2024 SURVIVOR'S PENSION PACKET

BRAZORIA COUNTY VETERANS SERVICE OFFICE
111 E. Locust, Bldg. A-29, Suite 120 • Angleton, Texas 77515
Telephone Number (979)864-1289 • Fax (979)864-1032

Sonya T. Broadway
Veteran Service Officer

Administrative Assistant
Kimberly Westbrook

2024

Dear Surviving Spouse:

Please find enclosed VA Form 21P-534EZ-Application for Survivor's Pension; VA Form 21-2680-Examination for Housebound Status or Permanent Need for A&A; VA Form 21-0779-Request for Nursing Home Information; Worksheets for Assisted Living/In-Home Attendant expenses; and VA Form 21P-0969-Income & Asset Statement. 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 (DVA) Department of Veterans Affairs is a Federal Agency,
which has the POWER to Grant or Deny VA Claims.

Checklist to file Survivor's Pension- Brazoria County VSO 2024:

_____Certified Copy of veterans DD214

_____ Copy of Death Certificate of Veteran

_____ Copy of marriage certificate to Veteran

_____Date and place of prior marriages of self and veteran

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

_____Mailing address where VA correspondence will be properly received

_____Day and Evening telephone number

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

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

_____Full name of veteran

_____Social Security Number of veteran

_____Date of Birth of Veteran

_____Place of Birth of veteran

_____Your Date of Birth

_____Your Social Security Number

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

_____Did you live with the veteran at the time of the veteran's death? –If no, reason for separation

_____Copy of Social Security Award Letter and 1099's from all other income sources

_____Copy of current Bank, Asset, Investment Account Statements

_____If In-home Care-Proof of payment from care provider (canceled checks, bank statements, etc.)

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

Survivors Pension Benefits-FOR THE SURVIVING SPOUSE/CHILD

What Is Survivors Pension?

Survivors pension is a needs-based benefit paid to surviving spouses and children of wartime Veterans, who meet certain age, disability, and marriage requirements

Who Is Eligible?

You may be eligible if:

- the deceased veteran was discharged from service under other than dishonorable conditions, **AND**
- he or she served 90 days or more of active duty with at least 1 day during a period of war time*, ***AND***
- you are the unmarried surviving spouse (or previously married and the marriage was terminated prior to November 1, 1990); **OR**
- you are the unmarried child of the deceased Veteran who is under 18, who became permanently helpless before 18, or is between 18-23 and pursuing a course of instruction at an approved educational institution, **AND**
- your countable income is below the amount listed in the chart below, **AND**
- you meet the net worth limitations

*If the deceased Veteran entered active duty after September 7, 1980, he or she must have served at least 24 months of active duty service. If the total length of service is less than 24 months, the Veteran must have completed their entire tour of active duty.

INCOME LIMITS (EFFECTIVE DECEMBER 1, 2023)

If you are a...	*Your income must be less than...* *Year*	*Month*
Surviving spouse with no dependent children	$11,102	925
Surviving spouse with one dependent child	$14,529	1,211
(add $2,831 to the limit for EACH child)		
Housebound surviving spouse with no dependents	$13,568	1,131
Housebound surviving spouse with one dependent	$16,989	1,416
Surviving spouse who needs aid and attendance-no dependents	$18,461	1,538
Surviving spouse who needs aid and attendance-one dependent	$21,166	1,764
Surviving child (no eligible parent)	$ 2,831	236

Note: *Some income is not counted toward the yearly limit (for example, welfare benefits, some wages earned by dependent children, and Supplemental Security Income.)*

How Much Does VA Pay?

VA pays you the difference between your countable income and the yearly income limit that describes your situation (see chart above). This difference is generally paid in 12 equal monthly payments rounded down to the nearest dollar.

**Countable family income may be reduced by unreimbursed out of pocket medical expenses, submit VA Form 21P-8416 Medical Expense Report with your claim.*

How Can You Apply?

You can apply by filling out VA Form 21P-534EZ, *Application for Dependency and Indemnity Compensation or Death Pension by surviving Spouse or Child.* If available, attach copies of dependency records (marriage & children's birth certificates).

For More Information, Contact Brazoria County Veterans Services 979-864-1289

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 02/28/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 4. Use this form to determine eligibility for aid and attendance or housebound benefits. For more information, you can contact us online through Ask VA: **https://ask.va.gov/**. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at **www.va.gov/vaforms**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable check box to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER — ___ – ___ – ____

3. VA FILE NUMBER (If applicable)

4. VETERAN'S SERVICE NUMBER (If applicable)

5. DATE OF BIRTH (MM/DD/YYYY) — __ – __ – ____

SECTION II: CLAIMAINT'S IDENTIFICATION INFORMATION

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

7. CLAIMANT'S SOCIAL SECURITY NUMBER — ___ – ___ – ____

8. RELATIONSHIP OF CLAIMANT TO VETERAN
☐ SELF ☐ PARENT
☐ SPOUSE ☐ CHILD

9. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY) — __ – __ – ____

10. 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 – ____

11. TELEPHONE NUMBER (Optional) (Include Area Code)
___ – ___ – ____ Enter International Phone Number (If applicable)

12. EMAIL ADDRESS (Optional) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III: CLAIM INFORMATION

13. SELECT ONE OF THE FOLLOWING BENEFITS (Choose one)

☐ **Special Monthly Compensation (SMC) -** Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A veteran or a deceased veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation or Dependency Indemnity Compensation (DIC). They are not paid <u>without</u> eligibility to compensation.

☐ **Special Monthly Pension (SMP) -** Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting them from the hazards of their daily environment, or are housebound (substantially confined to their immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

14A. IS THE CLAIMANT HOSPITALIZED?

☐ YES (If "YES," complete Items 14B, 14C & 14D)

☐ NO (If "NO," skip to Section V)

14B. DATE ADMITTED (MM/DD/YYYY)

__ – __ – ____

14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

SECTION V: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

15A. VETERAN/CLAIMANT'S SIGNATURE **(Required)**

15B. DATE SIGNED (MM/DD/YYYY)

__ – __ – ____

SECTION VI: EXAMINATION INFORMATION
(IMPORTANT: Remainder of form MUST be filled out by Examiner)

NOTE: Examiner **must be** a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.

16. DATE OF EXAMINATION (MM/DD/YYYY)

__ – __ – ____

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veteran/claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. Please provide as much description as needed for each question as this will assist VA to determine if the disease(s) or injury(ies) listed may lead to physical or mental impairment, loss of coordination or enfeeblement that require assistance with daily living. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well they ambulate, where they go, and what they are able to do during a typical day.

17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR EACH CONDITION (Diagnosis needs to equate to the level of assistance described in Items 26 through 37) (Describe below)

18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)

A.		**D.**	
B.		**E.**	
C.		**F.**	

19A. AGE	19B. WEIGHT	19C. HEIGHT
	ACTUAL LBS. ___ ESTIMATED LBS. ___	FEET ___ INCHES ___

20. NUTRITION	21. GAIT

22. BLOOD PRESSURE	23. PULSE RATE	24. RESPIRATORY RATE	25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

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

26. IF THE PATIENT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: [ ][ ] From 9 AM to 9 PM: [ ][ ]

27. DOES THE PATIENT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply)

- ☐ BATHING/SHOWERING
- ☐ TENDING TO HYGIENE NEEDS
- ☐ ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below)
- ☐ EATING OR SELF-FEEDING
- ☐ TRANSFERRING IN OR OUT OF BED/CHAIR
- ☐ DRESSING
- ☐ TOILETING
- ☐ AMBULATING WITHIN THE HOME OR LIVING AREA
- ☐ MEDICATION MANAGEMENT

28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)

- ☐ YES
- ☐ NO

28B. CORRECTED VISION

LEFT EYE	RIGHT EYE
[ ][ ][ ]	[ ][ ][ ]

29. DOES THE PATIENT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

- ☐ YES
- ☐ NO

30. IN YOUR JUDGMENT, DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYMENTS, OR ARE THEY ABLE TO DIRECT SOMEONE TO DO SO?

- ☐ YES
- ☐ NO

(If "NO," provide the disability(ies) that prevent them from performing this function and any rationale to support your conclusion in the space provided)

31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE

33. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. **(NOTE:** If indicated, comment specifically on weight bearing, balance and propulsion of each lower extremity)

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

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

35. DESCRIBE ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE; SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS PATIENT'S ABILITY TO PERFORM SELF-CARE, OR IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA

36. HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES (to include the level of assistance required) IS THE PATIENT ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES (Describe)

37. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION?

☐ YES (If "YES," check the applicable box or specify distance) ☐ 1 BLOCK ☐ 5 OR 6 BLOCKS ☐ 1 MILE OTHER (Specify distance)_____

☐ NO

SECTION VII: EXAMINER'S SIGNATURE

38. PRINTED NAME OF EXAMINER	39. TITLE OF EXAMINER
40. SIGNATURE OF EXAMINER **(REQUIRED)**	41. DATE SIGNED (MM/DD/YYYY) [ ][ ] – [ ][ ] – [ ][ ][ ][ ]

SECTION VIII: EXAMINER'S INFORMATION

42. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER OF EXAMINER

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

43. NAME OF MEDICAL FACILITY

44. ADDRESS OF MEDICAL FACILITY (Number and street or rural route, city, state, ZIP Code and Country)

45. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)

[ ][ ][ ] – [ ][ ][ ] – [ ][ ][ ][ ] Enter International Phone Number (If applicable)

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 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. 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). 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.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) 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 website at 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.

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)) (Attached)

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") (Attached) (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)*) (Attached)

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

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

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 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.

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

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.

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 08/31/2023

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

REQUEST FOR NURSING HOME INFORMATION IN CONNECTION WITH CLAIM FOR AID AND ATTENDANCE

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden. We use this form to determine eligibility in connection with a claim for aid and attendance. For more information, 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 Federal relay number is 711. VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI, 53547- 4444.**

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable circle to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* — —

SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION *(Complete this section ONLY IF the claimant is NOT the veteran)*

5. CLAIMANT'S NAME *(First, Middle Initial, Last)*

6. SOCIAL SECURITY NUMBER — —

7. VA FILE NUMBER *(If applicable)*

8. DATE OF BIRTH *(MM/DD/YYYY)* — —

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

10. ADDRESS OF NURSING HOME *(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 —

SECTION IV - GENERAL INFORMATION *(To be completed by a Nursing Home Official)*

NOTE: Your state's Medicaid program may use a different name.

11. DATE ADMITTED TO NURSING HOME *(MM/DD/YYYY)* — —

12. IS THE NURSING HOME A MEDICAID APPROVED FACILITY?
◯ YES ◯ NO

13. HAS THE PATIENT APPLIED FOR MEDICAID?
◯ YES ◯ NO

14A. IS THE PATIENT COVERED BY MEDICAID?
◯ YES ◯ NO *(If "YES," complete Item 14B)*

14B. DATE MEDICAID PLAN BEGAN *(MM/DD/YYYY)* — —

15. MONTHLY AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET $

16. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: *(Check one)*
◯ SKILLED NURSING CARE ◯ INTERMEDIATE NURSING CARE

17. NURSING HOME OFFICIAL'S NAME *(First and Last)*

18. NURSING HOME OFFICIAL'S TITLE

19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)* — —

Enter International Phone Number *(If applicable)*

SECTION V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

20. SIGNATURE OF NURSING HOME OFFICIAL *(REQUIRED)*

21. 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.

IF NOT IN A NURSING HOME BUT IN AN ASSISTED LIVING OR UNDER HOME HEALTHCARE COMPLETE THE WORKSHEET THAT PERTAINS TO YOUR SITUATION

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 WESITE 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 BELOW PLEASE CHECK THE BOX IF THIS 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 dangers incident 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 PROVIDED 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 dangers incident 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)

/ /

OMB Control No. 2900-0829
Respondent Burden: 30 minutes
Expiration Date: 11/30/2026

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME (First, Middle Initial (M.I.), Last)
First: MI: Last:

1B. VETERAN'S SOCIAL SECURITY NUMBER

1C. VETERAN'S FILE NUMBER (If known)

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION (If you are the Veteran, skip questions 2A and 2B)

2A. CLAIMANT'S NAME (First, Middle Initial (M.I.), Last)
First: MI: Last:

2B. CLAIMANT'S SOCIAL SECURITY NUMBER

2C. CLAIMANT'S TELEPHONE NUMBER (If known)

2D. TYPE OF CLAIMANT (Check only one box)
☐ VETERAN ☐ SURVIVING SPOUSE ☐ SURVIVING CHILD ☐ PARENT ☐ CUSTODIAN OF CHILD BENEFICIARY

This form is designed to provide VA with your income and net worth during a specific date range to determine your eligibility or adjust your benefits. If you are submitting an initial application, report current information. Your effective date is typically the earlies of the following dates:

- Date VA receives your application
- Date VA receives your intent to file
- Date of Veteran's death (Survivor's Benefits only)

If you are submitting this form as a response to VA correspondence, report your income and net worth information during the date range specified in that correspondence. If you are reporting an income change, report changes from the date the change took effect.

NOTE: Submit a separate VA Form 21P-0969 if reporting income and net worth information for additional date ranges.

2E. THE INFORMATION ON THIS FORM REPRESENTS INCOME AND NET WORTH FOR THE FOLLOWING PERIOD:
THROUGH -OR- ☐ DATE RECEIVED BY VA (For initial claims only.)

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (See instructions on Page 2)

3A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS FROM SOURCES NOT RELATED TO AN ACCOUNT OR YOUR ASSETS?
☐ YES ☐ NO (If NO, skip to Section IV)

3B.
(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3C.
(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (Continued)
(See instructions on Page 2)

3D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3E.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3F.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS
(See instructions on Page 2)

4A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS THAT IS RELATED TO FINANCIAL ACCOUNTS?
☐ YES ☐ NO (If NO, skip to Section V)

4B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$ ☐☐,☐☐☐,☐☐☐.☐☐

4C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$ ☐☐,☐☐☐,☐☐☐.☐☐

4D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child parent, or other)

(5). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$ ☐☐,☐☐☐,☐☐☐.☐☐

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS (Continued)
(See instructions on Page 2)

4E.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$, .

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$, , .

4F.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$, .

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$, , .

SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS
(See instructions on Page 2)

5A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS GENERATED BY OWNED PROPERTY OR OTHER PHYSICAL ASSETS?

☐ YES ☐ NO (If NO, skip to Section VI)

5B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$, .

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY
$, , .

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED
☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

5C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$, .

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other only)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY
$, , .

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED
☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

5D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$, .

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other only)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY
$, , .

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED
☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES
(See instructions on Page 2)

6A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES?

☐ YES ☐ NO (If NO, skip to Section VII)

6B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET
☐ BENEFITS FROM INTELLECTUAL PROPERTY ☐ EXTRACTION OF MINERALS/LUMBER ☐ USE OF LAND
☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET
$ ☐☐,☐☐☐,☐☐☐.☐☐

(6). CAN THE ASSET BE SOLD?
☐ YES ☐ NO

(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET

6C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET
☐ BENEFITS FROM INTELLECTUAL PROPERTY ☐ EXTRACTION OF MINERALS/LUMBER ☐ USE OF LAND
☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$ ☐☐,☐☐☐.☐☐

(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET
$ ☐☐,☐☐☐,☐☐☐.☐☐

(6). CAN THE ASSET BE SOLD?
☐ YES ☐ NO

(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET

SECTION VII: ASSET TRANSFERS
(See instructions on Page 2)

7A. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ANY ASSETS?

☐ YES ☐ NO (If NO, skip to Section VIII)

7B.

(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED
☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?
☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?
$ ☐☐,☐☐☐,☐☐☐.☐☐

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)
$ ☐☐,☐☐☐,☐☐☐.☐☐

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)
$ ☐☐,☐☐☐,☐☐☐.☐☐

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?
☐ YES ☐ NO

SECTION VII: ASSET TRANSFERS (Continued)
(See instructions on Page 2)

7C.

(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED
☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?
☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?
$ ☐☐,☐☐☐,☐☐☐.☐☐

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)
$ ☐☐,☐☐☐,☐☐☐.☐☐

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)
$ ☐☐,☐☐☐,☐☐☐.☐☐

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?
☐ YES ☐ NO

7D.

(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED
☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?
☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?
$ ☐☐,☐☐☐,☐☐☐.☐☐

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)
$ ☐☐,☐☐☐,☐☐☐.☐☐

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)
$ ☐☐,☐☐☐,☐☐☐.☐☐

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?
☐ YES ☐ NO

SECTION VIII: TRUSTS
(See instructions on Page 2)

8A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED A TRUST OR DO YOU OR YOUR DEPENDENTS HAVE ACCESS TO A TRUST? (If you have more than one trust to report, submit the information on a separate VA Form 21P-0969 or provide the information on VA Form 21-4138 for each trust established.)
☐ YES ☐ NO (If NO, skip to Section IX)

8B. DATE TRUST ESTABLISHED (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐

8C. SPECIFY MARKET VALUE OF ALL ASSETS WITHIN THE TRUST AT TIME OF ESTABLISHEMENT
$ ☐,☐☐☐,☐☐☐.☐☐

8D. SPECIFY TYPE OF TRUST ESTABLISHED
☐ REVOCABLE ☐ IRREVOCABLE
☐ BURIAL TRUST

8E. HAVE YOU ADDED FUNDS TO THE TRUST AFTER IT WAS ESTABLISHED?
☐ YES ☐ NO

8F. WHEN DID YOU ADD FUNDS? (MM/DD/YYYY) (If more than one date, submit a VA Form 21-4138 with all dates and amounts)
☐☐ – ☐☐ – ☐☐☐☐

8G. HOW MUCH DID YOU ADD?
$ ☐☐☐,☐☐☐,☐☐☐.☐☐

8H. ARE YOU RECEIVING INCOME FROM THE TRUST?
☐ YES ☐ NO

8I. HOW MUCH DO YOU RECEIVE ANNUALLY?
$ ☐☐☐,☐☐☐.☐☐

8J. IS THE TRUST BEING USED TO PAY FOR OR TO REIMBURSE SOMEONE ELSE FOR YOUR MEDICAL EXPENSES? (Such as a guardian, family member or other service provider)
☐ YES ☐ NO

8K. HOW MUCH IS BEING REIMBURSED MONTHLY?
$ ☐☐☐,☐☐☐.☐☐

8L. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?
☐ YES ☐ NO

8M. DO YOU HAVE ANY ADDITIONAL AUTHORITY OR CONTROL OF THE TRUST?
☐ YES ☐ NO

SECTION IX: ANNUITIES
(See instructions on Page 2)

9A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED AN ANNUITY? (If you have more than one annuity to report, submit the information below on a separate VA Form 21P-0969, or provide the below information on VA Form 21-4138 for each annuity established.)

☐ YES ☐ NO (If NO, skip to Section X)

9B. SPECIFY DATE ANNUITY WAS ESTABLISHED (MM/DD/YYYY)	9C. SPECIFY MARKET VALUE OF ASSET AT TIME OF ANNUITY PURCHASE	9D. HAVE YOU ADDED FUNDS TO THE ANNUITY IN THE CURRENT OR PRIOR THREE YEARS?
☐☐ – ☐☐ – ☐☐☐☐	$ ☐, ☐☐☐, ☐☐☐, ☐☐	☐ YES ☐ NO
9E. WHEN DID YOU ADD FUNDS? (MM/DD/YYYY)	**9F. HOW MUCH DID YOU ADD?**	**9G. IS THE ANNUITY REVOCABLE OR IRREVOCABLE?**
☐☐ – ☐☐ – ☐☐☐☐	$ ☐, ☐☐☐, ☐☐☐, ☐☐	☐ REVOCABLE ☐ IRREVOCABLE
9H. DO YOU RECEIVE INCOME FROM THE ANNUITY?	**9I. IF YES IN 9H, PROVIDE ANNUAL AMOUNT RECEIVED (If NO, skip to 9J)**	
☐ YES ☐ NO	$ ☐, ☐☐☐, ☐☐☐, ☐☐	
9J. CAN THE ANNUITY BE LIQUIDATED?	**9K. IF YES IN 9J, PROVIDE THE SURRENDER VALUE (If NO, skip to Section X)**	
☐ YES ☐ NO	$ ☐, ☐☐☐, ☐☐☐, ☐☐	

SECTION X: ASSETS PREVIOUSLY NOT REPORTED
(See instructions on Page 2)

10A. DO YOU OR YOUR DEPENDENTS HAVE ASSETS NOT ALREADY REPORTED?

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

10B.	(1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $ ☐☐, ☐☐☐, ☐☐☐, ☐☐
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10C.	(1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $ ☐☐, ☐☐☐, ☐☐☐, ☐☐
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10D.	(1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $ ☐☐, ☐☐☐, ☐☐☐, ☐☐
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10E.	(1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $ ☐☐, ☐☐☐, ☐☐☐, ☐☐
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)

SECTION XI: DISCONTINUED OR IRREGULAR INCOME
(See instructions on Page 2)

11A. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME THAT HAS STOPPED OR IS NO LONGER BEING RECEIVED WITHIN: THE REPORTING PERIOD (From question 2E)? **- OR -** LAST FULL CALENDAR YEAR (For initial claim)?

☐ YES ☐ NO (If NO, skip to Section XII)

11B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

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

(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)

(5). SPECIFY FREQUENCY OF INCOME RECEIVED
☐ RECURRING ☐ IRREGULAR
☐ ONE TIME PAYMENT

(6). DATE INCOME LAST PAID (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐

(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?
$ ☐☐☐,☐☐☐.☐☐

11C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other0)

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

(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)

(5). SPECIFY FREQUENCY OF INCOME RECEIVED
☐ RECURRING ☐ IRREGULAR
☐ ONE TIME PAYMENT

(6). DATE INCOME LAST RECEIVED (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐

(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?
$ ☐☐☐,☐☐☐.☐☐

SECTION XII: WAIVER OF RECEIPT OF INCOME
(See instructions on Page 2)

12A. DID YOU OR YOUR DEPENDENTS WAIVE OR EXPECT TO WAIVE ANY RECEIPT OF INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If NO, skip to Section XIII Certification and Signature)

12B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

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

(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE?
$ ☐☐☐,☐☐☐.☐☐

(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐
☐ This income will not resume

(6). WAIVED GROSS MONTHLY INCOME
$ ☐☐☐,☐☐☐.☐☐

12C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

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

(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE?
$ ☐☐☐,☐☐☐.☐☐

(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐
☐ This income will not resume

(6). WAIVED GROSS MONTHLY INCOME
$ ☐☐☐,☐☐☐.☐☐

SECTION XIII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on the form are true and correct to the best of my knowledge and belief. **I UNDERSTAND THAT** without consent, the Department of Veterans Affairs (VA) may disclose information that I provide to entities under a published "routine use." Under such a routine use, the VA may disclose information to third party entities that participate in VA claims processing and are authorized to assist the VA in administering benefits; to other federal agencies under computer matching programs, such as those with the Internal Revenue Service, Social Security Administration, Selective Service System, Department of Homeland Security, Department of Justice; and to members of Congress if they are assisting to help with Veteran's benefit questions.

13A. SIGNATURE

13B. DATE SIGNED (MM/DD/YYYY)
☐☐ – ☐☐ – ☐☐☐☐

SECTION XIV: WITNESS TO SIGNATURE
(Two witness signatures are required if the claimant signed item 13A with an "X")

14A. SIGNATURE OF FIRST WITNESS (If claimant signed above using an "X")

14B. PRINTED NAME OF FIRST WITNESS

FIRST: MI: LAST:

14C. ADDRESS OF FIRST WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code –

14D. SIGNATURE OF SECOND WITNESS (If claimant signed above using an "X")

14E. PRINTED NAME OF SECOND WITNESS

FIRST: MI: LAST:

14F. ADDRESS OF SECOND WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code –

Where to Send Correspondence - After completing the form, mail to:
Department of Veterans Affairs
Pension Intake Center
P.O. Box 5365
Janesville, WI 53547-5365

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.