2024

DIC

PACKET

BRAZORIA COUNTY VETERANS SERVICE OFFICE
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Telephone Number (979)864-1289 • Fax (979)864-1032

Sonya T. Broadway
Veteran Service Officer

Administrative Assistant
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2024

Surviving Spouse:

Please find enclosed VA Form 21P-534EZ-Application for Dependency and Indemnity Compensation. When you have gathered all necessary information on the enclosed checklist, please contact our office.

Respectfully,

Veteran Service Office
Brazoria County

Enclosures

********** PLEASE NOTE **********
The Brazoria County Veterans Service Office is a County Agency.
WE ARE NOT THE VA.
The (VA) Department of Veterans Affairs is a Federal Agency,
which has the POWER to Grant or Deny VA Claims.

Checklist to file DIC/Accrued/Burial Benefit- Brazoria County 2024:

_____Certified Copy of veterans DD214

_____Death Certificate of the Veteran

_____Copy of marriage certificate to the Veteran

_____Date and place of prior marriages of self and veteran

_____Date and place of dissolution of prior marriages of self and veteran

_____Are you currently expecting a child of the veteran? -yes or no

_____Your Date of Birth

_____Your Social Security Number

_____Home and Mailing address

_____Day & Evening telephone #

_____Best email address where your VA forms will be sent for your review and signature

_____Social Security Number of veteran if not on DD214

_____Full name of veteran

_____Date of Birth of Veteran

_____Place of Birth of veteran

_____**VOIDED CHECK**-for Direct Deposit Purposes

_____Did veteran get Medical Care through VA? –If yes, what VA facility?

_____Receipts showing paid in full for all Funeral/Burial related expenses

Dependency and Indemnity Compensation (DIC)-FOR THE SURVIVING SPOUSE

What is DIC?

DIC is a monthly benefit paid to eligible survivors of a

- Military service member who died while on active duty, active duty for training, or inactive duty training, OR
- Veteran whose death resulted from a service-connected injury or disease, OR
  - ✓ Veteran whose death resulted from a non service-connected injury or disease, and who were totally disabled from their service-connected disabilities for at least 10 years immediately preceding their death, OR
  - ✓ Since the veteran's release from active duty and for at least five years immediately preceding death, or
  - ✓ For at least one year immediately preceding death if the veteran was a former prisoner of war who died after September 30, 1999.

Who is Eligible?

The surviving spouse if he or she:

- Was married to a service member who died on active duty, active duty for training, or inactive duty training, OR
- Married the veteran before January 1, 1957 OR
- Married the veteran within 15 years of discharge from the period of military service in which the disease or injury that caused the veteran's death began or was aggravated, OR
- Was married to the veteran for at least one year, OR
- Had a child with the veteran, AND
- Cohabited with the veteran continuously until the veteran's death or, if separated, was not at fault for the separation, AND
- Is not currently remarried*

**May be eligible if you remarried on or after December 16, 2003, and were at least 57years of age.*

The **surviving child** if he/she is the surviving child of a service member who died in the line of duty, or a veteran whose death resulted from a service-connected injury or disease. Additionally you must be:

- Unmarried AND
- Under age 18, or between the ages of 18 and 23 and attending school.

Note: *Certain helpless adult children are entitled to DIC.*

The Surviving parent(s) may be eligible for an income-based benefit.

How Much Does VA Pay?

The basic monthly rate of DIC is $1,612.74 for an eligible surviving spouse. The rate is increased for each dependent child, also if the surviving spouse is housebound or in need of aid and attendance. VA also adds a transitional benefit of $399.54 to the surviving spouse's monthly DIC if there are children under age18. The amount is based on a family unit, not individual children. Benefit rate tables, including those for children alone and parents, can be found on the internet at http://benefits.va.gov/Compensation/current_rates_dic.asp

How Should a Claimant Apply?

Claimants should complete VA Form 21P-534EZ *Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child.*

What Are Some Related Benefits?

Health Care (CHAMPVA)	Federal Employment Preference
Home Loan Guaranty	Survivors' & Dependents' Educational Assistance

OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: 07/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 18. Use this form to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. For additional information or questions contact us online at **https://www.va.gov/contact-us** or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at **www.va.gov/vaforms**. If submitting by mail, send completed form to: **Department of Veterans Affairs, Pension Intake Center, P.O. Box 5365, Janesville, WI 53547-5365.**

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

NOTE: You may *either* complete the form by typing the information in on the computer or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

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

1B. VETERAN'S SOCIAL SECURITY NUMBER — – –

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

1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA? ◯ YES ◯ NO (If "YES," provide the file number in Item 1E)

1E. VA FILE NUMBER (If known)

1F. DID THE VETERAN DIE WHILE ON ACTIVE DUTY? ◯ YES ◯ NO

1G. VETERAN'S SERVICE NUMBER

1H. VETERAN'S DATE OF DEATH? (MM/DD/YYYY) / /

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

2A. YOUR NAME (First, Middle Initial, Last)

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)

◯ SURVIVING SPOUSE ◯ CHILD 18-23 IN SCHOOL ◯ CUSTODIAN FILING FOR CHILD UNDER 18 ◯ HELPLESS ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER — – –

2D. YOUR DATE OF BIRTH (MM/DD/YYYY) / /

2E. ARE YOU A VETERAN? ◯ YES ◯ NO

2F. MAILING 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

2G. YOUR TELEPHONE NUMBER (Include Area Code) — – – Enter International Phone Number (If applicable)

2H. E-MAIL ADDRESS (Optional)

2I. WHAT ARE YOU CLAIMING? (Check all that apply)

◯ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ◯ SURVIVORS PENSION ◯ ACCRUED BENEFITS

SECTION III: VETERAN'S SERVICE INFORMATION

(Skip to Section IV if the veteran was receiving VA compensation or pension benefits at the time of their death)

NOTE: Please refer to instructions page 4, Military Service Verification for more information pertaining to service information and relevant documents.

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME?

◯ YES ◯ NO (If "YES," list other names the veteran served under below)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)

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

3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY)

3D. BRANCH OF SERVICE

○ ARMY ○ NAVY ○ AIR FORCE ○ MARINE CORPS

○ COAST GUARD ○ SPACE FORCE ○ NOAA ○ USPHS

3E. PLACE OF LAST SEPARATION

3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard)

○ YES ○ NO (If "NO," skip to Item 3J)

3G. DATE OF ACTIVATION (MM/DD/YYYY)

3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

3J. WAS THE VETERAN EVER A PRISONER OF WAR?

○ YES ○ NO (If "NO," skip to Section IV)

3K. DATES OF CONFINEMENT (MM/DD/YYYY)

START:

END:

SECTION IV: MARITAL INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

○ YES ○ NO (If "YES," provide explanation below)

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF THE VETERAN'S DEATH?

○ YES ○ NO (If "NO," complete Item 4C)

4C. HOW DID YOUR MARRIAGE TO THE VETERAN END?

○ DEATH ○ DIVORCE ○ OTHER (Explain)

4D. DATES OF YOUR MARRIAGE TO THE VETERAN (MM/DD/YYYY)

START:

END:

4E. PLACE OF MARRIAGE (City/State or Country)

4F. PLACE OF MARRIAGE TERMINATION (City/State or Country)

4G. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.)

○ CEREMONIAL ○ OTHER (Explain):

4H. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

○ YES ○ NO

4I. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

○ YES ○ NO

4J. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF THE VETERAN'S DEATH?

○ YES ○ NO (If "YES," skip to Item 4L)

4K. WAS THE SEPARATION DUE TO MARITAL DISCORD, MEDICAL, OR FINANCIAL REASONS?

○ YES ○ NO (If "YES," provide explanation in space provided)

NOTE: Give, the reason, date(s), and duration of the separation
(If the separation was by court order, attach a copy of the order)

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4L. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?

○ YES ○ NO (If "NO," skip to Item 5A)

4M. WHAT ARE THE DATES OF YOUR REMARRIAGE? (MM/DD/YYYY)

START:

END:

4N. HOW DID YOUR REMARRIAGE END?

○ DEATH ○ DIVORCE ○ DID NOT END ○ OTHER (Explain)

4O. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH?

○ YES ○ NO (If "YES," please submit a VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for each marriage)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION V: MARITAL HISTORY

TELL US ABOUT ANY OTHER MARRIAGES YOU AND/OR THE VETERAN HAD. IF YOU AND THE VETERAN DID NOT HAVE ANY ADDITIONAL MARRIAGES SKIP TO SECTION VI.

VETERAN'S PRIOR MARRIAGES (If none skip to Item 5L)

5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain below)

5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: ___/___/____

END: ___/___/____

5D. PLACE OF MARRIAGE (City/State or Country)

5E. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain below)

5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: ___/___/____

END: ___/___/____

5I. PLACE OF MARRIAGE (City/State or Country)

5J. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?

◯ YES ◯ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN (If none skip to Section VI)

5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5M. HOW DID YOUR PREVIOUS MARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain below)

5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: ___/___/____

END: ___/___/____

5O. PLACE OF MARRIAGE (City/State or Country)

5P. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5R. HOW DID YOUR PREVIOUS MARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain below)

5S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: ___/___/____

END: ___/___/____

5T. PLACE OF MARRIAGE (City/State or Country)

5U. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?

◯ YES ◯ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VI: CHILD OF THE VETERAN INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)
(Skip to Section VII if you are NOT claiming benefits for a child(ren) of the veteran)

NOTE: Please refer to instructions page 2, under "*Special Circumstances*" for what is considered a dependent child. In most circumstances, children over the age of 23 are not considered dependent for VA purposes.

6A. HOW MANY DEPENDENT CHILDREN DO YOU HAVE?

(**NOTE**: Please complete a VA Form 21-686c, *Application Request to Add and/or Remove Dependents*, if you need more space for additional dependents)

6B. CHILD'S NAME (First, Middle Initial, Last)

6C. CHILD'S DATE OF BIRTH (MM/DD/YYYY) / /

6D. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6E. PLACE OF BIRTH (City/State or Country)

6F. WHAT IS THE CHILD'S STATUS? (Check all that apply)

◯ BIOLOGICAL ◯ ADOPTED ◯ STEPCHILD ◯ 18-23 YEARS OLD (in school) ◯ SERIOUSLY DISABLED ◯ CHILD PREVIOUSLY MARRIED

◯ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___,___.00

6G. CHILD'S NAME (First, Middle Initial, Last)

6H. CHILD'S DATE OF BIRTH (MM/DD/YYYY) / /

6I. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6J. PLACE OF BIRTH (City/State or Country)

6K. WHAT IS THE CHILD'S STATUS? (Check all that apply)

◯ BIOLOGICAL ◯ ADOPTED ◯ STEPCHILD ◯ 18-23 YEARS OLD (in school) ◯ SERIOUSLY DISABLED ◯ CHILD PREVIOUSLY MARRIED

◯ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___,___.00

6L. CHILD'S NAME (First, Middle Initial, Last)

6M. CHILD'S DATE OF BIRTH (MM/DD/YYYY) / /

6N. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ____

6O. PLACE OF BIRTH (City/State or Country)

6P. WHAT IS THE CHILD'S STATUS? (Check all that apply)

◯ BIOLOGICAL ◯ ADOPTED ◯ STEPCHILD ◯ 18-23 YEARS OLD (in school) ◯ SERIOUSLY DISABLED ◯ CHILD PREVIOUSLY MARRIED

◯ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___,___.00

6Q. DO YOUR CHILDREN WHO DO NOT LIVE WITH YOU (If listed above) RESIDE AT THE SAME ADDRESS?

◯ YES ◯ NO (If "YES," please complete Item 6R) (If "NO," please complete a VA Form 21-4138, *Statement in Support of Claim*, with the following information. Name of person the child is currently living with, and the full address where the child resides)

6R. PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHILD(RENS) CUSTODIAN BELOW:

Custodian's Name (First, Middle Initial, Last)

Custodian's Mailing 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 ___ – ____

VETERAN'S SOCIAL SECURITY NUMBER [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

SECTION VII: DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Skip to Section VIII if you are NOT claiming DIC)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

◯ DIC ◯ DIC under 38 U.S.C. 1151 (**Note:** DIC under 38 U.S.C. 1151 is a rare benefit. Please refer to Instructions page 5 for guidance on 38 U.S.C 1151) ◯ DIC due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 (PACT Act) (**Note:** Please refer to Instructions page 6 for guidance on PACT Act)

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: [ ][ ]/[ ][ ]/[ ][ ][ ][ ] END: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]
	START: [ ][ ]/[ ][ ]/[ ][ ][ ][ ] END: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]
	START: [ ][ ]/[ ][ ]/[ ][ ][ ][ ] END: [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC 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," please complete a 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/CRNP), or Clinical Nurse Specialist (CNS))

8B. ARE YOU NOW IN A NURSING HOME?

◯ YES ◯ NO (If "YES," complete VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance.* For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC") (If "NO," skip to Item 9A)

SECTION IX: INCOME AND ASSETS
(Skip to Section X if you are NOT claiming survivors pension benefits)

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.

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER $25,000.00 IN ASSETS? (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC)*)

(If "No," provide an estimate of the total value of your assets below)

$ [ ][ ][ ] , [ ][ ][ ] . [ ][ ]

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 a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC)*)

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

◯ YES ◯ NO (If "NO," skip to Item 9G)

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

◯ YES ◯ NO (If "NO," skip to Item 9H)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF THE 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) MARKETABLE?

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969)

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969, and ONLY report your Social Security income in Item 9I)

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969)

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IX: INCOME AND ASSETS (CONTINUED)
(Skip to Section X if you are not claiming survivors pension benefits)

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' DIC*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

NO.	(1) WHO IS THE INCOME RECIPIENT?	(2) WHAT IS THE TYPE/SOURCE OF INCOME?	(3) WHAT IS THE CURRENT GROSS MONTHLY INCOME?
9I	◯ SURVIVING SPOUSE ◯ CHILD (Provide name below)	◯ SOCIAL SECURITY ◯ PENSION/RETIREMENT ◯ CIVIL SERVICE ◯ INTEREST/DIVIDENDS ◯ OTHER (Specify Source i.e., inheritance, etc.)	$ ☐☐☐,☐☐☐.☐☐
9J	◯ SURVIVING SPOUSE ◯ CHILD (Provide name below)	◯ SOCIAL SECURITY ◯ PENSION/RETIREMENT ◯ CIVIL SERVICE ◯ INTEREST/DIVIDENDS ◯ OTHER (Specify Source i.e., inheritance, etc.)	$ ☐☐☐,☐☐☐.☐☐
9K	◯ SURVIVING SPOUSE ◯ CHILD (Provide name below)	◯ SOCIAL SECURITY ◯ PENSION/RETIREMENT ◯ CIVIL SERVICE ◯ INTEREST/DIVIDENDS ◯ OTHER (Specify Source i.e., inheritance, etc.)	$ ☐☐☐,☐☐☐.☐☐
9L	◯ SURVIVING SPOUSE ◯ CHILD (Provide name below)	◯ SOCIAL SECURITY ◯ PENSION/RETIREMENT ◯ CIVIL SERVICE ◯ INTEREST/DIVIDENDS ◯ OTHER (Specify Source i.e., inheritance, etc.)	$ ☐☐☐,☐☐☐.☐☐

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER 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 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, 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 were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report.*

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

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

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

IN-HOME CARE OR CARE FACILITY

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 19 and 20 for each provider.

10B (1). WHOSE EXPENSES WERE PAID?	10B (2). NAME OF PROVIDER AND TYPE OF CARE	10B (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
◯ SURVIVING SPOUSE ◯ OTHER (Specify below)	CHECK ONE: ◯ CARE FACILITY ◯ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $☐☐☐.00 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 in Item 10B (5))
START: ☐☐/☐☐/☐☐☐☐ END: ☐☐/☐☐/☐☐☐☐ ◯ NO END DATE	◯ MONTHLY ◯ ANNUALLY	$ ☐☐☐,☐☐☐.☐☐

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

IN-HOME CARE OR CARE FACILITY (Continued)

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 19 and 20 for each provider.

10C (1). WHOSE EXPENSES WERE PAID?	10C (2). NAME OF PROVIDER AND TYPE OF CARE	10C (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
◯ SURVIVING SPOUSE ◯ OTHER (Specify below)	CHECK ONE: ◯ CARE FACILITY ◯ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $___.00 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 in Item 10C (5))
START: __/__/____ END: __/__/____ ◯ NO END DATE	◯ MONTHLY ◯ ANNUALLY	$___,___.__

10D (1). WHOSE EXPENSES WERE PAID?	10D (2). NAME OF PROVIDER AND TYPE OF CARE	10D (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
◯ SURVIVING SPOUSE ◯ OTHER (Specify below)	CHECK ONE: ◯ CARE FACILITY ◯ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $___.00 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 in Item 10D (5))
START: __/__/____ END: __/__/____ ◯ NO END DATE	◯ MONTHLY ◯ ANNUALLY	$___,___.__

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E (1). WHOSE EXPENSES WERE PAID? (Check one)	10E (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
◯ SURVIVING SPOUSE ◯ CHILD (Specify below)	Provider: Purpose:

10E (3). DATE COSTS INCURRED (MM/DD/YYYY)	10E (4). PAYMENT FREQUENCY	10E (5). AMOUNT YOU PAY (Based on frequency selected in Item 10E (4))
__/__/____	◯ MONTHLY ◯ ANNUALLY ◯ ONE-TIME	$___,___.__

10F (1). WHOSE EXPENSES WERE PAID? (Check one)	10F (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
◯ SURVIVING SPOUSE ◯ CHILD (Specify below)	Provider: Purpose:

10F (3). DATE COSTS INCURRED (MM/DD/YYYY)	10F (4). PAYMENT FREQUENCY	10F (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4))
__/__/____	◯ MONTHLY ◯ ANNUALLY ◯ ONE-TIME	$___,___.__

10G (1). WHOSE EXPENSES WERE PAID? (Check one)	10G (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
◯ SURVIVING SPOUSE ◯ CHILD (Specify below)	Provider: Purpose:

10G (3). DATE COSTS INCURRED (MM/DD/YYYY)	10G (4). PAYMENT FREQUENCY	10G (5). AMOUNT YOU PAY (Based on frequency selected in Item 10G (4))
__/__/____	◯ MONTHLY ◯ ANNUALLY ◯ ONE-TIME	$___,___.__

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

10H (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10H (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10H (3). DATE COSTS INCURRED (MM/DD/YYYY) __/__/____

10H (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10H (5). AMOUNT YOU PAY (Based on frequency selected in Item 10H (4))
$ ___,___.__

10I (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10I (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10I (3). DATE COSTS INCURRED (MM/DD/YYYY) __/__/____

10I (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10I (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4))
$ ___,___.__

10J (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10J (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10J (3). DATE COSTS INCURRED (MM/DD/YYYY) __/__/____

10J (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10J (5). AMOUNT YOU PAY (Based on frequency selected in Item 10J (4))
$ ___,___.__

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

The Department of 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 Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

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

11B. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

11C. 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 ◯ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.:

SECTION XII: 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 except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled ***Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued 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 my 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.

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

12B. CLAIMANT'S SIGNATURE **OR** MARK WITH AN "X" IF UNABLE TO SIGN **(REQUIRED)**	12C. DATE SIGNED (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

SECTION XIII: WITNESSES TO SIGNATURE
(TWO (2) WITNESS SIGNATURES ARE REQUIRED ONLY IF ITEM 12B IS SIGNED WITH AN "X")

13A. SIGNATURE OF WITNESS (Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12B using an "X")	13B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:
13C. SIGNATURE OF WITNESS (Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12B using an "X")	13D. PRINTED NAME AND ADDRESS OF 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) ☐☐/☐☐/☐☐☐☐

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 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, verification of identity and status, and personnel administration. Your response 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 40 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.