check all that apply)	○ 24D. BIOLOGICAL ○ 24E. ADOPTED ○ 24F. STEPCHILD ○ 24G. 18-23 YEARS OLD (in school) ○ 24H. SERIOUSLY DISABLED ○ 24I. CHILD MARRIED ○ 24J. CHILD PREVIOUSLY MARRIED

Note - In Items 25A through 25D, tell us about the children listed in Item 24A who ***do not*** live with you.

25A. NAME OF DEPENDENT CHILD *(First, middle initial, last)*

25B. CHILD'S COMPLETE ADDRESS *(Number and street or rural route, city or P.O., city, State, ZIP Code and country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

25C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable) (First, middle initial, last)*

25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT $, .00

25A. NAME OF DEPENDENT CHILD *(First, middle initial, last)*

25B. CHILD'S COMPLETE ADDRESS *(Number and street or rural route, city or P.O., city, State, ZIP Code and country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

25C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable) (First, middle initial, last)*

25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT $, .00

SECTION VI: DEPENDENT CHILDREN *(COMPLETE IF YOU HAVE DEPENDENT CHILDREN) (CONTINUED)*

25A. NAME OF DEPENDENT CHILD *(First, middle initial, last)*

25B. CHILD'S COMPLETE ADDRESS *(Number and street or rural route, city or P.O., city, State, ZIP Code and country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

25C. NAME OF PERSON THE CHILD LIVES WITH *(If applicable) (First, middle initial, last)*

25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT $, .00

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

26. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

☐ YES ☐ NO *(If "Yes," complete Items A and B) (If "No," skip to Item 27)*

A. SOCIAL SECURITY RECIPIENT *(First, middle initial, last)*	B. GROSS MONTHLY AMOUNT
	$, .00
	$, .00
	$, .00
	$, .00
	$, .00

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

☐ YES ☐ NO *(If "Yes," complete Items 28A and 28B) (If "No," skip to Item 29A)*

28A. WHAT IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS?

Square feet

28B. COULD ANY PART OF THE LOT BE SOLD *WITHOUT SELLING THE RESIDENCE*?

☐ YES ☐ NO *(If "Yes," also complete 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.

29A. ***OTHER THAN SOCIAL SECURITY***, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?

☐ YES ☐ NO

29B. ***OTHER THAN SOCIAL SECURITY***, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?

☐ YES ☐ NO

29C. 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/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation).*

☐ YES ☐ NO

29D. 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

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

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

SECTION VIII: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

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

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 13 and 14.

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

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

A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	B. PAID TO *(Name of Provider, Insurance company, Nursing home, etc.)*	C. PURPOSE *(Medicare premiums, Nursing Home,etc.)*	D. DATE PAID *(MM-DD-YYYY)*	E. HOURLY RATE/ HOURS *(In-home Provider Only)*	F. AMOUNT YOU PAY
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00
				$ .00	$ .00

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

The Department of the 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, ***and*** attach either a voided personal check ***or*** a deposit slip. 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.

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

◯ CHECKING ◯ SAVINGS

Account No.:

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

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

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

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

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

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

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

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

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

35A. VETERAN'S SIGNATURE (**REQUIRED**)	35B. DATE SIGNED ☐☐ – ☐☐ – ☐☐☐☐

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

36A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	37A. SIGNATURE OF WITNESS (If veteran signed above using an "X")
36B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:	37B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:

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

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

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

(If "YES," all payments to the facility qualify as medical expenses in Items 30A - 30F. You are finished completing this worksheet)

STEP 2. Do ***all*** of the following apply to the facility?

- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with caregivers

◯ YES ◯ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the veteran) the disabled person?

◯ YES ◯ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

◯ YES ◯ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amounts you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 30A - 30F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the ***primary reason*** you live in the facility (or attend day care in the facility)?

◯ YES ◯ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 30A - 30F applicable amounts you pay the facility for (1) ***lodging and meals,*** (2) ***health care services or assistance with ADLs provided by a health care provider,*** and (3) ***custodial care***. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 30A - 30F. Skip to Step 8)

STEP 7. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the ***primary reason*** the disabled person lives in the facility (or attends day care in the facility)?

◯ YES ◯ NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 30A - 30F)

(If "NO," ***only*** claim payments you pay the facility for assistance with ***health care and/or assistance with custodial care*** as medical expenses in Items 30A - 30F. Payment to this facility for meals and lodging ***do not*** qualify)

STEP 8. Facility Certification: Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received.

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate

and reflects the current environment pertaining to _____
(Name of Person Staying at Facility)

and his or her care at this facility _____
(Name of Facility)

at _____
(Address of Facility (Line 1))

_____
(Address of Facility (Line 2))

_____
(Name of Person Certifying for the Facility)

_____
(Signature of Person Certifying for the Facility)

_____
(Title of Person Certifying for the Facility)

__ __ – __ __ – __ __ __ __
(Date Certified)

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: Only complete this worksheet if you are claiming expenses for in-home care.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.

Follow the steps below to determine whether or not:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care

STEP 1. Are you (the veteran) the disabled person?

◯ YES ◯ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

◯ YES ◯ NO (If "NO," payments to this in-home attendant for assistance with IADLs do not qualify as medical expenses. Please report separately in Items 30A - 30F applicable amounts you pay an in-home attendant for (1) health care services or assistance with ADLs provided by a health care provider, and (2) custodial care. Skip to Step 6)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to this in-home attendant ***may*** qualify as medical expenses in Items 30A - 30F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Item 30A - 30F amounts you pay an in-home attendant for (1) health-care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs, and (3) custodial care. Skip to Step 6.)

(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 30A - 30F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6.)

STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," the attendant ***must be a health care provider***. Only report payments to the in-home attendant for ***health care services or assistance with ADLs*** provided by the health care provider as medical expenses in Items 30A - 30F. Payments for assistance with IADLs do not qualify as medical expenses. Skip to Step 6.)

STEP 5. Is the ***primary responsibility*** of the in-home attendant to provide the disabled person with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 30A - 30F.)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 30A - 30F. Payment for assistance with IADLs ***do not*** qualify as a medical expense)

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

ADLs: ◯ EATING ◯ BATHING/SHOWERING ◯ DRESSING ◯ TRANSFERRING ◯ USING THE TOILET

IADLs: ◯ SHOPPING ◯ FOOD PREPARATION ◯ HOUSEKEEPING ◯ LAUNDERING ◯ MANAGING FINANCES

◯ HANDLING MEDICATIONS ◯ USING THE TELEPHONE ◯ TRANSPORTATION FOR NON-MEDICAL PURPOSES

STEP 7. **In-Home Attendant Certification**: Please submit a current breakdown of the time the attendant spends assisting the veteran or disabled person with health care services, ADLs and IADLs.

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

(Name of Person Requiring Care)

and his or her care from

(Name of Attendant)

(Name of Certifying Official)

(Signature of Certifying Official)

(Title of Certifying Official)

– – (Date Certified)