OMB Control No. 2900-0002
Respondent Burden: 30 minutes
Expiration Date: 08/31/2025

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)*
John E Doe

1B. VETERAN'S SOCIAL SECURITY NUMBER
333 – 22 – 4444

1C. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
01 / 01 / 1960

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

1E. VA FILE NUMBER *(If applicable)*
12345678

SECTION II: VETERAN'S CONTACT INFORMATION

2A. MAILING ADDRESS

No. & Street: 123 8th st

Apt./Unit Number: A-3

City: Hadley

State/Province: ME

Country: US

ZIP Code/Postal Code: 01050 –

2B. TELEPHONE NUMBER *(Include Area Code)*
555 – 123 – 4567

International Phone Number *(If applicable)*: 001-555-123-4567

2C. VETERAN'S E-MAIL ADDRESS *(Optional)*
test@example.com

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)*
03 / 02 / 2003

3C. FINAL RELEASE DATE FROM ACTIVE DUTY *(MM/DD/YYYY)*
03 / 20 / 2007

3D. YOUR SERVICE NUMBER
123456

3E. BRANCH OF SERVICE
(•) ARMY (•) NAVY ( ) AIR FORCE
( ) COAST GUARD ( ) MARINE CORPS
( ) SPACE FORCE ( ) USPHS ( ) NOAA

3F. PLACE OF YOUR LAST SEPARATION
Westbrookfield, MA

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

3H. DATES CONFINEMENT STARTED *(MM/DD/YYYY)*
02 / 26 / 1971

3I. DATES CONFINEMENT ENDED *(MM/DD/YYYY)*
03 / 02 / 1973

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)*

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 ( ) 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 *(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)*

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: Dallas VA Medical Center

4G. HAVE YOU RECENTLY RECEIVED TREATMENT FROM ANY FEDERAL MEDICAL FACILITIES *(Military base, etc.)*?
(•) YES ( ) NO Specify Facility: Memphis Health Care

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?
Customer service

5C. HOW MANY HOURS PER WEEK DO YOU AVERAGE? 20

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)*

6A. WHAT IS YOUR MARITAL STATUS? *(Check one)*
( ) MARRIED (•) SEPARATED ( ) NOT MARRIED *(Widowed or Never Married - Skip to Section VIII)*

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

6C. SPOUSE'S BIRTH DATE *(MM/DD/YYYY)*
01/01/1960

6D. SPOUSE'S SOCIAL SECURITY NUMBER
333 – 22 – 4444

6E. DATE AND PLACE OF MARRIAGE *(MM/DD/YYYY)*
03/02/1994

CITY AND STATE OR COUNTRY
North Adams, MA

6F. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, etc.)*
( ) CEREMONIAL (•) OTHER *(Specify)* Other reason

6G. IS YOUR SPOUSE ALSO A VETERAN?
( ) YES (•) NO *(If "NO," skip question 6H)*

6H. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? *(If any)*
234234444

6I. IF YOU ARE SEPARATED, PLEASE TELL US THE REASON YOU ARE SEPARATED *(Illness, work, etc.)*
( ) MEDICAL REASON ( ) MARITAL DISCORD ( ) WORK (•) OTHER *(Specify)* Personal reason

6J. SPOUSE'S MAILING ADDRESS *(If separated)*
No. & Street: 123 7th st
Apt./Unit Number: Apt 3
City: Pittsfield
State/Province: MA
Country: US
ZIP Code/Postal Code: 01050 –

6K. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? *(If separated)*
$ 2,444.00

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.

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

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

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

7C. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START: 03/02/1989
END: 03/02/1990

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

7E. PLACE OF MARRIAGE TERMINATION *(City and State or Country)* San Antonio, TX

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

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

Jennie M Dane

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

○ DEATH ◉ DIVORCE ○ OTHER *(Specify)*

7H. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

START: 03/02/1983

END: 03/02/1984

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

7J. PLACE OF MARRIAGE TERMINATION *(City and State or Country)* San Antonio, TX

7K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?

○ YES ◉ NO *(If "YES," please submit a VA Form 21-686c, Declaration of Status of 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)***

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

Joe F Generic

7M. HOW DID THE PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*

◉ DEATH ○ DIVORCE ○ OTHER *(Specify)*

7N. WHAT ARE THE DATES OF THE PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

START: 03/02/1980

END: 03/02/1990

7O. PLACE OF MARRIAGE *(City and State or Country)* Seattle, WA

7P. PLACE OF MARRIAGE TERMINATION *(City and State or Country)* Tacoma, WA

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

John F Person

7R. HOW DID THE PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*

○ DEATH ○ DIVORCE ◉ OTHER *(Specify)*

Other reason

7S. WHAT ARE THE DATES OF THE PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

START: 03/02/1995

END: 03/02/2005

7T. PLACE OF MARRIAGE *(City and State or Country)* Seattle, WA

7U. PLACE OF MARRIAGE TERMINATION *(City and State or Country)* Tacoma, WA

7V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR YOUR SPOUSE?

○ YES ◉ NO *(If "YES", please submit a VA Form 21-686c, Declaration of Status of 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.**

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.)*

1

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

Bobby M Doe

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

03/02/1997

8D. CHILD'S SOCIAL SECURITY NUMBER

333-22-4444

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

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

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

◉ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $ 3,444.00

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

Emily M Doe

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

03/02/1993

8I. CHILD'S SOCIAL SECURITY NUMBER

333-22-4444

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)* ○ PREVIOUSLY MARRIED ◉ ADOPTED

○ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $, .

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

Jack M Doe

8M. CHILD'S BIRTH DATE *(MM/DD/YYYY)*: 04/01/1992

8N. CHILD'S SOCIAL SECURITY NUMBER: 333-22-4444

8O. PLACE OF BIRTH *(City and State or Country)*: Troy, MT

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

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

◉ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $ 2,300.00

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 AND THE ADDRESS OF CHILDREN NOT LIVING WITH YOU

NAME OF CUSTODIAN *(First, Middle Initial, Last)*: Joe M Smith

No. & Street: 123 8th st

Apt./Unit Number: City: Hadley

State/Province: ME Country: US ZIP Code/Postal Code: 01050-

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 $25,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?

○ YES ◉ NO *(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.))*

$ 1,550.00 *(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.)*

$,75,000.00

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. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

○ YES ◉ NO *(If "YES," please submit VA Form 21P-0969 and **ONLY** report your Social Security Income below)*

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)*: Bobby Doe

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.)*: John Doe

9H(4) CURRENT GROSS MONTHLY INCOME: $,278.05

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)*	○ SOCIAL SECURITY ● INTEREST/DIVIDENDS ○ CIVIL SERVICE ○ PENSION/RETIREMENT ○ OTHER *(Specify type of income)*	John Doe 9I(4) CURRENT GROSS MONTHLY INCOME $, 7 8 . 5 0
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)*	○ SOCIAL SECURITY ○ INTEREST/DIVIDENDS ○ CIVIL SERVICE ○ PENSION/RETIREMENT ● OTHER *(Specify type of income)* part-time Uber	John Doe 9J(4) CURRENT GROSS MONTHLY INCOME $, 2 7 8 . 9 9
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)*	○ SOCIAL SECURITY ○ INTEREST/DIVIDENDS ○ CIVIL SERVICE ○ PENSION/RETIREMENT ● OTHER *(Specify type of income)* full time job	John Doe 9K(4) CURRENT GROSS MONTHLY INCOME $ 3 , 2 7 8 . 7 5

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 and attach a separate 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 complete the applicable worksheet(s) on **pages 16 and 17** for each provider.

10B(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10B(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10B(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
● VETERAN ○ SPOUSE ○ CHILD *(Specify)*	NYC Care Provider ● CARE FACILITY ○ IN-HOME CARE ATTENDANT	$ 1 0 0 . 0 0 PER HOUR 2 0 HOURS WORKED PER WEEK

10B(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10B(5). PAYMENT FREQUENCY	10B(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: 0 8 / 0 1 / 2 0 2 0 END: 0 5 / 2 5 / 2 0 2 3 ○ NO END DATE	● MONTHLY ○ ANNUALLY	$ 2 , 5 0 0 . 0 0

10C(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10C(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10C(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
○ VETERAN ● SPOUSE ○ CHILD *(Specify)*	MA Care Provider ○ CARE FACILITY ● IN-HOME CARE ATTENDANT	$ 1 5 0 . 0 0 PER HOUR 1 5 HOURS WORKED PER WEEK

10C(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10C(5). PAYMENT FREQUENCY	10C(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: 0 8 / 0 1 / 2 0 2 1 END: 0 5 / 2 5 / 2 0 2 2 ○ NO END DATE	● MONTHLY ○ ANNUALLY	$ 1 , 5 0 0 . 0 0

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

10D(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10D(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10D(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
○ VETERAN ○ SPOUSE ◉ CHILD *(Specify)* Joe Doe	LA Care Provider ◉ CARE FACILITY ○ IN-HOME CARE ATTENDANT	$ 2 0 0 . 0 0 PER HOUR 1 0 HOURS WORKED PER WEEK

10D(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10D(5). PAYMENT FREQUENCY	10D(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: 0 8 / 0 1 / 2 0 2 0 END: / / ◉ NO END DATE	○ MONTHLY ◉ ANNUALLY	$ 2 2 , 5 0 0 . 0 0

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES

10E(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10E(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10E(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
◉ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	Funeral Home 10E(3) PURPOSE *(Insurance premium, medical supplies, etc.)* Burial expenses	0 3 / 1 5 / 2 0 2 0 10E(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ◉ ONE-TIME 10E(6) AMOUNT YOU PAY *(Based on Frequency selected)* $ 1 0 , 0 0 0 . 0 0

10F(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10F(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10F(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ◉ CHILD *(Specify)* Joe Doe	Health Provider 10F(3) PURPOSE *(Insurance premium, medical supplies, etc.)* Medical expenses	0 7 / 0 1 / 2 0 2 3 10F(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ◉ ONE-TIME 10F(6) AMOUNT YOU PAY *(Based on Frequency selected)* $ 1 0 , 0 0 0 . 0 0

10G(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10G(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10G(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ◉ SPOUSE ○ CHILD *(Specify)*	Health Provider 10G(3) PURPOSE *(Insurance premium, medical supplies, etc.)* Medical expenses	0 7 / 0 1 / 2 0 2 3 10G(5) PAYMENT FREQUENCY ◉ MONTHLY ○ ANNUALLY ○ ONE-TIME 10G(6) AMOUNT YOU PAY *(Based on Frequency selected)* $, 5 0 0 . 0 0

10H(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10H(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10H(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ◉ CHILD *(Specify)* Joe Doe	Health Provider 10H(3) PURPOSE *(Insurance premium, medical supplies, etc.)* Medical expenses	0 7 / 0 1 / 2 0 2 3 10H(5) PAYMENT FREQUENCY ○ MONTHLY ◉ ANNUALLY ○ ONE-TIME 10H(6) AMOUNT YOU PAY *(Based on Frequency selected)* $ 5 , 0 0 0 . 0 0

10I(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10I(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10I(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ◉ SPOUSE ○ CHILD *(Specify)*	Health Provider 10I(3) PURPOSE *(Insurance premium, medical supplies, etc.)* Medical expenses	0 7 / 0 1 / 2 0 2 3 10I(5) PAYMENT FREQUENCY ◉ MONTHLY ○ ANNUALLY ○ ONE-TIME 10I(6) AMOUNT YOU PAY *(Based on Frequency selected)* $, 2 0 0 . 0 0

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES *(Continued)*

10J(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10J(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10J(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ◉ CHILD *(Specify)* Joe Doe	Health Provider 10J(3) PURPOSE *(Insurance premium, medical supplies, etc.)* Medical fee	07 / 01 / 2023 10J(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ◉ ONE-TIME 10J(6) AMOUNT YOU PAY *(Based on Frequency selected)* $, 100 . 00

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, **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 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)*

Best Bank

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 NO.
123123123	001122334455

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; **OR**, I have checked the box in item 12A 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.

12A. 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 rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

12B. SIGNATURE OR MARK	12C. DATE SIGNED *(MM/DD/YYYY)*
John Edmund Doe	07 / 25 / 2017

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 AND ADDRESS OF FIRST WITNESS Name: Address:
13C. SIGNATURE OF THE SECOND WITNESS *(If claimant signed above using an "X")*	13D. PRINTED NAME AND ADDRESS OF SECOND WITNESS Name: Address:

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: 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 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestion about this form.

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'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

8. PLEASE 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.

○ 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. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. *(MM/DD/YYYY)*

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)*
(Select "Indefinite" if the care you provide is not temporary.)
○ INDEFINITE

13. PLEASE PROVIDE THE 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.

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

15. 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. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)*
(Select "Indefinite" if the care you provide is not temporary.)
__ / __ / ____ ○ INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$ ___ . __ PER HOUR

14. 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.

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

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