2024 VETERAN 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 Veteran:

Please find enclosed VA Form 21P-527EZ-Application for Veteran Pension; VA Form 21-2680-Examination for Housebound Status or Permanent Need for Regular 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 (VA) Department of Veterans Affairs is a Federal Agency,
which has the POWER to Grant or Deny VA Claims.

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

_____Certified Copy of veterans DD214

_____Full current name of 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

_____Social Security Number of veteran

_____Date of Birth of Veteran

_____Place of Birth of veteran

_____VOIDED CHECK-for Direct Deposit Purposes-(If not already on VA record)

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

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

_____Copy of current Bank, Asset, Investment Account Statements

_____Amounts paid for reoccurring monthly Medical Expenses-Medicare, Private HI, Nursing Home...

Pension- FOR THE VETERAN

What Is VA Pension?

Pension is a benefit paid to wartime veterans with limited income, and who are permanently and totally disabled *or* age 65 or older.

Who Is Eligible?

You may be eligible if:

- you were discharged from service under other than dishonorable conditions, ***AND***
- you served 90 days or more of active duty with at least 1 day during a period of war time*, ***AND***
- your countable family income is below a yearly limit set by law, ***AND***
- you are permanently and totally disabled, ***OR***
- you are age 65 or older.

****Note***: Anyone who enlists after September 7, 1980, generally must have served at least 24 months or the full period for which called or ordered to active duty. Service from August 2, 1990 to present is considered to be a period of war (Gulf War) in addition to other periods of war such as World War II, Korea, and Vietnam.

FAMILY INCOME LIMITS (EFFECTIVE DECEMBER 1, 2023)		
	Your income must be less than...	
If you are a...	***Year***	***Month***
Veteran with no dependents	**$16,551**	**1,379**
Veteran with a spouse or a child	**$21,674**	**1,806**
(Veterans with additional children: add $2,831 to the limit for EACH child)		
Housebound veteran with no dependents	**$20,226**	**1,686**
Housebound veteran with one dependent	**$25,348**	**2,112**
Veteran who needs aid and attendance and has no dependents	**$27,609**	**2,301**
Veteran who needs aid and attendance and has one dependent	**$32,729**	**2,727**

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 family 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.

Note: Certain expenses (i.e., medical expenses, education expenses, or expenses related to the last illness or burial of a dependent) paid by you are taken into consideration when arriving at your countable family income.

How Can You Apply?

You can apply by filling out VA Form 21P-527EZ, *Veteran's Application for Pension.* If available, attach copies of dependency records (marriage & children's birth certificates) and current medical evidence (doctor & hospital reports).

Related Benefits

Vocational Rehabilitation Program
Medical Care

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 without 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?	14B. DATE ADMITTED (MM/DD/YYYY)
☐ YES (If "YES," complete Items 14B, 14C & 14D) ☐ NO (If "NO," skip to Section V)	[ ][ ] - [ ][ ] - [ ][ ][ ][ ]

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.

Veterans Pension Application Checklist

In addition to your application, VA may require some of the evidence described in this checklist. Information not provided will be requested, which will result in delaying your claim. Additional evidence may be needed beyond this checklist depending on your specific situation.

Service Verification (Requested in Section III and/or Page 4 of Instructions)

- ○ Copy of your DD Form 214 (or equivalent) for all periods of military service. Must demonstrate military service dates, type of service and character of discharge.

Income and Net Worth (Requested in Section IX and/or Page 4 of Instructions)

- ○ VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension, is required if instructed in Section IX of this application. If you have specific types of income or assets additional evidence may be required. If reporting:
  - ○ Farm - VA Form 21P-4165, Pension Claim Questionnaire for Farm Income
  - ○ Business - VA Form 21P-4185, Report of Income from Property or Business
  - ○ Rental Property - VA Form 21P-4185, Report of Income from Property or Business
  - ○ Royalties - VA Form 21-4138, Statement in Support of Claim
  - ○ Trust - Submit complete Trust documents to include the Schedule of Assets
  - ○ Interest, Dividends or Financial Investments - Current account statements from financial institution (Bank, Investment, Annuity, etc.)

Special Circumstances Regarding Your Medical Care (Requested in Section IV, Section X and/or Page 4 of Instructions)

Claim for Special Monthly Pension (SMP) - Aid and Attendance or Household Status

- ○ VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance

Claim for Medicare Nursing Home and/or $90.00 Rate Reduction Request

- ○ VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance

Claim for Fiduciary Assistance

- ○ VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance

Statement of Medical Care

- ○ Care Worksheets (found at the end of the application)
  - ○ Proof of Payment from care provided (Canceled checks, bank statements, etc.)
  - ○ Signed verification from care service provider

Dependent Children (Requested in Section VIII and/or Pages 4 and 5 of Instructions)

- ○ If children are adopted, the adoption decree or a revised birth certificate is required.
- ○ If your child is over 18 but under 23, please submit VA Form 21-674, Request for Approval of School Attendance.
- ○ Medical records for each seriously disabled child.

Medical Expenses (Requested in Section X)

- ○ If additional space is needed, submit VA Form 21P-8416, Medical Expense Report.

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1B. VETERAN'S SOCIAL SECURITY NUMBER

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

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

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

SECTION II: VETERAN'S CONTACT INFORMATION

2A. MAILING ADDRESS
No. & Street
Apt./Unit Number
City
State/Province
Country
ZIP Code/Postal Code

2B. TELEPHONE NUMBER *(Include Area Code)*
International Phone Number *(If applicable)*

2C. VETERAN'S E-MAIL ADDRESS *(Optional)*

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

3A. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER *(If None, leave blank)*

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

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

3D. YOUR SERVICE NUMBER

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

3F. PLACE OF YOUR LAST SEPARATION

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

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

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

SECTION IV: PENSION INFORMATION

4A. ARE YOU OVER THE AGE OF 65 OR HAVE YOU BEEN DETERMINED TO BE DISABLED BY SOCIAL SECURITY ADMINISTRATION?
YES NO *(If "YES," skip question 4B)*

4B. ARE YOU MEDICALLY INCAPABLE OF WORKING?
YES NO *(If "YES," you must submit medical evidence with this application)*

4C. DO YOU LIVE IN A NURSING HOME?
YES NO *(If "NO," skip question 4D)*

4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED FOR MEDICAID?
YES NO *(If "YES," please have an official from your nursing home complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance)*

4E. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL IMPAIRMENT OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?
YES NO *(If "YES," complete and attach with this application, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS))*

4F. HAVE YOU RECEIVED TREATMENT FROM A VA MEDICAL CENTER?
◯ YES ◯ NO Specify Facility:

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

SECTION V: EMPLOYMENT HISTORY

5A. ARE YOU CURRENTLY EMPLOYED?
◯ YES ◯ NO *(If "NO," skip questions 5B and 5C)*

5B. WHAT KIND OF WORK ARE YOU CURRENTLY DOING?

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

5D. WHEN DID YOU LAST WORK? *(MM/DD/YYYY)*
/ /

5E. HOW MANY HOURS PER WEEK DID YOU AVERAGE?

5F. WHAT WAS YOUR JOB TITLE?

5G. WHAT KIND OF WORK DID YOU DO?

SECTION VI: MARITAL STATUS *(MUST COMPLETE)*

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

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

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

6D. SPOUSE'S SOCIAL SECURITY NUMBER
– –

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

CITY AND STATE OR COUNTRY

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

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

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

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

6J. SPOUSE'S MAILING ADDRESS *(If separated)*
No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

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

SECTION VII: PRIOR MARITAL HISTORY

Tell us about your and your spouse's previous marriages. If you have never been married or your current marriage is yours and your spouse's only marriage skip to Section VIII.

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

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

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

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

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

7E. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

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

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

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

7H. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START: __ / __ / ____
END: __ / __ / ____

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

7J. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?
○ YES ○ NO *(If "YES," please submit a VA Form 21-686c, Declaration of Status of Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)*

SPOUSE'S PRIOR MARRIAGES *(If "None," skip to Section VIII)*

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

7M. HOW DID THE PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
○ DEATH ○ DIVORCE ○ OTHER *(Specify)* ____________

7N. WHAT ARE THE DATES OF THE PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START: __ / __ / ____
END: __ / __ / ____

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

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

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

7R. HOW DID THE PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
○ DEATH ○ DIVORCE ○ OTHER *(Specify)* ____________

7S. WHAT ARE THE DATES OF THE PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START: __ / __ / ____
END: __ / __ / ____

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

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

7V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR YOUR SPOUSE?
○ YES ○ NO *(If "YES", please submit a VA Form 21-686c, Declaration of Status of Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history.)*

SECTION VIII: DEPENDENT CHILDREN

NOTE: Please refer to the Special Circumstances on the instructions page for information regarding dependents and the necessary forms if additional space is required to list all dependents. If None, skip to Section IX. **In most circumstances, children over the age of 23 are not considered dependent for VA purposes.**

8A. HOW MANY DEPENDENT CHILDREN LIVE WITH YOU? *(Please complete a VA Form 21-686c, Application Request to Add and/or Remove Dependents, if you need more space for additional dependents.)*

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

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

8D. CHILD'S SOCIAL SECURITY NUMBER
___ – __ – ____

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

8F. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*
○ BIOLOGICAL ○ STEPCHILD ○ SERIOUSLY DISABLED ○ 18-23 YEARS OLD *(in school)* ○ PREVIOUSLY MARRIED ○ ADOPTED
○ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $ __ , ___ . __

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

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

8I. CHILD'S SOCIAL SECURITY NUMBER
___ – __ – ____

8J. PLACE OF BIRTH *(City and State or Country)*

SECTION VIII: DEPENDENT CHILDREN *(CONTINUED)*

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

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

○ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $ ___ , ___ . ___

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

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

8N. CHILD'S SOCIAL SECURITY NUMBER ___ – ___ – ___

8O. PLACE OF BIRTH *(City and State or Country)*

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

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

○ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $ ___ , ___ . ___

8Q. DO ALL OF YOUR CHILDREN THAT ARE NOT LIVING WITH YOU AS ANSWERED ABOVE RESIDE AT THE SAME ADDRESS?

○ YES ○ NO *(If "NO," Please submit a VA Form 21-4138, Statement in Support of Claim, with the following information: Who the child is currently living with, and the full address of where the child resides.)*

8R. PLEASE PROVIDE THE NAME OF THE CUSTODIAN AND THE ADDRESS OF CHILDREN NOT LIVING WITH YOU

NAME OF CUSTODIAN *(First, Middle Initial, Last)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code ___ – ___

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS

NOTE: Assets are all the money and property you or your dependents own. Assets do not include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

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

○ YES ○ NO *(If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.))*

$ ___ , ___ .00 *(If "NO," please estimate the total value of your assets)*

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? *(Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)*

○ YES ○ NO *(If "YES," please submit VA Form 21P-0969)*

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

○ YES ○ NO *(If "NO," skip to Item 9G)*

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

○ YES ○ NO *(If "NO," skip to Item 9G)*

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES? *(Do not include the value of the residence or the first 2 acres.)*

$ ___ , ___ , ___ .00

9F. IS THE LAND OVER 2 ACRES (87, 120 SQ FT) REPORTED IN QUESTION 9E MARKETABLE?

○ YES ○ NO *(If "YES," please submit VA Form 21P-0969)*

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

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

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C., by questions 9A through 9G, we only require Social Security income reported below. All other income should be reported on VA Form 21P-0969. Income will be counted as reported, do not duplicate.

NOTE: If reporting income in 9H through 9K, any items skipped or left blank will be considered as an unspecified income and could require a request for further information, potentially delaying your claim. If you leave the entire question blank, we will assume you have no income to report.

9H(1) WHO IS THE INCOME RECIPIENT? *(Select one)*

○ VETERAN

○ SPOUSE

○ CHILD *(Specify)*

9H(2) SPECIFY THE TYPE OF INCOME

○ SOCIAL SECURITY ○ INTEREST/DIVIDENDS

○ CIVIL SERVICE ○ PENSION/RETIREMENT

○ OTHER *(Specify type of income)*

9H(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*

9H(4) CURRENT GROSS MONTHLY INCOME

$ ___ , ___ . ___

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS *(Continued)*

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*
- VETERAN
- SPOUSE
- CHILD *(Specify)*

9I(2) SPECIFY THE TYPE OF INCOME
- SOCIAL SECURITY
- INTEREST/DIVIDENDS
- CIVIL SERVICE
- PENSION/RETIREMENT
- OTHER *(Specify type of income)*

9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*

9I(4) CURRENT GROSS MONTHLY INCOME

$, .

9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*
- VETERAN
- SPOUSE
- CHILD *(Specify)*

9J(2) SPECIFY THE TYPE OF INCOME
- SOCIAL SECURITY
- INTEREST/DIVIDENDS
- CIVIL SERVICE
- PENSION/RETIREMENT
- OTHER *(Specify type of income)*

9J(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*

9J(4) CURRENT GROSS MONTHLY INCOME

$, .

9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*
- VETERAN
- SPOUSE
- CHILD *(Specify)*

9K(2) SPECIFY THE TYPE OF INCOME
- SOCIAL SECURITY
- INTEREST/DIVIDENDS
- CIVIL SERVICE
- PENSION/RETIREMENT
- OTHER *(Specify type of income)*

9K(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*

9K(4) CURRENT GROSS MONTHLY INCOME

$, .

SECTION X: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

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

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

- YES
- NO *(If "NO," skip to Section XI)*

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed in questions 10B through 10J. Do not include expenses paid by other family members, insurance, etc.

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or residential care, adult daycare, or similar care facility, you must complete the applicable worksheet(s) on **pages 16 and 17** for each provider.

10B(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- VETERAN
- SPOUSE
- CHILD *(Specify)*

10B(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*
- CARE FACILITY
- IN-HOME CARE ATTENDANT

10B(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?

$. PER HOUR

HOURS WORKED PER WEEK

10B(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*

START: / /

END: / /

- NO END DATE

10B(5). PAYMENT FREQUENCY
- MONTHLY
- ANNUALLY

10B(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED

$, .

10C(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- VETERAN
- SPOUSE
- CHILD *(Specify)*

10C(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*
- CARE FACILITY
- IN-HOME CARE ATTENDANT

10C(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?

$. PER HOUR

HOURS WORKED PER WEEK

10C(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*

START: / /

END: / /

- NO END DATE

10C(5). PAYMENT FREQUENCY
- MONTHLY
- ANNUALLY

10C(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED

$, .

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

10D(1). WHOSE EXPENSES WERE PAID? *(Select one)*

- VETERAN
- SPOUSE
- CHILD *(Specify)*

10D(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*

- CARE FACILITY
- IN-HOME CARE ATTENDANT

10D(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?

$ ___ . ___ PER HOUR

___ HOURS WORKED PER WEEK

10D(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*

START: ___ / ___ / ___

END: ___ / ___ / ___

- NO END DATE

10D(5). PAYMENT FREQUENCY

- MONTHLY
- ANNUALLY

10D(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED

$ ___ , ___ . ___

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES

10E(1) WHOSE EXPENSES WERE PAID? *(Select one)*

- VETERAN
- SPOUSE
- CHILD *(Specify)*

10E(2) PAID TO *(Name of Provider, Insurance Company, etc.)*

10E(3) PURPOSE *(Insurance premium, medical supplies, etc.)*

10E(4) DATE COSTS INCURRED *(MM/DD/YYYY)*

___ / ___ / ___

10E(5) PAYMENT FREQUENCY

- MONTHLY
- ANNUALLY
- ONE-TIME

10E(6) AMOUNT YOU PAY *(Based on Frequency selected)*

$ ___ , ___ . ___

10F(1) WHOSE EXPENSES WERE PAID? *(Select one)*

- VETERAN
- SPOUSE
- CHILD *(Specify)*

10F(2) PAID TO *(Name of Provider, Insurance Company, etc.)*

10F(3) PURPOSE *(Insurance premium, medical supplies, etc.)*

10F(4) DATE COSTS INCURRED *(MM/DD/YYYY)*

___ / ___ / ___

10F(5) PAYMENT FREQUENCY

- MONTHLY
- ANNUALLY
- ONE-TIME

10F(6) AMOUNT YOU PAY *(Based on Frequency selected)*

$ ___ , ___ . ___

10G(1) WHOSE EXPENSES WERE PAID? *(Select one)*

- VETERAN
- SPOUSE
- CHILD *(Specify)*

10G(2) PAID TO *(Name of Provider, Insurance Company, etc.)*

10G(3) PURPOSE *(Insurance premium, medical supplies, etc.)*

10G(4) DATE COSTS INCURRED *(MM/DD/YYYY)*

___ / ___ / ___

10G(5) PAYMENT FREQUENCY

- MONTHLY
- ANNUALLY
- ONE-TIME

10G(6) AMOUNT YOU PAY *(Based on Frequency selected)*

$ ___ , ___ . ___

10H(1) WHOSE EXPENSES WERE PAID? *(Select one)*

- VETERAN
- SPOUSE
- CHILD *(Specify)*

10H(2) PAID TO *(Name of Provider, Insurance Company, etc.)*

10H(3) PURPOSE *(Insurance premium, medical supplies, etc.)*

10H(4) DATE COSTS INCURRED *(MM/DD/YYYY)*

___ / ___ / ___

10H(5) PAYMENT FREQUENCY

- MONTHLY
- ANNUALLY
- ONE-TIME

10H(6) AMOUNT YOU PAY *(Based on Frequency selected)*

$ ___ , ___ . ___

10I(1). WHOSE EXPENSES WERE PAID? *(Select one)*

- VETERAN
- SPOUSE
- CHILD *(Specify)*

10I(2) PAID TO *(Name of Provider, Insurance Company, etc.)*

10I(3) PURPOSE *(Insurance premium, medical supplies, etc.)*

10I(4) DATE COSTS INCURRED *(MM/DD/YYYY)*

___ / ___ / ___

10I(5) PAYMENT FREQUENCY

- MONTHLY
- ANNUALLY
- ONE-TIME

10I(6) AMOUNT YOU PAY *(Based on Frequency selected)*

$ ___ , ___ . ___

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

10J(1) WHOSE EXPENSES WERE PAID? *(Select one)*

- VETERAN
- SPOUSE
- CHILD *(Specify)*

10J(2) PAID TO *(Name of Provider, Insurance Company, etc.)*

10J(3) PURPOSE *(Insurance premium, medical supplies, etc.)*

10J(4) DATE COSTS INCURRED *(MM/DD/YYYY)*

/ /

10J(5) PAYMENT FREQUENCY

MONTHLY   ANNUALLY   ONE-TIME

10J(6) AMOUNT YOU PAY *(Based on Frequency selected)*

$, .

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

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and attach either a voided personal check or a deposit slip**. If you **do not** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP) and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address questions or concerns you may have.

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

11B. TYPE OF ACCOUNT *(Check the appropriate box and provide the account number or simply write "Established," if you have a direct deposit with VA.)*

CHECKING   SAVINGS   I CERTIFY I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

11C. ROUTING NUMBER

11D. ACCOUNT NO.

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

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

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA Medical Center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in item 12A indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

12A. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

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

12B. SIGNATURE OR MARK

12C. DATE SIGNED *(MM/DD/YYYY)*

/ /

SECTION XIII: WITNESSES TO SIGNATURE

(TWO (2) WITNESS SIGNATURES ARE REQUIRED IF THE CLAIMANT SIGNED ITEM 12B WITH AN "X")

13A. SIGNATURE OF THE FIRST WITNESS *(If claimant signed above using an "X")*

13B. PRINTED NAME AND ADDRESS OF FIRST WITNESS

Name:

Address:

13C. SIGNATURE OF THE SECOND WITNESS *(If claimant signed above using an "X")*

13D. PRINTED NAME AND ADDRESS OF SECOND WITNESS

Name:

Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE *(NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)*

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED *(MM/DD/YYYY)*
	/ /

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

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

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestion about this form.

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 09/30/2026

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 on page 2. VA uses this form to determine eligibility for pension and aid and attendance benefits based on nursing home status. For more information you can contact us online through **Ask VA:** https://ask.va.gov, or call us toll-free at 1-800-827-1000 (TTY: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 checkbox 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 WEBSITE ADDRESS?

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

- A. EATING
- B. BATHING/SHOWERING
- C. TRANSFERRING IN OR OUT OF BED OR CHAIR
- D. DRESSING
- E. USING THE TOILET
- F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT, PLEASE CHECK THE BOX IF THE STATEMENT IS TRUE FOR THE FACILITY.

- THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
- THE FACILITY IS LICENSED
- THE FACILITY IS RESIDENTIAL
- THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)

- YES
- NO, Care is being provided by a third-party provider.
- NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each in-home provider complete an In-Home Attendant Worksheet.

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

/ /

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

/ / INDEFINITE

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

$, . PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the care recipient and the facility.

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

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

/ /

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, Medical Expense Report. In addition, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? *(Name of Care Recipient, either the Claimant or Dependent)*

2. WHO IS COMPLETING THIS WORKSHEET? *(In-Home Care Attendant or Agency Administrator, Provider)*

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL? *(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)*

YES NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

YES NO *(If "NO," skip to question 7)*

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

– –

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR

D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

A. SHOPPING B. FOOD PREPARATION C. NON-MEDICAL TRANSPORTATION

D. LAUNDERING E. USING TELEPHONE F. MANAGING FINANCES

G. HOUSEKEEPING H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? *(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)*

YES NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. *(MM/DD/YYYY)*

/ /

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

/ / INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

$. PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

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

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

/ /

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

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):

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

(3). WHAT ASSET WAS TRANSFERRED?

(4). WHO RECEIVED THE ASSET?

(5). RELATIONSHIP TO NEW OWNER

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

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)
__ __ - __ __ - __ __ __ __

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

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

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

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

7D.

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

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

(3). WHAT ASSET WAS TRANSFERRED?

(4). WHO RECEIVED THE ASSET?

(5). RELATIONSHIP TO NEW OWNER

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

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)
__ __ - __ __ - __ __ __ __

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

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

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

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

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?

☐ YES ☐ NO

9I. IF YES IN 9H, PROVIDE ANNUAL AMOUNT RECEIVED (If NO, skip to 9J)

$ ☐,☐☐☐,☐☐☐.☐☐

9J. CAN THE ANNUITY BE LIQUIDATED?

☐ YES ☐ NO

9K. IF YES IN 9J, PROVIDE THE SURRENDER VALUE (If NO, skip to Section X)

$ ☐,☐☐☐,☐☐☐.☐☐

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.