Department of Veterans Affairs

# NOTICE TO VETERAN OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR VETERANS NON SERVICE-CONNECTED PENSION BENEFITS

(This notice is applicable to veterans claims for: Non Service-Connected Pension • Non Service-Connected Pension with Aid and Attendance or Housebound Benefits • Benefits Based on a Veteran's Seriously Disabled Child)

Use this notice and the attached application to submit a claim for veterans non service-connected pension benefits. This notice informs you of the evidence necessary to substantiate your claim.

**Want your claim processed faster?** The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed and there is no risk to participate! To participate in the FDC Program, if you are making a claim for veterans non service-connected pension benefits, simply submit your claim in accordance with the "FDC Criteria" shown below. If you are making a claim for veterans disability compensation or related compensation benefits, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. If you are making a claim for survivor benefits, use VA Form 21-534EZ, *Application for DIC, Death Pension, and/or Accrued Benefits*. VA forms are available at www.va.gov/vaforms

**FDC Criteria** (Claim(s) for Veterans Non Service-Connected Pension Benefits)

1. Submit your claim on a signed and completed VA Form 21-527EZ, *Application for Pension* (attached).

2. Submit simultaneously with your claim:

   - All necessary income and net-worth information; **AND**
   - All, if any, relevant, private medical treatment records and an identification of any relevant treatment records available at a Federal facility, such as a VA medical center

   Special Circumstances

   Under the special circumstances shown below, you must also submit simultaneously with your claim:

   - **If claiming non service-connected pension with aid and attendance or housebound benefits,** a completed VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance,* and a completed VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance;*
   - **If claiming a child in school between the ages of 18 and 23,** a completed VA Form 21-674, *Request for Approval of School Attendance;*
   - **If claiming benefits for a seriously disabled (helpless) child,** all, if any, relevant, private medical treatment records for the child's pertinent disabilities.

3. Report for any VA medical examinations VA determines are necessary to decide your claim.

**The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed, and there is no risk to participate!** Participation in the FDC Program is optional and will not affect the quality of care you receive or the benefits to which you are entitled. If you file a claim in the FDC Program and it is determined that other records exist and VA needs the records to decide your claim, then VA will simply remove the claim from the FDC Program (Optional Expedited Process) and process it in the Standard Claim Process. See below for more information. If you wish to file your claim in the FDC Program, see FDC Program (Optional Expedited Process). If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process.

## WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession..

| FDC Program (Optional Expedited Process) | Standard Claim Process |
|---|---|
| You must:<br>• Submit your claim in accordance with the "FDC Criteria" (see page 1) | You must:<br>• If you know of evidence not in your possession and want VA to try to get it for you, give VA enough information about the evidence so that we can request it from the person or agency that has it<br><br>If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. ***It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.*** |

## HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

| FDC Program (Optional Expedited Process) | Standard Claim Process |
|---|---|
| VA will:<br>• Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain<br>• Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim | VA will:<br>• Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain<br>• Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim<br>• Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from State or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records or records from current or former employers |

## WHEN YOU SHOULD SEND WHAT WE NEED

| FDC Program (Optional Expedited Process) | Standard Claim Process |
|---|---|
| You must:<br>• Send the information and evidence simultaneously with your claim<br><br>If you submit additional information or evidence after you submit your "fully developed" claim, then VA will remove the claim from the FDC Program Expedited Process and process it in the Standard Claim Process. If we decide your claim before one year from the date we receive the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim. | You are strongly encouraged to:<br>• Send any information or evidence as soon as you can<br><br>You have up to one year from the date we receive the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we receive the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim. |

## WHERE TO SEND INFORMATION AND EVIDENCE

Mail or take your application and any evidence in support of your claim to the closest VA regional office. VA regional office addresses are available on the Internet at www.va.gov/directory.

## WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

| If you are claiming... | See the evidence table titled... |
|---|---|
| Non Service-connected needs-based benefits (pension) | Non Service-Connected Pension |
| Increased pension benefits because your disabilities cause you to be in need of aid and attendance or to be confined to your residence | Non Service-Connected Pension with Aid and Attendance or Housebound Benefits |
| Benefits because your child is severely disabled | Helpless Child |

## EVIDENCE TABLES

### Non Service-Connected Pension

To support a claim for non **service-connected pension**, the evidence must show:

1. You met certain minimum requirements regarding active service during a period of war. Generally, those requirements involve:

   - 90 days of consecutive service at least one day of which was during a period of war; **OR**
   - 90 days of combined service during at least one period of war:

   ***(Note: If your service began after September 7, 1980, additional length of service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligation)***

   - **OR**, any length of active service during a period of war with a discharge due to a service-connected disability

2. You are age 65 or older *or* are permanently and totally disabled. You are considered permanently and totally disabled if medical evidence shows you are:

   - A patient in a nursing home for long-term care; **OR**
   - Receiving Social Security disability benefits; **OR**
   - Unemployable due to a disability reasonably certain to continue throughout your lifetime; **OR**
   - Suffering from a disability that is reasonably certain to continue throughout your lifetime that would make it impossible for an average person to follow a substantially gainful occupation; **OR**
   - Suffering from a disease or disorder that VA determines causes persons who have that disease or disorder to be permanently and totally disabled

3. Your net worth and income do not exceed certain requirements.

### Non Service-Connected Pension with Aid and Attendance or Housebound Benefits

To support a claim for non **increased disability pension benefits based on the need for aid and attendance**, the evidence must show:

- You have corrected vision of 5/200 or less in both eyes; **OR**
- You have contraction of the concentric visual field to 5 degrees or less; **OR**
- You are a patient in a nursing home due to mental or physical incapacity; **OR**
- You require the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment; **OR**
- You are bedridden, in that your disability requires that you remain in bed apart from any prescribed course of convalescence or treatment

To support your claim for **increased disability pension benefits based on being housebound**, the evidence must show:

- You have a single permanent disability evaluated as 100 percent disabling; **AND** due to such disability, you are permanently and substantially confined to your immediate premises; **OR**
- You have significant additional disability (rated 60% or higher) in addition to any disability necessary to establish pension eligibility

**Helpless Child**

To support a claim for **benefits based on a veteran's child being helpless**, the evidence must show that the child, before his or her 18th birthday, became permanently incapable of self-support due to a mental or physical disability.

**IMPORTANT**

If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later datewhen you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognized marriages is available at http://www.va.gov/opa/marriage/.

**How VA Determines the Effective Date**

If we grant your claim, the beginning date of your entitlement will generally be based on when we received your claim.

Higher levels of non service-connected pension may be assigned for disabilities that affect your ability to perform certain activities of daily living or the ability to leave your home. Higher levels of pension may be effective from the date the medical evidence first shows entitlement.

For more information on the FDC Program, visit our web site at http://benefits.va.gov/transformation/fastclaims/.
For more information on VA benefits, visit our web site at www.va.gov, contact us at http://iris.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.
VA forms are available at www.va.gov/vaforms.

**IMPORTANT**

If you wish to make a claim for veterans **disability compensation and/or related compensation benefits**, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. VA forms are available at www.va.gov/vaforms. If you cannot access this form, write the words "Will claim compensation - send VA Form 21-526EZ" under Item 9 or at the top of the attached application and VA will send you the form.

OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 4/30/2016

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

# APPLICATION FOR PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 8 before completing the form.

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

| 1. VETERAN'S NAME (Last, first, middle) | 2. SOCIAL SECURITY NUMBER | 3. DATE OF BIRTH (MM,DD,YYYY) |
|---|---|---|
| | | |

| 4. SEX | 5. HAVE YOU EVER FILED A CLAIM WITH VA? | 6. VA FILE NUMBER |
|---|---|---|
| ☐ MALE ☐ FEMALE | ☐ YES ☐ NO (If "Yes," provide your file number in Item 6) | |

| 7A. MAILING ADDRESS | 7B. TELEPHONE NUMBERS (Include Area Code) |
|---|---|
| Street address, rural route, or P.O. Box Apt. number | DAYTIME ( ) |
| | EVENING ( ) |
| City State ZIP Code Country | CELL PHONE ( ) |

| 8A. PREFERRED E-MAIL ADDRESS (If applicable) | 8B. ALTERNATE E-MAIL ADDRESS (If applicable) |
|---|---|
| | |

9. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING?

| A. DISABILITY(IES) | B. DATE DISABILITY(IES) BEGAN |
|---|---|
| | |
| | |

10. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES

| A. NAME AND LOCATION OF VA MEDICAL CENTER | B. DATE(S) OF TREATMENT |
|---|---|
| | |
| | |

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

| 11A. DID YOU SERVE UNDER ANOTHER NAME? | 11B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER |
|---|---|
| ☐ YES (If "Yes," complete Item 11B) ☐ NO (If "No," skip to Item 12A) | |

| 12A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY) | 12B. BRANCH OF SERVICE | 12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE |
|---|---|---|
| | | |

| 12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? | 12E. PLACE OF LAST OR ANTICIPATED SEPARATION |
|---|---|
| ☐ YES ☐ NO | |

| 13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. (National Guard)? | 13B. DATE OF ACTIVATION (MM,DD,YYYY) |
|---|---|
| ☐ YES ☐ NO (If "Yes," provide date of activation in Item 13B) | |

| 14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT? | 14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? (Include Area Code) |
|---|---|
| | ( ) |

| 15A. HAVE YOU EVER BEEN A PRISONER OF WAR? | 15B. DATES OF CONFINEMENT ON (MM,DD,YYYY) |
|---|---|
| ☐ YES ☐ NO (If "Yes," complete Item 15B) (If "No," skip to Item 16A) | From: To: |

| 16A. DID YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE RETIRED PAY? | 16B. LIST AMOUNT (If known) | 16C. LIST TYPE (If known) |
|---|---|---|
| ☐ YES ☐ NO (If "Yes," complete Items 16B and 16C) | $ | |

## SECTION III: VETERAN'S WORK HISTORY *(MUST COMPLETE)*

***NOTE:** In the table below, tell us about all of your employment, including self-employment, for **one** year before you became disabled to the present.*

| 17A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER? | 17B. WHAT WAS YOUR JOB TITLE? | 17C. WHEN DID YOUR JOB BEGIN? | 17D. WHEN DID YOUR JOB END? | 17E. HOW MANY DAYS WERE LOST DUE TO DISABILITY? | 17F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS? |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |

## SECTION IV: MARITAL STATUS *(MUST COMPLETE)*

18A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED (Skip to Section VI if never married)

**TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES**

18B. HOW MANY TIMES HAVE YOU BEEN MARRIED (including current marriage)?

| 19A. DATE (month, day, year) AND PLACE OF MARRIAGE (city/state or country) | 19B. TO WHOM MARRIED (first, middle, last name) | 19C. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other) | 19D. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated) | 19E. DATE (month, day, year) AND PLACE MARRIAGE TERMINATED (city/state or country) |
|---|---|---|---|---|
| | | | | |
| | | | | |

19F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 19C, PLEASE EXPLAIN:

## SECTION V: CURRENT MARITAL INFORMATION *(COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)*

**Note** - Skip to Section VI if not currently married.

**TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES**

20. HOW MANY TIMES HAS YOUR SPOUSE BEEN MARRIED (including current marriage)?

| 21A. DATE (month, day, year) AND PLACE OF MARRIAGE (city/state or country) | 21B. TO WHOM MARRIED (first, middle, last name) | 21C. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other) | 21D. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated) | 21E. DATE (month, day, year) AND PLACE MARRIAGE TERMINATED (city/state or country) |
|---|---|---|---|---|
| | | | | |
| | | | | |

21F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21C, PLEASE EXPLAIN:

| 22A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (month, day, year) | 22B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER? | 22C. IS YOUR SPOUSE ALSO A VETERAN? ☐ YES ☐ NO | 22D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (if any)? |
|---|---|---|---|
| | | | |

22E. DO YOU LIVE WITH YOUR SPOUSE?

☐ YES ☐ NO (If "Yes," skip to Section VI) (If "No," complete Items 22F - 22H)

22F. WHAT IS YOUR SPOUSE'S ADDRESS? (Number and street or rural route, city or P.O., State, ZIP Code and country)

22G. TELL US THE REASON WHY YOU ARE NOT LIVING WITH YOUR SPOUSE (i.e.; illness, work, etc.)

22H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT?

$

## SECTION VI: DEPENDENT CHILDREN *(COMPLETE IF YOU HAVE DEPENDENT CHILDREN)*

**Note** - Skip to Section VII if you have no dependent children.

| 23A. NAME OF DEPENDENT CHILD (First, middle initial, last) | 23B. DATE AND PLACE OF BIRTH (city, state or country) | 23C. SOCIAL SECURITY NUMBER | *(Check all that apply)* 23D. BIOLOGICAL | 23E. ADOPTED | 23F. STEPCHILD | 23G. 18-23 YEARS OLD (in school) | 23H. SERIOUSLY DISABLED | 23I. CHILD MARRIED | 23J. CHILD PREVIOUSLY MARRIED |
|---|---|---|---|---|---|---|---|---|---|
| | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Note** - In Items 24A through 24D, tell us about the children listed in Item 23A who ***do not*** live with you.

| 24A. NAME OF DEPENDENT CHILD (First, middle initial, last) | 24B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country) | 24C. NAME OF PERSON THE CHILD LIVES WITH (If applicable) | 24D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |

## SECTION VII: INCOME VERIFICATION - NET WORTH *(MUST COMPLETE)*

25. **NET WORTH** (DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")

Report total net worth for your household. You must report your net worth and the net worth of your dependents (spouse, child, etc.), if any. Identify the ***specific*** owner for each net worth source, yourself or another person in your household, as applicable.

| SOURCE | AMOUNT | OWNER | SOURCE | AMOUNT | OWNER |
|---|---|---|---|---|---|
| CASH/NON-INTEREST BEARING BANK ACCOUNTS | $ | | REAL PROPERTY *(Not your home, vehicle, furniture, or clothing)* | $ | |
| INTEREST-BEARING BANK ACCOUNTS | $ | | ALL OTHER PROPERTY *(Please write source)* | $ | |
| IRA'S, KEOGH PLANS, ETC. | $ | | ALL OTHER PROPERTY *(Please write source)* | $ | |
| STOCKS, BONDS, MUTUAL FUNDS, ETC. | $ | | OTHER *(Provide source)* | $ | |

## SECTION VIII: INCOME VERIFICATION - MONTHLY INCOME *(MUST COMPLETE)*

26. **GROSS MONTHLY INCOME** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report total monthly income for your household. You must report your income and the income of your dependents (spouse, child, etc.), if any. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable.

| SOURCE | AMOUNT | RECIPIENT | SOURCE | AMOUNT | RECIPIENT |
|---|---|---|---|---|---|
| SOCIAL SECURITY | $ | | SERVICE RETIREMENT | $ | |
| SOCIAL SECURITY | $ | | SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE | $ | |
| U.S. CIVIL SERVICE | $ | | OTHER *(Provide source)* | $ | |
| U.S. RAILROAD RETIREMENT | $ | | OTHER *(Provide source)* | $ | |
| BLACK LUNG BENEFITS | $ | | OTHER *(Provide source)* | $ | |

## SECTION IX: EXPECTED INCOME *(MUST COMPLETE)*

27. **EXPECTED INCOME - NEXT 12 MONTHS** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report expected total household income for the next 12 months. You must report your expected income and the expected income of your dependents (spouse, child, etc.), if any. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable.

| SOURCE | AMOUNT | RECIPIENT | SOURCE | AMOUNT | RECIPIENT |
|---|---|---|---|---|---|
| GROSS WAGES AND SALARY | $ | | OTHER INCOME EXPECTED *(Provide source)* | $ | |
| GROSS WAGES AND SALARY | $ | | OTHER INCOME EXPECTED *(Provide source)* | $ | |
| TOTAL DIVIDENDS AND INTEREST | $ | | OTHER INCOME EXPECTED *(Provide source)* | $ | |

## SECTION X: MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES *(MUST COMPLETE)*

28. MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES (IF NONE WRITE "0" OR "NONE")

Report your family medical expenses and certain other expenses actually paid by you that may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction you paid 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 paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. ***Do not include any expenses for which you were reimbursed.***

| AMOUNT PAID BY YOU | DATE PAID (mm/dd/yy) | PURPOSE (Doctor's fees, hospital charges, attorney fees, tuition, education materials, etc.) | PAID TO (Name of doctor, hospital, pharmacy, etc.) | RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.) |
|---|---|---|---|---|
| $ | | | | |
| $ | | | | |
| $ | | | | |
| $ | | | | |

## 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. Please attach a voided personal check or deposit slip or provide the information requested below in Items 29, 30, and 31 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. 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.

29. 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.:_____ Account No.:_____

| 30. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit) | 31. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check) |
|---|---|
| | |

## 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 and I 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 Non-Service Connected 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 32, 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.

32. 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.

| 33A. VETERAN'S SIGNATURE (REQUIRED) | 33B. DATE SIGNED |
|---|---|
| | |

## SECTION XIII: WITNESSES TO SIGNATURE *(MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 33A WITH AN "X")*

| 34A. SIGNATURE OF WITNESS (If veteran signed above using an "X") | 34B. PRINTED NAME AND ADDRESS OF WITNESS |
|---|---|
| | |
| **35A. SIGNATURE OF WITNESS (If veteran signed above using an "X")** | **35B. PRINTED NAME AND ADDRESS OF WITNESS** |
| | |

**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 Vocational Rehabilitation 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 obligation to respond 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 25 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 Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 5-31-2018

Department of Veterans Affairs

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

| 1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN | 2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT | 3. RELATIONSHIP OF CLAIMANT TO VETERAN |
|---|---|---|
| | | |

| 4A. VETERAN'S SOCIAL SECURITY NUMBER | 4B. CLAIMANT'S SOCIAL SECURITY NUMBER | 5. CLAIM NUMBER |
|---|---|---|
| | | |

| 6. DATE OF EXAMINATION | 7. HOME ADDRESS |
|---|---|
| | |

| 8A. IS CLAIMANT HOSPITALIZED? ☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)* | 8B. DATE ADMITTED | 9. NAME AND ADDRESS OF HOSPITAL |
|---|---|---|
| | | |

**NOTE: EXAMINER PLEASE READ CAREFULLY**

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person.

The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable.

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 he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

| 11A. AGE | 11B. SEX | 12. WEIGHT ACTUAL: LBS. ESTIMATED: LBS. | 13. HEIGHT FEET: INCHES: |
|---|---|---|---|
| | | | |

| 14. NUTRITION | 15. GAIT |
|---|---|
| | |

| 16. BLOOD PRESSURE | 17. PULSE RATE | 18. RESPIRATORY RATE | 19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS? |
|---|---|---|---|
| | | | |

20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*

☐ YES ☐ NO

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

| 24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)* ☐ YES ☐ NO | 24B. CORRECTED VISION | |
|---|---|---|
| | LEFT EYE | RIGHT EYE |
| | | |

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*

☐ YES ☐ NO

26. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*

☐ YES ☐ NO

28. POSTURE AND GENERAL APPEARANCE *(Attach a separate sheet of paper if additional space is needed)*

29. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE *(Attach a separate sheet of paper if additional space is needed)*

30. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

32. SET FORTH 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 CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

33. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

34. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? *(If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)*

☐ YES

☐ NO *(If "YES," give distance) (Check applicable box or specify distance)* ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

| 35A. PRINTED NAME OF EXAMINING PHYSICIAN | 35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN | 35C. DATE SIGNED |
|---|---|---|
| | | |

| 36A. NAME AND ADDRESS OF MEDICAL FACILITY | 36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)* |
|---|---|
| | |

**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 Vocational Rehabilitation Records - VA, and 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 pate 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 Approved No: 2900-0652
RESPONDENT BURDEN: 10 Minutes

| Department of Veterans Affairs | REQUEST FOR NURSING HOME INFORMATION IN CONNECTION WITH CLAIM FOR AID AND ATTENDANCE | VA DATE STAMP (Do Not Write In This Space) |
|---|---|---|

INSTRUCTIONS: For free help in completing this form, call VA toll-free at 1-800-827-1000. (Hearing Impaired TDD line 1-800-829-4833.)

## Section I - IDENTIFICATION INFORMATION

| 1A. NAME OF NURSING HOME | 1B. ADDRESS OF NURSING HOME |
|---|---|
| | |

2. ADDRESS OF VA REGIONAL OFFICE

3. FIRST NAME - MIDDLE INITIAL- LAST NAME OF CLAIMANT

| 4. SOCIAL SECURITY NUMBER | 5. VA FILE NUMBER |
|---|---|
| | |

## SECTION II - NURSING HOME INFORMATION *(To be completed by a Nursing Home Official)*

| 6. DATE ADMITTED TO NURSING HOME *(Month, Day, Year)* | 7. DATE MEDICAID BEGAN *(Month, Day, Year)* |
|---|---|
| | |

8. AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET

$

9. 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

10. NURSING HOME OFFICIAL'S NAME *(First & Last) (Please print)*

| 11. NURSING HOME OFFICIAL'S TITLE *(Please print)* | 12. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)* |
|---|---|
| | |

| 13A. SIGNATURE OF NURSING HOME OFFICIAL | 13B. DATE SIGNED |
|---|---|
| | |

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 5, Code of Federal Regulations 1.526 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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.