

 <b>Department of Veterans Affairs</b>			<b>VA DATE STAMP</b> <b>(DO NOT WRITE IN THIS SPACE)</b>		
<b>REQUEST FOR DETAILS OF EXPENSES</b>					
<b>IMPORTANT:</b> Please read the Privacy Act and Respondent Burden on page 3 before completing the form. For mail/fax information see Page 3 of the application.					
<b>INSTRUCTIONS</b> - We need additional information to determine whether you are entitled to benefits. Please complete all items. If an answer is "none" or "0" write that. For additional space, use Item 20, "Remarks," or attach a separate sheet indicating the item number to which the answers apply. If you have any questions or need assistance, please call 1-800-827-1000 (Hearing Impaired TDD line 711).					
<b>NOTE:</b> You may <b>either</b> complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.					
<b>SECTION I: VETERAN'S PERSONAL INFORMATION (MUST COMPLETE)</b>					
1. VETERAN'S NAME ( <i>Last, first, middle</i> )					
2. VETERAN'S SOCIAL SECURITY NUMBER (SSN)  — —		3. VA CLAIM NUMBER		4. VETERAN'S DATE OF BIRTH ( <i>MM,DD,YYYY</i> ) Month — Day — Year	
<b>SECTION II: CLAIMANT'S PERSONAL INFORMATION (MUST COMPLETE)</b>					
5. CLAIMANT'S NAME ( <i>Last, first, middle</i> )					
6. CLAIMANT'S SOCIAL SECURITY NUMBER (SSN)  — —		7. CLAIMANT'S DATE OF BIRTH ( <i>MM,DD,YYYY</i> ) Month — Day — Year		8. CLAIMANT'S RELATIONSHIP TO VETERAN	
9. CLAIMANT'S MAILING ADDRESS ( <i>Number and street or rural route, P.O. Box, City, State, ZIP Code and Country</i> ) No. & Street  Apt./Unit Number City  State/Province Country ZIP Code/Postal Code —					
10. TELEPHONE NUMBER(S) ( <i>Include Area Code</i> ) Daytime Evening				11. PREFERRED E-MAIL ADDRESS ( <i>Optional</i> )	
<b>SECTION III - DEPENDENTS NOT LIVING WITH YOU</b> ( <i>List ONLY persons you support who DO NOT live with you</i> )					
12A. NAME		12B. AGE	12C. RELATIONSHIP	12D. AMOUNT YOU CONTRIBUTE TO SUPPORT	
				\$	
				\$	
				\$	
				\$	
				\$	
<b>SECTION IV - DEPENDENTS LIVING WITH YOU</b> ( <i>List ONLY persons you support who DO live with you</i> )					
13A. NAME		13B. AGE	13C. RELATIONSHIP		

**SECTION V - MONTHLY EXPENSES (EXCEPT MEDICAL)  
FOR YOU AND THOSE LISTED IN ITEM 13A AS LIVING WITH YOU**

14A. ITEM	14B. AMOUNT	14A. ITEM (Continued)	14B. AMOUNT (Continued)
HOUSING	\$	UTILITIES	\$
FOOD	\$	EDUCATION OF CHILDREN	\$
TAXES	\$	OTHER (Specify)	\$
INTEREST	\$		\$
CLOTHING	\$		\$

**SECTION VI - HOSPITAL AND MEDICAL EXPENSES**

15A. DO YOU HAVE OR EXPECT TO HAVE ANY LARGE OR UNUSUAL HOSPITAL OR MEDICAL EXPENSES FOR YOURSELF AND OTHERS YOU SUPPORT AND LIVE WITH? <input type="checkbox"/> YES <input type="checkbox"/> NO	15B. ESTIMATED COST PER YEAR \$
15C. EXPLANATION	

**SECTION VII - EDUCATIONAL EXPENSES**

16. DO YOU EXPECT TO MAKE PROVISIONS FOR YOUR CHILDREN'S EDUCATIONAL NEEDS, INCLUDING ADVANCED TECHNICAL OR COLLEGE EDUCATION? <input type="checkbox"/> YES <input type="checkbox"/> NO
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**SECTION VIII - EXPENSES OF LAST ILLNESS AND BURIAL OF VETERAN, SPOUSE, OR CHILD  
AND JUST DEBTS OF DECEASED VETERAN OR PARENT'S SPOUSE**

17A. NAME OF DECEASED PERSON (First-middle-last)	17B. RELATIONSHIP TO YOU <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT	17C. DATE OF DEATH
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**EXPENDITURES FOR PERSON NAMED IN ITEM 17A**

NOTE - Furnish information concerning unreimbursed expense as follows:

A VETERAN - For his/her spouse's or child's last illness and burial.	A SPOUSE - For the last illness and burial of veteran's child.
A CHILD - For veteran's last illness, burial and just debts.	A WIDOW(ER) - For veteran's last illness, (paid before or after the veteran's death), burial and just debts and for the last illness and burial of veteran's child.
A PARENT - For his/her spouse's or veteran's last illness and burial and for his/her spouse's just debts.	

18A. NAME AND ADDRESS OF PERSON TO WHOM PAID	18B. NATURE OF EXPENSES OR DEBT	18C. TOTAL AMOUNT OF EXPENSES OR DEBT	18D. AMOUNT PAID BY YOU	18E. DATE PAID
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

**SECTION IX - COMMERCIAL LIFE INSURANCE PAYMENTS**

<b>NOTE:</b> Under Public Law 108-454, VA may not count as income the lump sum proceeds of a life insurance policy on a veteran who dies after December 9, 2004. Proceeds from all other insurance payments may be countable.		AMOUNT
19A.	TOTAL RECEIVED OR EXPECTED BY CLAIMANT	\$
19B.	EXPECTED OR ACTUAL DATE OF RECEIPT (If paid by installments, explain payment schedule in Item 12, Remarks)	
19C.	NAME OF THE DECEASED FOR WHOM PAYMENT IS RECEIVED.	

**SECTION X - REMARKS, CERTIFICATION AND SIGNATURE**

20. REMARKS

**PENALTY** - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission or any statement or evidence of a material fact, knowing it to be false (18 U.S.C. §§ 1001-1002).

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

21A. SIGNATURE OF CLAIMANT (*Do not print, sign in ink*)

21B. DATE SIGNED

**MAIL TO**

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

**FAX TO**

**844-655-1604 (Toll Free)**

**Privacy Act Information:** The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. You are required to respond to obtain or retain benefits. The requested information is considered relevant and necessary to determine entitlement to benefits. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies. 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 entitlement to pension or parent's dependency and indemnity compensation (38 U.S.C. 1503 and 1315). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at [www.reginfo.gov/public/do/PRAMain](http://www.reginfo.gov/public/do/PRAMain). If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.