Aid & Attendance Guide

Updated for 2026 • In-Home Care Edition

A practical resource to help Veterans and surviving spouses understand and access the VA Aid & Attendance pension benefit.

COMFORT KEEPERS®
Proud National VA Provider

Prepared by:
Comfort Keepers of Central and Southern New Jersey
(732) 530-3636

Elevating the Human Spirit® through comfort, compassion, and care.

This guide was developed to support Veterans and surviving spouses in navigating the Aid & Attendance benefit and understanding how it can help pay for in-home care.

Comfort Keepers®

Dear Veterans and families,

Thank you for your service, sacrifice, and commitment to our nation. At Comfort Keepers, we are honored to serve those who have served us. We recognize that navigating the Department of Veterans Affairs (VA) system—especially when it comes to financial benefits such as the Aid & Attendance (A&A) pension—can feel confusing and overwhelming.

This booklet was created to provide a clear, step-by-step overview of what Aid & Attendance is, who may qualify, and how the benefit can help pay for in-home care. Our goal is to support you in remaining safe, independent, and comfortable in your own home, with the personal care and companionship you deserve.

This guide is for educational purposes only. It does not replace legal, tax, or financial advice, and it does not substitute for the guidance of a VA-accredited representative. However, it can help you understand your options and prepare for conversations with the VA, your healthcare providers, and your care team.

With respect and gratitude,

The Comfort Keepers® Team

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1. What Is VA Aid & Attendance?

Understanding this important pension enhancement.

Aid & Attendance (A&A) is an increased tax-free monthly payment added to a Veteran's or surviving spouse's VA pension when they need help with everyday personal care. A&A is not a standalone benefit—it is an enhancement to the VA pension for those who qualify and who require regular assistance with activities of daily living. A&A pays the Veteran, couple or surviving spouse directly.

If you are not receiving the VA Pension and are eligible you can apply for both the VA Pension and Aid & Attendance at the same time in a single application.

Aid & Attendance can be used for in-home care services such as:

- Personal care (bathing, dressing, grooming, toileting)
- Mobility and transfer assistance
- Meal preparation
- Medication reminders
- Supervision and safety monitoring
- Memory loss and dementia-related care
- Light housekeeping and companionship
- Respite care to relieve family caregivers

You do *not* need a service-connected disability rating to qualify.

Eligibility is based on:

1. Wartime service
2. Medical need
3. Financial criteria

Comfort Keepers IN HOME CARE

2. Who May Qualify?

Service, medical, and financial requirements.

A. Service Eligibility

The Veteran must have:

- Service before Sept. 8, 1980: Have served at least 90 days of active duty with at least 1 day during wartime.
- Enlisted service after Sept. 7, 1980: Have served at least 24 months or the full period for which you were called or ordered to active duty (with some exceptions) with at least 1 day during wartime.
- Officer service after Oct. 16, 1981: Started active duty after this date and you hadn't previously served on active duty for at least 24 months.
- Possess a discharge other than dishonorable

B. Medical Eligibility

The Veteran or surviving spouse must require regular assistance, such as:

- Needing help with two or more Activities of Daily Living (ADLs)
- Needing supervision for dementia or cognitive impairment
- Residing in a nursing home
- Being blind or nearly blind (even with glasses or contact lenses you have only 5/200 or less in both eyes; or concentric contraction of the visual field to 5 degrees or less)

C. Financial Eligibility

The VA evaluates:

- Income
- Assets
- Unreimbursed medical expenses (including Comfort Keepers in-home care)

Net worth must be below the VA limit. The current net worth limit to be eligible is $163,699.

3. VA-Recognized Wartime Periods

For VA pension purposes, the following wartime service periods are recognized:

- **World War II**: Dec 7, 1941 – Dec 31, 1946
- **Korean War**: June 27, 1950 – Jan 31, 1955
- **Vietnam War**:
  - Nov 1, 1955 – May 7, 1975 (served in the Republic of Vietnam)
  - Aug 5, 1964 – May 7, 1975 (served elsewhere outside the Republic of Vietnam)
- **Gulf War**: Aug 2, 1990 – present (end date to be set by law or presidential proclamation)

At least one day of the Veteran's active-duty service must fall within a recognized wartime period in order to meet basic pension eligibility.

4. Activities of Daily Living (ADLs)

The VA focuses on how much help you need with core Activities of Daily Living, such as:

- Bathing – getting in/out, washing, grooming
- Dressing – putting clothes on or taking them off
- Eating – cutting food or bringing food to your mouth
- Toileting – getting to the bathroom and cleaning up
- Transferring – moving safely (bed, chair, walking)
- Continence – managing bladder or bowel needs

Needing regular hands-on help or supervision with two or more ADLs is a strong indicator that Aid & Attendance may be appropriate. Conditions such as dementia, Parkinson's disease, stroke, or severe arthritis often lead to these needs.

Relevant Form:
VA Form 21-2680 – Examination for Housebound Status or Permanent Need for Regular Aid & Attendance

VA Form 21-2680 is completed by a licensed healthcare provider and documents the Veteran's or surviving spouse's diagnoses, limitations, and need for personal care. The VA uses this form as key medical evidence when deciding whether to grant Aid & Attendance.

Comfort Keepers can provide a written care summary—including ADLs assisted, frequency of visits, and safety concerns—that the provider may reference when completing VA Form 21-2680.

VA Form 21-2680

FEB 2023

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

Department of Veterans Affairs

VA DATE STAMP
(DO NOTWRITEINTHISSPACE)

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: CLAIMANT'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 VeteransPension or Survivors benefits.

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

14A. IS THE CLAIMANT HOSPITALIZED?

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

☐ NO (If "NO," skip to Section V)

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

__ – __ – ____

14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

SECTION V: CERTIFICATION AND SIGNATURE

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

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

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

__ – __ – ____

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

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

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

__ – __ – ____

NOTE: EXAMINER PLEASE READ CAREFULLY

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

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

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

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

19A. AGE ___

19B. WEIGHT — ACTUAL LBS. ___ ESTIMATED LBS. ___

19C. HEIGHT — 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
- ☐ EATING OR SELF-FEEDING
- ☐ DRESSING
- ☐ AMBULATING WITHIN THE HOME OR LIVING AREA
- ☐ TENDING TO HYGIENE NEEDS
- ☐ TRANSFERRING IN OR OUT OF BED/CHAIR
- ☐ TOILETING
- ☐ MEDICATION MANAGEMENT
- ☐ ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below)

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.

5. Financial Eligibility & Net Worth Limit

The VA considers both household income and assets when determining eligibility for VA pension and Aid & Attendance. The combined total is called net worth. The VA publishes a net worth limit that applies to all pension claimants.

Countable assets generally include:

- Checking and savings accounts
- Certificates of deposit and money market funds
- Stocks, bonds, and mutual funds
- Real estate other than your primary residence
- Retirement accounts (IRA, 401(k), etc.), depending on access and withdrawals

Generally not counted as assets:

- Primary residence (within certain lot size limits)
- Primary vehicle
- Basic personal belongings and household goods

The VA also applies a three-year “look-back” period for certain asset transfers. Gifts or transfers made below fair market value during this period can sometimes result in a penalty period during which pension cannot be paid.

Relevant Form:
VA Form 21P-0969 – Income, Asset, and Transfer Statement

VA Form 21P-0969 is used to provide detailed information about household income, assets, and transfers. It is commonly required when the financial situation is more complex or when additional documentation is needed to evaluate net worth.

VA Form 21P-0969

NOV 2023

Department of Veterans Affairs

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

This form should be used to report or verify income and/or net worth. Changes to income and net worth over multiple years must be reported on a separate VA Form 21P-0969 for each year. Changes to dependents and medical expenses may impact your benefits. Submit the following forms if you need to update dependent or medical expense information.

- To update dependents, submit VA Form 21-686c, *Application Request to Add and/or Remove Dependents.*
- To update medical expenses, submit VA Form 21P-8416, *Medical Expense Report.*

INFORMATION FOR CLAIMANTS

NOTE:The term assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of your or your dependents' primary residence including the residential lot area, not to exceed 2 acres); less the amount of mortgages or other (specify) encumbrances specific to the mortgages or encumbered property. Personal property means the value of personal effects that are in excess of being suitable consistent with a reasonable mode of life. There is a space on your initial application form to provide the value of the portion of your primary residence that exceeds 2 acres.

If you are a **Veteran**, you must report income and assets for:

- Yourself
- Your spouse (**unless** you live apart, **and** you are estranged, **and** you do not contribute to your spouse's support)
- Your child or children (**unless** you do not have custody,* **and** you do not contribute to your child's or children's support)

If you are a **Surviving Spouse**, you must report income and assets for:

- Yourself
- Your child or children (**unless** you do not have custody,* **and** you do not contribute to your child's or children's support)

If you are a **Surviving Child** or the **Custodian of a Surviving Child**, you must report income and assets for:

- Yourself and/or the surviving child
- Child's custodian (unless the child's custodian is an institution)
- Custodian's spouse

If you are a **Parent**, you must report income for**:

- Yourself
- Your spouse (even if your spouse is the veteran's other parent. If your spouse is the veteran's other parent, you should file separate claims.)

* Child custody for pension purposes is defined in 38 C.F.R. § 3.57(d). A natural or adoptive parent has custody of a child unless custody is legally removed. For pension purposes, a child who has attained age 18 remains in the custody of the person who had custody before the child turned 18 unless custody is legally removed.

** Parents' D.I.C. claimants do **not** need to report or provide documentation of their assets.

THIS FORM IS COMPRISED OF 14 SECTIONS. BE SURE TO ANSWER THE QUESTION(S) IN EACH SECTION AS REQUIRED.

SECTION I: VETERAN'SIDENTIFICATIONINFORMATION
SECTION II: CLAIMANT'SIDENTIFICATIONINFORMATION
SECTION III: RECURRINGINCOMENOTASSOCIATEDWITH ACCOUNTS OR ASSETS
SECTION IV: INCOME ANDNETWORTHASSOCIATEDWITH FINANCIAL ACCOUNTS
SECTION V: INCOME ANDNETWORTHASSOCIATEDWITH OWNED ASSETS
SECTION VI: INCOME ANDNETWORTHASSOCIATEDWITH ROYALTIES AND OTHERPROPERTIES
SECTION VII: ASSET TRANSFERS
SECTION VIII: TRUSTS
SECTION IX: ANNUITIES
SECTION X: ASSETSPREVIOUSLY NOT REPORTED
SECTION XI: DISCONTINUEDORIRREGULAR INCOME
SECTION XII: WAIVEROFRECEIPT INCOME
SECTION XIII: CERTIFICATIONAND SIGNATURE
SECTION XIV: WITNESS TO SIGNATURE

INSTRUCTIONS FOR INDIVIDUAL SECTIONS

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS

This section is for reporting all income not attached to a physical asset, financial account or other type of net worth. Income generated from assets will be captured in other sections of this form. Examples of income not associated with accounts or assets may include:

- Pensions (Pension received from the Philippine Veterans Affairs Office (PVAO) is reportable income for VA Pension)
- Military Retirement
- Private Retirement
- Social Security Income
- Civil Service Retirement
- Black Lung Benefits
- Railroad Retirement Benefits
- Wages
- Unemployment Benefits

NOTE: If submitting this form with an initial application, do not report income(s) previously reported on your application (VA Form 21P-527EZ or VAForm 21P-534EZ.)

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS

This section is for reporting assets not related to property that generates income. Examples of income and net worth associated with accounts may include:

- Savings Bonds
- Stocks and Dividends
- Annuities
- Interest Earning Accounts (Checking, Savings, etc)
- Individual Retirement Account (IRA) Distributions (Including RMDs)
- Pension Plans with Cash Value (Employee, SEP, etc)

SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS

This section is for reporting physical assets that generate income. These assets may be partially owned by third parties. Only report the portion of the asset that you own. When reporting the asset value of your portion of the property within this section, you may subtract from the reported value any mortgage or other encumbrance that you still owe for each, if applicable. Examples of current income and net worth associated with owned assets may include:

- Rental Property
- Farm Earnings
- Business Earnings

Additional documentation may be required for each of the following income sources:

- Property assets may require submission of a statement showing the fair market value (not an evaluation for property taxes, as appraisal from a licensed appraiser, realtor, or an established online estimation tool is preferred).
- If you are in receipt of income from a:
  - Farm - You must submit VA Form 21P-4165, *Pension Claim Questionnaire for Farm Income.*
  - Business or a rental property - You must submit VA Form 21P-4185, *Report of Income from Property or Business.*

SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES

This section is for reporting income generated from royalties and other owned assets. For these types of assets, you may submit any documentation you have demonstrating the sell-ability, value and income of the asset. Examples of income generated from royalties and other properties include:

- Intellectual Property Royalties (i.e., Acting, Written Works, Invention)
- Mineral Royalties
- Other Land Use

SECTION VII: ASSETS TRANSFERS

This section is for clarifying the specific details of any applicable asset transfers. If income is received from the sale of a asset, in addition to reporting the details of the transfer in this section, ensure the remaining proceeds (if any) are reported as part of your assets within the other appropriate sections of this form.

- Sold - Exchange of property ownership for monetary benefit
- Traded - Exchange of property ownership for alternative property
- Gave Away - Exchange of property ownership without benefit
- Conveyed - Exchange of property ownership through a legal process

NOTE: A transfer for less than fair market value means you disposed of an asset for less than the asset was worth.

SECTION VIII: TRUSTS

This section is for reporting aspects of trusts to include possible income(s), value and controlling interest. Trusts may be countable as an asset and may generate income depending on the terms of the 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 additional trust established. Provide the following additional evidence for each trust:

- Initial contract from your financial institution establishing the trust
- Current statement showing surrender value and monthly payments
- Schedule of Assets must be included

SECTION IX: ANNUITY

This section is for reporting annuity benefits. If additional space is needed due to ownership of multiple annuities, submit VA Form 21-4138, *Statement in Support of Claim,* with the information requested in this section for each additional annuity. You may need to submit the following evidence for each annuity:

- Initial contract from your financial institution establishing the annuity
- Current statement showing surrender value and monthly payments

SECTION X: ASSETS PREVIOUSLY NOT PREPORTED

This section is for reporting any assets that have not been reported previously. For proceeds from asset transfers identified in Section VI, only include assets that you still have access to (not spent). Examples of assets that may not have been reported previously include:

- Non-Interest-Bearing Accounts
- Collectible Valuables
- Real Estate
- Cash

SECTION XI: DISCONTINUED OR IRREGULAR INCOME

This section is for reporting all discontinued or irregular income received during the period reported in question 2E. If this form is submitted with your initial claim, submit information pertaining to the previous calendar years. You may need to submit copies of closed account documents, or current statements showing non-receipt of income such as a bank statement with no generated interest. Examples of discontinued or irregular income include:

- Discontinued Wages
- Interest or Dividends from Depleted Accounts
- Unemployment Income
- Lottery or Gambling Winnings

These incomes are typically classified as:

- Recurring - Income that occurred at a regular interval
- One-Time - Income that only occurred once
- Irregular - Income received several times during the reporting period at irregular intervals or irregular amounts

SECTION XII: WAIVER OF RECEIPT OF INCOME

Waived income, or income you are entitled to receive but have chosen not to accept at this time is considered countable income for VA pension purposes. It is unlawful to waive of entitlement of any income to create a need for pension. Examples include:

- Deferred Compensation
- Life Insurance
- Legal Settlements

EXCEPTION: Waiving income from the Social Security Administration done so to get a higher amount of SSA by waiting longer is allowed.

NOTICE

FEES FOR CLAIMS : Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

IMPORTANT: VA will compare the information you report on this form to Internal Revenue Service (IRS) and Social Security Administration (SSA) records to verify your income for the past three tax years for which information is available. Information from the IRS or SSA that conflicts with the income information you provide with your application may delay your claim and/or reduce your benefit amount.

PRIVACY ACT NOTICE: 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 response is required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

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 suggestions about this form.

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

Department of Veterans Affairs

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

First: MI: Last:

1B. VETERAN'S SOCIAL SECURITY NUMBER

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

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION

(If youare the Veteran,skipquestions 2A and2B)

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 earliest 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 *((MM/DD/YYYY) THROUGH (MM/DD/YYYY))*:

THROUGH -OR- ☐ DATE RECEIVED BY VA *(For initial claims only.)*

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS

(See instructions onPage 2)

3A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTINGTORECEIVEANYINCOMEINTHE 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 onPage 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 ofbusiness,financialinstitution,orprogram,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 onPage 2)

4A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTINGTORECEIVEANYINCOMEINTHE 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 onPage 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 *(OnlyneededifCustodian 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 *(OnlyneededifCustodian 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 onPage 2)

5A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTINGTORECEIVEANYINCOMEINTHE 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)*

(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)*

(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 onPage 2)

6A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTINGTORECEIVEANYINCOMEANDNET 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 onPage 2)

7A. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DIDYOUORYOURDEPENDENTSSELL,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 onPage 2)

7C.

(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TOVETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER *(Specify)*:

(7).SPECIFYDATE OF TRANSFER *(MM/DD/YYYY)*

☐☐ – ☐☐ – ☐☐☐☐

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED

☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER *(Specify)*:

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?

☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

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

$ ☐☐,☐☐☐,☐☐☐.☐☐

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? *(If applicable)*

$ ☐☐,☐☐☐,☐☐☐.☐☐

(5). RELATIONSHIP TO NEW OWNER

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

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?

☐ YES ☐ NO

$ ☐☐,☐☐☐,☐☐☐.☐☐

7D.

(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER *(Specify)*:

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

☐☐ – ☐☐ – ☐☐☐☐

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED

☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER *(Specify)*:

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?

☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

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

$ ☐☐,☐☐☐,☐☐☐.☐☐

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? *(If applicable)*

$ ☐☐,☐☐☐,☐☐☐.☐☐

(5). RELATIONSHIP TO NEW OWNER

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

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?

☐ YES ☐ NO

$ ☐☐,☐☐☐,☐☐☐.☐☐

SECTION VIII: TRUSTS
(See instructions onPage 2)

8A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED A TRUSTORDOYOUORYOURDEPENDENTS HAVE ACCESS TO A TRUST? *(If you have more than one trusttoreport,submit theinformationona separateVAForm21P-0969orprovidetheinformationonVAForm21-4138foreachtrust 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 thanonedate,submitaVAForm 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 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 onPage 2)

9A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED AN ANNUITY? *(If you have morethanoneannuity to report, submit the information below on a separate VA Form21P-0969,orprovide thebelowinformationonVAForm21-4138 for each annuity established.)*

☐ YES ☐ NO *(If"NO," skiptoSectionX)*

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 onPage 2)

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

☐ 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)*:

(2). SPECIFY TYPE OF ASSET *(Cash, art, etc.)*

(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$ ☐☐☐,☐☐☐,☐☐☐.☐☐

(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)*:

(2). SPECIFY TYPE OF ASSET *(Cash, art, etc.)*

(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$ ☐☐☐,☐☐☐,☐☐☐.☐☐

(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)*:

(2). SPECIFY TYPE OF ASSET *(Cash, art, etc.)*

(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$ ☐☐☐,☐☐☐,☐☐☐.☐☐

(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)*:

(2). SPECIFY TYPE OF ASSET *(Cash, art, etc.)*

(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$ ☐☐☐,☐☐☐,☐☐☐.☐☐

(4). SPECIFY ASSET LOCATION *(Financial institution, property address,etc.)*

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

11A. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME THAT HAS STOPPEDORISNOLONGERBEING 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 *(OnlyneededifCustodian 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?
$ ☐☐☐, ☐☐☐. ☐☐

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

12A. DID YOU OR YOUR DEPENDENTS WAIVE OR EXPECT TOWAIVEANYRECEIPTOFINCOMEIN 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 *(OnlyneededifCustodian 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 andcorrect to the best of myknowledge and belief. **IUNDERSTAND 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 signaturesarerequiredif theclaimantsigneditem 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.

6. Benefit Amounts (MAPR) & Pension Calculation

The VA sets a Maximum Annual Pension Rate (MAPR) for different household types, including single Veterans, Veterans with a spouse, surviving spouses, and two-Veteran couples. When you qualify medically and financially, the VA compares your countable income to the MAPR and may pay the difference as a tax-free monthly pension.

In simplified terms, the VA's pension calculation looks like this:

Annual Pension = MAPR – (Household Income – Deductible Medical Expenses)

Deductible medical expenses may include in-home care costs paid to Comfort Keepers, certain health insurance premiums, Medicare premiums, and other unreimbursed medical costs. Because MAPR limits and net worth thresholds change periodically, always refer to the most recent tables on VA.gov or consult a VA-accredited representative.

Approximate 2026 Maximum Monthly Amounts

Veteran with no dependents	$**2,424**
Veteran with a spouse or dependent	$**2,874**
Surviving spouse	$**1,558**
Two married Veterans, both qualifying	$**3,845**

Effective December 1, 2025 through November 30, 2026. The net worth limit for the same period is $163,699. These are maximum rates, not the amount every household receives. Your actual benefit depends on countable income after unreimbursed medical expenses, including in-home care, are deducted. The VA sets the rates and decides eligibility. Current rates: va.gov/pension/veterans-pension-rates

Comfort Keepers. IN HOME CARE

7. Required Forms & Supporting Documents

This section summarizes the VA forms and personal documents commonly required when applying for a VA pension with Aid & Attendance.

Primary VA Pension Application Forms
For Veterans: VA Form 21P-527EZ – Application for Veterans Pension.
For Surviving Spouses or Dependents: VA Form 21P-534EZ – Application for Dependency and Indemnity Compensation (DIC), Survivors Pension, and Accrued Benefits.

These forms collect personal, service, and financial information, and they are the main applications used to establish eligibility for pension benefits, including Aid & Attendance when combined with medical evidence such as VA Form 21-2680.

Common Supporting Documents

- DD-214 or other discharge papers
- Marriage certificate (if applicable)
- Death certificate of the Veteran (for surviving spouse claims)
- Birth certificates or adoption records for dependent children (if relevant)
- Financial records: bank statements, income statements, and asset documentation
- Care-related invoices or estimates from Comfort Keepers and other providers

7. Required Forms & Supporting Documents (continued)

Other Helpful or Situational VA Forms

- VA Form 21-4138 – Statement in Support of Claim (used to clarify special circumstances).
- VA Form 21-0845 – Authorization to Disclose Personal Information to a Third Party.
- VA Form 21-0779 – Request for Nursing Home Information in Connection with Claim for Aid & Attendance (for nursing home residents).
- VA Form 24-0296 – Direct Deposit Enrollment.

VA Form 21P-527EZ

DEC 2025

NOTICE TO VETERAN OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR VETERANS PENSION BENEFITS

This notice provides information regarding the evidence necessary to substantiate a claim for:

- Veterans Pension (a needs-based income program for veterans)
- Special Monthly Pension
- Benefits Based on a Veteran's Seriously Disabled Child

If you are making a claim for:

Pension Benefits	Complete and submit VA Form 21P-527EZ, *Application for Veterans Pension*
Survivors Benefits	Complete and submit VA Form 21P-534EZ, *Application for D.I.C., Survivors Pension, and/or Accrued Benefits*
Supplemental Claim	Complete and submit VA Form 20-0995, *Decision Review Request: Supplemental Claim*

If you are not ready to submit a claim for Veterans Pension, please complete a VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or D.I.C.*, to protect your date of claim. If you complete the VA Form 21P-527EZ within one year of filing the VA Form 21-0966, your completed application will be considered filed as of the date VA receives the VA Form 21-0966.

VA forms are available at www.va.gov/vaforms.

For more information on Veterans Pension see https://www.va.gov/pension/eligibility/.

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)
You may wish to contact an accredited Veterans Service Officer (VSO) to assist you with your application. For a list of accredited Veterans Service Organizations, go to https://www.benefits.va.gov/vso/. You may also contact your state office of Veteran's Affairs at https://www.va.gov/statedva.htm. To assign a VSO as your power of attorney for the claims process, submit VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents
Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veterans Affairs at https://www.va.gov/ogc/apps/accreditation/index.asp. To assign a private attorney for the claims process, submit VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims: Generally, an accredited attorney or claims agent can ONLY charge claimants a fee after the VA has issued a decision on a claim. Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

WHEN TO USE THIS FORM

The attached application is needed to submit a claim for Veterans Pension. There are worksheets included to help verify care expenses if you claim them. Please leave items in a section blank if it does not apply to you.

THE APPLICATION HAS 14 SECTIONS			
SECTION I:	VETERAN'S IDENTIFICATION INFORMATION	SECTION IX:	QUESTIONS REGARDING INCOME AND ASSETS
SECTION II:	VETERAN'S CONTACT INFORMATION		
SECTION III:	VETERAN'S SERVICE INFORMATION	SECTION X:	INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES
SECTION IV:	PENSION INFORMATION		
SECTION V:	EMPLOYMENT HISTORY	SECTION XI:	DIRECT DEPOSIT INFORMATION
SECTION VI:	MARITAL STATUS	SECTION XII:	CLAIM CERTIFICATION AND SIGNATURE
SECTION VII:	PRIOR MARITAL HISTORY	SECTION XIII:	WITNESSES TO SIGNATURE
SECTION VIII:	DEPENDENT CHILDREN	SECTION XIV:	ALTERNATE SIGNER CERTIFICATION AND SIGNATURE

WHAT YOU NEED TO DO

Submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession. A substantially complete claim must contain: (1) The claimant's name; (2) Sufficient service information for VA to verify the claimed service, if applicable; (3) The benefit sought and any medical condition(s) on which it is based; (4) The claimant's signature; (5) A statement of income.

To get the quickest response, you must

1. Submit your claim on a signed and complete VA Form 21P-527EZ, *Application for Veterans Pension* (Attached)
2. Submit simultaneously with your claim (See special circumstances below):
   - All necessary income and asset 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.*******
   - Any additional forms and evidence as the situation requires. Special Circumstances below indicates the most common circumstances. The application and other VA Forms may require additional evidence.
3. Report for any VA medical examinations VA determines are necessary to decide your claim.

*****IMPORTANT:** If you are a veteran who is claiming pension and you are age 65 or older or determined to be disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application unless you are claiming Special Monthly Pension. Special Monthly Pension is an increased amount paid to individuals who, due to mental or physical disability, require the aid of another person to perform activities of daily living, are a patient in a nursing home, have severe visual problems, or are substantially confined to their home.

SPECIAL CIRCUMSTANCES (Additional Forms that may be needed to remain eligible)

VA Form 21P-0969, *Income and Asset Statement in Support Claim for Pension or Parents' D.I.C.*, may be required if you:

- Have multiple income sources
- Have more than $75,000 in Assets
- Additional forms as noted on the VA Form 21P-0969 may be required

If claiming Veterans Pension with Special Monthly Pension:

- Please have a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinic Nurse Specialist (CNS) complete VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*, **- OR -**
- If you are a patient in a nursing home, VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*.

If claiming a child:

- And they are in school between the ages of 18 and 23, a completed VA Form 21-674, *Request for Approval of School Attendance*
- If the child was adopted, please submit the adoption papers or amended birth certificate
- If claiming benefits for a child who became seriously disabled prior to reaching the age of 18, submit all, if any, relevant, private medical treatment records for the child's pertinent disabilities.

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

The VA will retrieve evidence on your behalf in some circumstances. If the VA is unable to retrieve the necessary evidence, we 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.

VA will:

• Retrieve relevant records from a Federal facility such as a VA medical center, that you adequately identify and authorize VA to obtain.

• Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim.

• 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 from current or former employers.

WHEN YOU SHOULD SEND WHAT WE NEED

You must:

- Send the information and evidence simultaneously with your claim.

You are strongly encouraged to:

- Send any information or evidence as soon as you can.

You have up to one year from the date we received 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.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See the evidence table titled...
Veterans Pension (a needs-based benefit)	• Military Service Verification
	• Veterans Pension
Special Monthly Pension	• Veterans Pension with Special Monthly Pension
Benefits because your child is severely disabled	• Child Permanently Incapable of self-support

EVIDENCE TABLES

Military Service Verification
To support your claim for Veterans Pension, your military service must be verified. The following evidence can be submitted to verify military service: • A photocopy of your DD Form 214 (or equivalent) for all periods of military service. You may request a copy of the DD Form 214 through the National Archives' National Personnel Records Center (NPRC) using SF180, *Request Pertaining to Military Records*, (available at https://www.archives.gov/veterans/military-service-records/standard-form-180.html) or through your local public custodian of records.
Fire Related Military Records As you may know, there was a fire at the National Archives and Records Administration on July 12, 1973, which destroyed approximately; • 80 percent of the records NPRC held for Veterans who were discharged from the Army between November 1, 1912, and January 1, 1960, and • 75 percent of the records NPRC held for Veterans with surnames beginning (alphabetically) with Hubbard and running through the end of the alphabet, and who were discharged from the Air Force between September 25, 1947, and January 1, 1964. If your military records were stored there on that date, they may have been destroyed in the fire. If you believe your military records may have been destroyed in the fire go to https:www.archives.gov/veterans/military-service-records for other methods to request military service records and to avoid delays in processing your claim. **Note**: The Veterans Benefits Administration (VBA) is no longer able to retrieve or return original documents submitted. Please **do not** submit original documents to the VA. They will not be returned.

Veterans Pension

To support a claim for Veterans Pension, the evidence must show:

1. You met certain minimum active service requirements during a period of war. Generally, those requirements are:
   - 90 days of service during a period of war; **OR**
   - 90 days of consecutive service at least one day of which was during a period of war; **OR**
   - 90 days of combined service during more than one period of war:
     (None: 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. Your disability or disabilities do not have to be related to your military service. You are considered permanently and totally disabled if medical evidence shows you are:
   - A patient in a nursing home for long-term care or medical foster home; **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 income and assets are within established limits. You must report income and assets for:
   - Yourself
   - Your spouse (unless you live apart and you are estranged, and you do not contribute to your spouse's support)
   - Your child/children (unless custody has been legally removed by a court and you do not contribute to your child's support or the child's income is not reasonably available to you).

   Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the primary residence including the residential lot area, not to exceed 2 acres unless the additional acreage is not marketable) less the amount or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

Veterans Pension with Special Monthly Pension

To support a claim for increased pension eligibility based on the need for aid and attendance, the evidence must show:

- You have corrected visual acuity of 5/200 or less in both eyes; **OR**
- You have concentric contraction of the visual field to 5 degrees or less; **OR**
- You are a patient in a nursing home due to mental or physical incapacity; **OR**
- You need the aid of another person to perform activities of daily living (ADLs), such as bathing or showering, dressing, eating, toileting, and transferring (e.g. getting in and out of bed); **OR**
- You require regular supervision because you are unsafe if you are left alone due to a mental disorder, **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 pension eligibility 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 a single permanent disability evaluated as 100 percent disabled, **AND** you have an additional disability or disabilities rated 60 percent or higher.

Child Permanently Incapable of Self-Support

The information necessary to establish the extent of the child's disability includes;

- The extent to which the child is and was, prior to reaching their 18th birthday, physically or mentally deficient, as evidenced by factors such as their ability to perform self-care functions, and ordinary tasks expected of a child of that age
- Whether or not the child attended school and, if so, the maximum grade attended
- If any material improvement in the child's condition has occurred
- If the child has ever been employed and, if so, the nature and dates of such employment, and amount of pay received
- Whether or not the child has ever married, and
- A description of the child's present condition.

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 date when 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 or when we received an intent to file (ITF) for pension, if your completed application is received within a year of the ITF.

Special monthly pension may be assigned for disabilities that affect your ability to perform certain activities of daily living or the ability to leave your home. Special monthly pension may be effective from the date the medical evidence first shows entitlement.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

When you have completed this application, you can either submit it online or mail it to the Pension Intake Center listed below. Be sure to attach any materials that support and explain your claim. Make a photocopy of your application and all supporting material you submit to VA before submitting it.

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs Pension Intake Center P.O. Box 5365 Janesville, Wisconsin 53547-5365	VA gov: www.va.gov Direct Upload via: access.va.gov

TERMS AND CALCULATIONS FOR PENSION

Maximum Annual Pension Rate (MAPR)
This is the maximum payable amount of the benefit. Your MAPR is based on how many dependents you have, if you're married to another Veteran who qualifies for a pension, and if your disabilities qualify you for housebound or aid and attendance benefits. The MAPR is adjusted each year for cost-of-living increases.

Medical Deductible
The unreimbursed expenses must exceed 5 percent of the applicable **MAPR**. The deductible increases based on the number of dependents but is not adjusted for aid and attendance (A&A) or housebound benefits.

Countable Medical Expenses
Your countable medical expenses are only those medical expenses that exceed the **Medical Deductible**. Medical expenses are typically considered on a calendar year basis. Your initial year is considered separately, and we will count medical expenses which provide the greatest benefit.

- Recurring Medical Expenses
  - Examples include: Medicare Part B, medical related insurance, in-home care provider, or care provided by a care facility
- One-Time Medical Expenses
  - Examples include: medical co-payments, prescription medications, and durable medical equipment

Reported Annual Medical Expenses - Medical Deductible = Countable Medical Expenses (Min. Zero)

Countable Income
We count the **gross** income you receive as reported or the income we discover from data matching programs with other federal sources. If our data match shows a significant discrepancy, you will be asked to clarify the discrepancy. We count incomes in three ways:

- One-time income is income that you receive once. VA will count it for one year from the first of the following month from receipt date.
  - Examples include: lottery winnings, gifts, capital gains from property sales, irregular IRA (Individual Retirement Account) or stock disbursements.
- Irregular income is income that you receive at different times or in irregular amounts throughout the year. VA will count it for one year from the first of the following month from receipt date.
  - Examples include: odd jobs or contract work and interest income.
- Recurring income is counted continuously until we are informed that you are no longer in receipt of it.
  - Examples include: wages from employment, retirement payments, required minimal distributions from an IRA

Income for VA Purposes (IVAP)
VA counts all of your family income and considers any unreimbursed medical expenses reported when determining your IVAP. The following calculation is a way for you to estimate your IVAP.

Countable Annual Income - Countable Medical Expenses = IVAP

Pension Rate
Your maximum annual benefit is the difference of the current MAPR and what the VA calculates as your IVAP. To convert into a monthly benefit, take this amount and divide by 12 then rounded down to the nearest dollar.

MAPR - IVAP = Annual Pension Rate

Net Worth
The net worth limit is increased by the same percentage as the Social Security increase when there is a cost-of-living adjustment. For purposes of entitlement to VA Pension, net worth includes your and your spouse's assets and your and your dependent's annual income. VA considers children's net worth separately if their net worth would cause you to exceed the limit. VA won't consider them as a dependent when determining your pension entitlement.

Additional information about how VA calculates net worth, Income, and benefits rates can be found at:
https://www.va.gov/pension/veterans-pension-rates/

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 3 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 or Parents' Dependency and Indemnity Compensation (D.I.C.)*, 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 21P-0969, *Income and Asset Statement in Support of Claim for Pension for Parents' Dependency and Indemnity Compensation (D.I.C)*
  - ☐ Trust - Submit complete Trust documents to include the Schedule of Assets

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 Housebound 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 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: 12/31/2028

VA | U.S. 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 known)*

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 and Section V)*

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 *(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)*

☐ 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

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)*

NOTE: If reporting the United States as the place a marriage happened, you must report the City and State of the marriage.

6A. WHAT IS YOUR MARITAL STATUS? *(Check one)*

☐ MARRIED ☐ SEPARATED ☐ NOT MARRIED *(If Widowed or Divorced - Skip to Section VII; If 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 OF MARRIAGE *(MM/DD/YYYY)* ___ / ___ / ___

6F. PLACE OF MARRIAGE (City)

6G. STATE

6H. COUNTRY

6I. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, etc.)*

☐ CEREMONIAL ☐ OTHER *(Specify)*

6J. IS YOUR SPOUSE ALSO A VETERAN?

☐ YES ☐ NO *(If "NO," skip question 6K)*

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

6L. IF YOU ARE SEPARATED, PLEASE TELL US THE REASON YOU ARE SEPARATED *(Illness, work, etc.)*

☐ MEDICAL REASON ☐ MARITAL DISCORD ☐ WORK ☐ OTHER *(Specify)* _____

6M. SPOUSE'S MAILING ADDRESS *(If separated)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

6N. 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.

NOTE: If reporting the United States as the place a marriage happened, you must report the City and State of the marriage.

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

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 IS THE START DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)* ___ / ___ / ___

7D. WHAT IS THE END DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)* ___ / ___ / ___

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

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

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

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

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

☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)*

7I. WHAT IS THE START DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7J. WHAT IS THE END DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

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

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

7M. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?

☐ YES ☐ NO *(If "YES," please submit a VA Form 21-686c, Application Request to Add and/or Remove 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)***

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

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

☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)*

7P. WHAT IS THE START DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7Q. WHAT IS THE END DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

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

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

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

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

☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)*

7V. WHAT IS THE START DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

7W. WHAT IS THE END DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

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

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

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

☐ YES ☐ NO *(If "YES", please submit a VA Form 21-686c, Application Request to Add and/or Remove 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 unless they have been rated incapable of self-support.** If reporting the United States as the place a birth happened, you must report the City and State of the birth.

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)* ☐ MARRIED/PREVIOUSLY MARRIED ☐ ADOPTED

☐ CHILD DOES NOT LIVE WITH YOU BUT YOU MONTHLY CONTRIBUTE $

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)* ☐ MARRIED/PREVIOUSLY MARRIED ☐ ADOPTED

☐ CHILD DOES NOT LIVE WITH YOU BUT YOU MONTHLY CONTRIBUTE $

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)* ☐ MARRIED/PREVIOUSLY MARRIED ☐ ADOPTED

☐ CHILD DOES NOT LIVE WITH YOU BUT YOU MONTHLY CONTRIBUTE $

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 OF CHILDREN NOT LIVING WITH YOU *(First, Middle Initial, Last)*

8S. PLEASE PROVIDE THE ADDRESS OF THE CUSTODIAN OF CHILDREN NOT LIVING WITH YOU

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.

NOTE: When reporting an amount, please use a separate box for a comma and a period if needed.

9A. DO YOU AND YOUR DEPENDENTS HAVE OVER $75,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?

☐ YES *(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.))*

☐ NO *(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.)*

$

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. HOW MANY INCOME SOURCES DOES YOUR FAMILY HAVE?

☐ NO INCOME ☐ 1 - 4 SOURCES OF INCOME ☐ 5+ SOURCES OF INCOME *(If 5+, please submit VA Form 21P-0969)*

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 Name)*

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)*	9I(2) SPECIFY THE TYPE OF INCOME	9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9I(4) CURRENT GROSS MONTHLY INCOME $
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9J(2) SPECIFY THE TYPE OF INCOME	9J(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9J(4) CURRENT GROSS MONTHLY INCOME $
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9K(2) SPECIFY THE TYPE OF INCOME	9K(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)* _____	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 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 also complete the applicable worksheet(s) on **pages 16 and 17** for each provider. **All in-home care fees or facility fees you pay must be reported on this form if you want VA to use them as a deductible expenses.**

10B(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10B(2). NAME OF PROVIDER	10B(4). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE HOURLY RATE?
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	10B(3). TYPE OF CARE *(Select one)* ☐ NURSING HOME ☐ RESIDENTIAL CARE FACILITY ☐ ADULT DAYCARE ☐ IN-HOME CARE ATTENDANT	$ 10B(5). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT ARE THE HOURS WORKED PER MONTH?
10B(6). PROVIDER START DATE *(MM/DD/YYYY)* __/__/____	10B(8). PAYMENT FREQUENCY	10B(9). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
10B(7). PROVIDER END DATE *(MM/DD/YYYY)* __/__/____ ☐ CONTINUING	☐ MONTHLY ☐ ANNUALLY	$

10C(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10C(2). NAME OF PROVIDER	10C(4). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE HOURLY RATE?
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify Name)* _____	10C(3). TYPE OF CARE *(Select one)* ☐ NURSING HOME ☐ RESIDENTIAL CARE FACILITY ☐ ADULT DAYCARE ☐ IN-HOME CARE ATTENDANT	$ 10C(5). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT ARE THE HOURS WORKED PER MONTH?
10C(6). PROVIDER START DATE *(MM/DD/YYYY)* __/__/____	10C(8). PAYMENT FREQUENCY	10C(9). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
10C(7). PROVIDER END DATE *(MM/DD/YYYY)* __/__/____ ☐ CONTINUING	☐ MONTHLY ☐ ANNUALLY	$

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

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

10D(2). NAME OF PROVIDER

10D(3). TYPE OF CARE *(Select one)*
- ☐ NURSING HOME
- ☐ RESIDENTIAL CARE FACILITY
- ☐ ADULT DAYCARE
- ☐ IN-HOME CARE ATTENDANT

10D(4). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE HOURLY RATE?
$

10D(5). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT ARE THE HOURS WORKED PER MONTH?

10D(6). PROVIDER START DATE *(MM/DD/YYYY)*

10D(7). PROVIDER END DATE *(MM/DD/YYYY)*
☐ CONTINUING

10D(8). PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY

10D(9). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
$

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES

10E

10E(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)*

10E(2) PAID TO *(Name of Provider)*

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

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

10E(5) PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

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

10F

10F(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)*

10F(2) PAID TO *(Name of Provider)*

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

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

10F(5) PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

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

10G

10G(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)*

10G(2) PAID TO *(Name of Provider)*

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

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

10G(5) PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

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

10H

10H(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)*

10H(2) PAID TO *(Name of Provider)*

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

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

10H(5) PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

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

10I

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

10I(2) PAID TO *(Name of Provider)*

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

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

10I(5) PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

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

10J

10J(1) WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ VETERAN
- ☐ SPOUSE
- ☐ CHILD *(Specify Name)*

10J(2) PAID TO *(Name of Provider)*

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

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

10J(5) PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME

10J(6) AMOUNT YOU PAID *(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. 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 NUMBER

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 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.

12A. SIGNATURE OR MARK	12B. DATE SIGNED *(MM/DD/YYYY)*
	/ /

SECTION XIII: WITNESSES TO SIGNATURE

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

13A. SIGNATURE OF THE FIRST WITNESS *(If claimant signed above using an "X")*	13B. PRINTED NAME OF FIRST WITNESS
	13C. PRINTED ADDRESS OF FIRST WITNESS
13D. SIGNATURE OF THE SECOND WITNESS *(If claimant signed above using an "X")*	13E. PRINTED NAME OF SECOND WITNESS
	13F. PRINTED ADDRESS OF SECOND WITNESS

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE *(NOTE: REQUIRED ONLY IF ITEM 12A 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: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0002, and it expires 12/31/2028. Public reporting burden for this collection of information is estimated to average 30 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Please refer to OMB Control No. 2900-0002 in any correspondence. Do not send your completed VA Form 21P-527EZ to this email address.

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 OR ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

8. 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.

YES	NO	
☐	☐	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. DATE THE CARE RECIPIENT WAS ADMITTED TO THE FACILITY. *(MM/DD/YYYY)* / /

12. DO YOU EXPECT THIS CARE TO END? *(If "Yes," provide the date the care is expected to end in question 13.)*
☐ YES ☐ NO

13. DATE YOU EXPECT CARE TO END. *(MM/DD/YYYY)* / /

14. PROVIDE THE CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY PAYS PER MONTH.
$ 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.

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

16. 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. 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. 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. PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. *(MM/DD/YYYY)*
__ / __ / ____

12. DO YOU EXPECT THIS CARE TO END? *(If "Yes," provide the date the care is expected to end in question 13.)*
☐ YES ☐ NO

13. DATE YOU EXPECT CARE TO END. *(MM/DD/YYYY)*
__ / __ / ____

14. PROVIDE THE CHARGES THE CARE RECIPIENT PAYS PER HOUR.
$ _____ PER HOUR

15. 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.

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

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

VA Form 21P-534EZ

AUG 2025

NOTICE TO SURVIVOR OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

This notice provides information regarding evidence necessary to substantiate a claim for:

- Survivors Pension
- Dependency Indemnity Compensation (D.I.C.)
- D.I.C. under 38 U.S.C. 1151
- D.I.C. re-evaluation based on PL 117-16 (PACT ACT)
- Increased Survivor Benefits Based on Need for Special Monthly Pension or Special Monthly D.I.C.
- Accrued Benefits
- Benefits Based on a Veteran's Seriously Disabled Child

If you are making a claim for:

Pension Benefits	Complete and Submit VA Form 21P-527EZ, *Application for Veterans Pension*
Compensation Benefits	Complete and Submit VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*
Parents' D.I.C Benefits	Complete and Submit VA Form 21P-535, *Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation when Applicable)*
Accrued Benefits	Complete and Submit VA Form 21P-601, *Application for Accrued Benefits Due a Deceased Beneficiary*
Supplemental Claim	Complete and Submit VA Form 20-0995, *Decision Review Request: Supplemental Claim*

If you are ***not*** ready to submit a claim for D.I.C., Survivors Pension, and/or Accrued Benefits, please complete a VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or D.I.C.*, to protect your date of claim. If you complete the VA Form 21P-534EZ within one year of filing the VA Form 21-0966, your completed application will be considered filed as of the date of receipt of the VA Form 21-0966.

VA forms are available at www.va.gov/vaforms.

For more information on survivors benefits see https://www.va.gov/family-and-caregiver-benefits/survivor-compensation/dependency-indemnity-compensation/

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)

You may wish to contact an accredited Veteran Service Officer to assist you with your application. For a list of accredited Veteran's Service Organizations go to https://www.va.gov/vso/. You may also contact your state office of Veterans Affairs at https://discover.va.gov/external-resources/?_resource_type=state-veterans-affairs-office. To assign a VSO as your power of attorney for the claims process, submit VA Form 21-22, *Appointment of Veteran's Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents

Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veterans Affairs go to: https://www.va.gov/ogc/apps/accreditation/index.asp. To assign a private attorney for the claims process, submit a VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims

Generally, an accredited attorney or claims agent can ONLY charge claimants a fee after the VA has issued a decision on a claim. Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

WHEN TO USE THIS FORM

The attached application is needed to submit a claim for D.I.C., Survivors Pension and/or Accrued Benefits. There are worksheets included to help verify care expenses if you claim them. This notice details the evidence necessary to substantiate your claim. Leave items in a section blank if they do not apply to you.

THIS APPLICATION HAS 14 SECTIONS	
SECTION I: VETERAN'S IDENTIFICATION INFORMATION	SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT ON A CLAIM FOR A SPECIAL MONTHLY PENSION
SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION	SECTION IX: INCOME AND ASSETS
SECTION III: VETERAN'S SERVICE INFORMATION	SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES
SECTION IV: MARITAL INFORMATION	SECTION XI: DIRECT DEPOSIT INFORMATION
SECTION V: MARITAL HISTORY	SECTION XII: CLAIM CERTIFICATION AND SIGNATURE
SECTION VI: CHILD OF VETERAN INFORMATION	SECTION XIII: WITNESSES TO SIGNATURE
SECTION VII: D.I.C	

To qualify you must:

1. Submit your claim on a completed, signed and dated VA Form 21P-534EZ, *Application for D.I.C., Survivors Pension, and/or Accrued Benefits* (Attached).
2. Submit simultaneously with your claim:
   - A copy of the veteran's death certificate (unless the veteran died on active duty); AND

If claiming Survivor's Pension:

- All necessary income and asset information; AND
- Any additional forms and evidence as the situation requires. Special Circumstances below indicate the most common circumstances. The application and other VA Forms may require additional evidence.

If claiming D.I.C.:

- All, if any, of the veteran's relevant, private medical treatment records and an identification of any of the veteran's treatment records available at a Federal facility, such as a VA medical center, that supports your claim that a service-connected disability caused the veteran's death or the veteran's death was caused by the VA;
- Any and all Service Treatment and Personnel Records in the custody of the veteran's Guard or Reserve Unit(s) if applicable; AND
- Any additional forms and evidence as the situation requires. Special Circumstances below indicate the most common circumstances. The application and other VA Forms may require additional evidence.

For more information on VA benefits, visit our website at www.va.gov, contact us at https://www.va.gov/contact-us or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.

SPECIAL CIRCUMSTANCES:

Additional forms may be needed to remain eligible.

This includes VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, which may be required if you:

- Have multiple income sources
- Have more than $75,000 in assets
- Additional forms as noted on the VA Form 21P-0969 may be required

If claiming Special Monthly Pension or Special Monthly D.I.C.:

- Please have a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinic Nurse Specialist (CNS) complete VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*, **OR**
- If you are a patient in a nursing home complete VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

If claiming benefits for a child of the veteran:

- And they are in school between the ages of 18 and 23, a completed VA Form 21-674, *Request for Approval of School Attendance*
- If the child was adopted, please submit the adoption papers or amended birth certificate
- If claiming benefits for a child of the veteran who became seriously disabled prior to reaching the age of 18, submit all, if any, relevant private medical treatment records for the child's pertinent disabilities
- If the child is over 18 and you are claiming DIC, the child will have to apply for DIC with their own application.

SUBMITTING A CLAIM

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. If your claim involves a disability the veteran had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before the veteran's entry into service. A substantially complete claim must contain: (1) The claimant's name; (2) Their relationship to the veteran; (3) Sufficient service information for VA to verify the claimed service, if applicable; (4) The benefit sought and any medical condition(s) on which it is based; (5) The claimant's signature; (6) A statement of income, if applicable.

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

VA will retrieve evidence on your behalf in some circumstances. If VA is unable to retrieve the necessary evidence, we 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.

VA will:

- Retrieve relevant records from a Federal facility that you adequately identify and authorize VA to obtain.
- Get a medical opinion if we determine it is necessary to decide your claim.
- 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 from current or former employers.

WHEN YOU SHOULD SEND WHAT WE NEED

You are strongly encouraged to send any information or evidence as soon as you can.

NOTE: 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 received the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim. In order to go back to your original effective date, you will need to submit a supplemental claim if you choose to submit the necessary information or evidence within that year.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming...	See Evidence Tables titled...
Survivors Pension (an income and asset-based benefit for surviors of a veteran with wartime service)	Military Service Verification Survivors Pension
D.I.C. because the veteran's death was related to the veteran's service, OR D.I.C. because the veteran was receiving or entitled to receive benefits for a service-connected disability rated totally disabling	Dependency and Indemnity Compensation (D.I.C.)
D.I.C. because the veteran's death was a result of VA medical treatment, vocational rehabilitation, or compensated work therapy	D.I.C. under 38 U.S.C. 1151
D.I.C. re-evaluation of a previously denied claim based on eligibility under PL 117-168 (PACT Act)	D.I.C. re-evaluation based on PL 117-168 (PACT Act)
D.I.C. that was previously denied by VA	Supplemental D.I.C.
Special Monthly Pension or Special Monthly D.I.C. based on the need for aid and attendance or housebound benefits	Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly D.I.C.
Benefits that were due to the veteran at the time of the veteran's death	Accrued Benefits
Benefits because the child of the veteran is severely disabled	Child incapable of self-support

EVIDENCE TABLES

MILITARY SERVICE VERIFICATION

To support your claim for Survivors benefits, the veteran's military service must be verified. The following evidence can be submitted to verify the veteran's military service:

- A photocopy of the veteran's DD 214 (or equivalent) for all periods of military service. You may request a copy of the DD 214 through the National Archives' National Personnel Records Center (NPRC) using Standard Form 180 (SF-180), *Request Pertaining to Military Records*, (available at https://www.gsa.gov/forms) or through your local public custodian of records

Fire Related Military Records

As you may know, there was a fire at the National Archives and Records Administration on July 12, 1973, which destroyed approximately:

- 80 percent of the records NPRC held for Veterans who were discharged from the Army between November 1, 1912, and January 1, 1960, and
- 75 percent of the records NPRC held for Veterans with surnames beginning (alphabetically) with Hubbard and running through the end of the alphabet, and who were discharged from the Air Force between September 25, 1947, and January 1, 1964.

If the veteran's military records were stored there on that date, they may have been destroyed in the fire. If you believe the veteran's military records may have been destroyed in the fire, NA Form 13075, *Questionnaire About Military Service*, should be completed to avoid delays in processing your claim. NA Form 13075 is available at: https://www.archives.gov/files/st-louis/military-personnel/na-13075-questionnaire-about-military-service.pdf.

NOTE: The Veterans Benefits Administration (VBA) is no longer able to retrieve or return original documents submitted. Please ***do not*** submit original documents to VA since they ***will not*** be returned to you.

SURVIVORS PENSION

To support your claim for **Survivors Pension**, the evidence must show:

1. The veteran met certain minimum active service requirements during a period of war. Generally, those requirements are:
   - 90 days of service during a period of war; **OR**
   - 90 days of consecutive service at least one day of which was during a period of war; **OR**
   - 90 days of combined service during more than one period of war (**Note**: If the veteran's 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 obligations.); **OR**
   - any length of active service during a period of war when:
     - at the time of death, the veteran was receiving (or entitled to receive) VA disability compensation or retirement pay for a service-connected disability; **OR**
     - the veteran was discharged from active service due to a service-connected disability.
2. Your income and assets do not exceed certain requirements.

Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the primary residence including the residential lot area that does not exceed 2 acres, unless the additional acreage is not marketable) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

EVIDENCE TABLES (Continued)

DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

To support a claim for **Dependency and Indemnity Compensation (D.I.C.) based on a service-connected disability:**

- The veteran died while on active service; **OR**
- The veteran had a service-connected disability(ies) that was either the principal or contributory cause of the veteran's death; **OR**
- The veteran died from non-service-connected injury or disease **AND** was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling:
  - For at least 10 years immediately before death; **OR**
  - For at least 5 years after the veteran's release from active duty preceding death; **OR**
  - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999.

To support a claim for **D.I.C. based on a disability VA had not previously determined was service-connected** or for which the veteran did not file a claim during their lifetime, the evidence must show:

- An injury or disease that was incurred or aggravated during active service, or an event in service that caused an injury or disease; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the disability associated with the cause of death and an injury, disease, or event in service. This may be shown by medical records or medical opinion or, in certain cases, by lay evidence.

To support your claim for **D.I.C. based upon the service person's active duty for training**, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty and the disease or injury caused or contributed to the service person's death.

NOTE: If VA granted service connection for a disease or injury during the service person's lifetime, evidence that the service-connected disease or injury caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **D.I.C. based on a disability that was not service-connected** or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the principal or contributory cause of death and the disability due to injury or disease, incurred in the line of duty. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support your claim for **D.I.C. based upon the service person's inactive duty training**, the evidence must show:

- The service person died during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident during such training; **OR**
- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; and that injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death.

NOTE: If VA granted service connection for an injury, acute myocardial infarction, or cerebrovascular accident during the service person's lifetime, evidence that the service-connected condition caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **D.I.C. based on a disability that was not service-connected** or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; **AND**
- The injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death.

D.I.C. UNDER 38 U.S.C. 1151

In order to support your claim for **D.I.C. under 38 U.S.C. 1151**, the evidence must show:

- The deceased veteran died as a result of undergoing VA hospitalization, medical or surgical treatment, examination, or training; **AND**
- The death was:
  - the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment; **OR**
  - the direct result of an event that was not a reasonably expected result or complication of the VA care or treatment; **OR**
  - the direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program.

D.I.C. RE-EVALUATION BASED ON PL 117-168 (PACT ACT)

Public Law 117-168 (PACT ACT) was signed into law on August 10, 2022. This resulted in a substantial expansion of a veteran's military service that qualifies for presumptive toxic exposure and new presumptive conditions linked to that exposure. The law allows prior claimants for D.I.C. to request a re-evaluation based on the expanded eligibility within the PACT Act. More information about the PACT Act can be found at https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

In order to support your claim for **D.I.C. re-evaluation based on PL 117-168 (PACT Act)** the evidence must show:

- A claim was submitted and denied prior to August 10, 2022, the date the PACT Act went into effect; **AND**
- The claimant has elected re-evaluation of the previously denied claim.

SUPPLEMENTAL CLAIM D.I.C.

In order to reopen a **claim previously denied by VA**, we need:

- The prescribed supplemental claim form, VA Form 20-0995, *Decision Review Request: Supplemental Claim*; **AND**
- New and relevant evidence. New and relevant evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.
  - To qualify as new evidence is evidence not previously part of the actual record before agency adjudicators.
  - In order to be considered relevant, the evidence is information that tends to prove or disprove a matter at issue in a claim. Relevant evidence includes evidence that raises a theory of entitlement that was not previously addressed.

INCREASED SURVIVOR BENEFITS BASED ON SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY D.I.C.

In order to support your claim for **increased survivor 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 concentric contraction of the visual field to 5 degrees; **OR**
- you are a patient in a nursing home due to mental or physical incapacity; **OR**
- you require the aid of another person 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 (38 Code of Federal Regulations 3.352(a)); **OR**
- you are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulations 3.352(a)); **OR**

In order to support your claim for **increased benefits based on being housebound**, the evidence must show:

- you are substantially confined to your immediate premises because of permanent disability

ACCRUED BENEFITS

To support a claim for **accrued benefits**, the evidence must show:

- Benefits were due the veteran based on existing ratings, decisions, or evidence in VA's possession at the time of death, but the benefits were not paid before the veteran's death; **AND**
- You are the surviving spouse, child, or dependent parent of the deceased veteran

VA pays accrued benefits in the following order of priority: spouse, children of the veteran (in equal shares) and dependent parents (in equal shares)

NOTE: Child means an unmarried child of the veteran who is under 18 years of age, or at least 18 but under 23 years of age and pursuing an approved course of education or became incapable of self-support prior to reaching age 18.
If there are no living persons who are entitled on the basis of relationship, accrued benefits may be used to reimburse the person or persons who paid for or are responsible to pay the expenses of last illness and burial of a beneficiary. The claim should be filed by the person or persons whose funds were or will be used to pay such expenses using VA Form 21P-601, *Application for Accrued Amounts Due a Deceased Beneficiary*.

CHILD INCAPABLE OF SELF-SUPPORT

To support a **claim for benefits based on a veteran's child being incapable of self-support**, the evidence must show that the child, before their 18th birthday became permanently incapable of self-support due to mental or physical disability. The information necessary to establish the extent of the child's disability includes:

- the extent to which the child is and was, prior to reaching their 18th birthday, physically or mentally deficient as evidenced by factors such as their ability to perform self-care functions, and ordinary tasks expected of a child of that age
- whether or not the child attended school and, if so, the maximum grade attended
- if any material improvement in the child's condition has occurred
- if the child has ever been employed and, if so, the nature and dates of such employment, and amount of pay received
- whether or not the child has ever been married, and
- a description of the child's present condition

PRESUMPTIVE SERVICE CONNECTION

To support a claim for presumptive service connection the evidence must show:

- The veteran served in a recognized location that qualifies for the presumption of exposure; **AND/OR**
- The veteran died of a disability that qualifies for the presumption of service connection. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable.

Under certain circumstances, VA may presume that certain current diseases were caused by service, even if there is no specific evidence proving this in your particular claim. Service connection is presumed for certain diseases for the following veterans:

- Former prisoners of war;
- Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;
- Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;
- Veterans who were exposed to certain herbicides, such as by service in/on:
  - Vietnam or qualifying offshore waters, from January 9, 1962, through May 7, 1975;
  - a unit determined by VA or the Department of Defense to have operated in the Korean DMZ, from September 1, 1967, through August 31, 1971;
  - individuals who performed service in the Air Force or Air Force Reserve and regularly and repeatedly operated, maintained, or served on board C-123 aircraft known to have used to spray an herbicide agent during the Vietnam era;
  - Thailand at any United States or Royal Thai base, from January 9, 1962, through June 30, 1976;
  - Laos, from December 1, 1965, through September 30, 1969;
  - Cambodia at Mimot or Krek, Kampong Cham Province, from April 16, 1969, through April 30, 1969;
  - Guam or American Samoa, or in the territorial waters thereof, from January 9, 1962, through July 31, 1980;
  - Johnston Atoll or on a ship that called at Johnston Atoll, from January 1, 1972, through September 30, 1977.
- Veterans who served at Camp Lejeune for no less than 30 days (consecutive or nonconsecutive) between August 1, 1953 and December 31,1987; **OR**
- Veterans who served in the Gulf War:
  - On or after August 2, 1990, and served in:
    - Bahrain; Iraq; the neutral zone between Iraq and Saudi Arabia; Kuwait; Oman; Qatar; Saudi Arabia; Somalia; United Arab Emirates; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; the Red Sea; Afghanistan; Israel; Egypt; Turkey; Syria; or Jordan; **OR**
  - On or after September 11, 2001, and served in:
    - Afghanistan; Djibouti; Egypt; Jordan; Lebanon; Syria; Yemen; or Uzbekistan.

IMPORTANT INFORMATION REGARDING MARRIAGE

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 date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant a claim for Survivors Benefits, the beginning date of your entitlement will generally be the date we received your claim, or the intent to file (ITF) for Survivor Benefits, if received within a year of the ITF. If VA receives your claim within one year after the veteran's death, the entitlement will be from the first day of the month in which the veteran died. The veteran's death certificate is evidence relevant to determining the effective date of any benefits we award.

Aid and attendance or housebound benefits may be available for a veteran's surviving spouse who is unable to perform certain activities of daily living, are a patient in a nursing home, or are substantially confined to their immediate premises. Special monthly pension may be effective from the date medical evidence first shows entitlement.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

When you have completed this application, you can either submit online or mail it to the Pension Intake Center listed below. Attach any materials that support and explain your claim. Also, make a photocopy of your application and any evidence you send to VA before submitting.

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs Pension Intake Center P.O. Box 5365 Janesville, WI 53547-5365	VA gov: www.va.gov QuickSubmit via: access.va.gov

TERMS AND CALCULATIONS FOR PENSION

Maximum Annual Pension Rate (MAPR)
This is the maximum payable amount of the benefit. Your MAPR is based on how many dependents you have, if you're married to another Veteran who qualifies for a pension, and if your disabilities qualify you for housebound or aid and attendance benefits. The MAPR is adjusted each year for cost-of-living increases.

Medical Deductible
The unreimbursed expenses must exceed 5 percent of the applicable **MAPR**. The deductible increases based on the number of dependents but is not adjusted for aid and attendance (A&A) or housebound benefits.

Countable Medical Expenses
Your countable medical expenses are only those medical expenses that exceed the **Medical Deductible**. Medical expenses are typically considered on a calendar year basis. Your initial year is considered separately, and we will count medical expenses which provide the greatest benefit.

Recurring Medical Expenses

- Examples include: Medicare Part B, medical related insurance, in-home care provider, or care provided by a care facility

One-Time Medical Expenses

- Examples include: medical co-payments, prescription medications, and durable medical equipment

Reported Annual Medical Expenses - Medical Deductible = Countable Medical Expenses (Min. Zero)

Countable Income
We count the **gross** income you receive as reported or the income we discover from data matching programs with other federal sources. If our data match shows a significant discrepancy, you will be asked to clarify the discrepancy. We count incomes in three ways:

- One-time income is income that you receive once. VA will count it for one year from the first of the following month from receipt date.
  - Examples include: lottery winnings, gifts, capital gains from property sales, irregular IRA (Individual Retirement Account) or stock disbursements.
- Irregular income is income that you receive at different times or in irregular amounts throughout the year. VA will count it for one year from the first of the following month from receipt date receipt date.
  - Examples include: odd jobs or contract work and interest income.
- Recurring income is counted continuously until we are informed that you are no longer in receipt of it.
  - Examples include: wages from employment, retirement payments, required minimal distributions from an IRA (Individual Retirement Account).

Income for VA Purposes (IVAP)
VA counts all of your family income and considers any unreimbursed medical expenses reported when determining your IVAP. The following calculation is a way for you to estimate your IVAP:

Countable Annual Income - Countable Medical Expenses = IVAP

Pension Rate
Your maximum annual benefit is the difference of the current MAPR and what the VA calculates as your IVAP. To convert into a monthly benefit, take this amount and divide by 12 then rounded down to the nearest dollar.

MAPR - IVAP = Annual Pension Rate

Net Worth
The net worth limit is increased by the same percentage as the Social Security increase when there is a cost-of-living adjustment. For purposes of entitlement to VA Pension, net worth includes your and your spouse's assets and your and your dependent's annual income. VA considers children's net worth separately if their net worth would cause you to exceed the limit. VA won't consider them as a dependent when determining your pension entitlement.

Additional information about how VA calculates net worth, Income, and benefits rates can be found at:
https://www.va.gov/pension/veterans-pension-rates/

SURVIVORS BENEFITS APPLICATION CHECKLIST

In addition to your application, VA may require some of the evidence described in this checklist. Failure to provide needed evidence, may delay the decision on your claim. This checklist does not apply to claims for Accrued benefits. Please carefully read pages 5 and 6 of the Instructions if you are claiming service-connected death (Dependency and Indemnity Compensation (D.I.C.) only. Please note, the items marked with an asterisk (*) are required.

VERIFICATION OF VETERAN'S DEATH* *(Requested on page 2 of Instructions)*

- ☐ A Death certificate for the veteran, clearly showing the primary cause(s) of death and any contributing factors or conditions *(If the veteran's death certificate lists the cause of death as "Pending," please have the medical examiner submit evidence that shows the cause of death)*.

SERVICE VERIFICATION* *(Requested on page 4 of Instructions and Section III of the form)*

- ☐ Copy of the veteran's 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 on page 2 of Instructions and Section IX of the form)*

- ☐ VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C.*, is required if instructed in Section IX of this application form. **NOTE**: If you have specific types of income or assets the VA Form 21P-0969 requires additional evidence:
  - ☐ 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* (provide details, such as Royalty source, joint owners, etc.)
  - ☐ Trust - Submit complete Trust documents to include the Schedule of Assets

SPECIAL CIRCUMSTANCES REGARDING YOUR MEDICAL CARE
(Requested on page 2 of Instructions and in Sections VIII and X of the form)

Claim for Special Monthly Pension (SMP) - Aid and Attendance or Housebound 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 on pages **19** and **20** of the form)
- ☐ Proof of Payment from care provided (canceled checks, bank statements, etc.)
- ☐ Signed verification from care service provider

DEPENDENT CHILDREN* *(Requested on page 2 of Instructions and Section VI of the form)*

- ☐ A birth certificate must be included clearly showing the veteran as the parent if you do not reside within the U.S. or its territories. (A state includes the District of Columbia, Puerto Rico and other territories and possessions of the U.S.)
- ☐ If child(ren) is/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 of the form)*

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

OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: 08/31/2028

U.S. Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR D.I.C., SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION *(Must complete)*

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

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

1B. VETERAN'S SOCIAL SECURITY NUMBER — —

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

1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?
☐ YES ☐ NO

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

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

1G. VETERAN'S SERVICE NUMBER

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

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(Must complete)*

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

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? *(Check one)*
☐ SURVIVING SPOUSE ☐ CHILD 18-23 IN SCHOOL ☐ CUSTODIAN FILING FOR CHILD UNDER 18 ☐ DISABLED ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER — —

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

2E. ARE YOU A VETERAN?
☐ YES ☐ NO

2F. MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code —

2G. YOUR TELEPHONE NUMBER *(Include Area Code)* — —

International Phone Number *(If applicable)* _____

2H. E-MAIL ADDRESS *(Optional)*

2I. WHAT ARE YOU CLAIMING? *(Check all that apply)*
☐ DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.) ☐ SURVIVORS PENSION ☐ ACCRUED BENEFITS

SECTION III: VETERAN'S SERVICE INFORMATION

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

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

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME?
☐ YES ☐ NO *(If "YES," list other names the veteran served under below) (First, Middle Initial, Last)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION III: VETERAN'S SERVICE INFORMATION *(Continued)*

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

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

3D. BRANCH OF SERVICE

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS
☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA ☐ USPHS

3E. PLACE OF LAST SEPARATION

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

☐ YES ☐ NO *(If "NO," skip to Item 3J)*

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

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

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

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

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

☐ YES ☐ NO *(If "NO," skip to Section IV)*

3L. START DATE OF CONFINEMENT *(MM/DD/YYYY)* START:

3M. END DATE OF CONFINEMENT *(MM/DD/YYYY)* END:

SECTION IV: MARITAL INFORMATION

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

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

NOTE: When reporting place, if the country is the United States, VA needs city and state as well.

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

☐ YES ☐ NO *(If "YES," provide explanation below)*

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF HIS/HER DEATH?

☐ YES ☐ NO *(If "NO," complete Item 4C)*

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

☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

4D. START DATE OF YOUR MARRIAGE TO THE VETERAN

4E. END DATE OF YOUR MARRIAGE TO THE VETERAN

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

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

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

☐ CEREMONIAL ☐ OTHER *(Explain)*:

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

☐ YES ☐ NO

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

☐ YES ☐ NO

4K. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?

☐ YES ☐ NO *(If "YES," skip to Item 4N)*

4L. WHAT WAS THE REASON FOR SEPARATION?

☐ MEDICAL/FINANCIAL REASONS
☐ MARITAL DISCORD/OTHER (*if you select this option fill out 4M)*

4M. EXPLANATION OF SEPARATION (*Give, the reason, date(s), and duration of the separation, to include the court order if separation is due to court order)*

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

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

☐ YES ☐ NO *(If "NO," skip to Item 5A)*

4O. START DATE OF YOUR REMARRIAGE? *(MM/DD/YYYY)*

4P. END DATE OF YOUR REMARRIAGE? *(MM/DD/YYYY)*

4Q. HOW DID YOUR REMARRIAGE END?

☐ DEATH ☐ DIVORCE ☐ DID NOT END ☐ OTHER *(Explain)*

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

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

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION V: MARITAL HISTORY

NOTE: When reporting place, if the country is the United States, VA needs city and state as well.

5A. WERE YOU RECOGNIZED AS THE SPOUSE BY VA BEFORE THE DEATH OF THE VETERAN OR WERE YOU AND THE VETERAN ONLY EVER MARRIED TO EACH OTHER? IF YES, SKIP TO SECTION VI.

☐ YES ☐ NO

VETERAN'S PRIOR MARRIAGES *(If None, skip to Item 5O)*

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

5C. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

5D. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* START: __/__/____

5E. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* END: __/__/____

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

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

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

5I. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

5J. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* START: __/__/____

5K. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* END: __/__/____

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

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

5N. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
☐ YES ☐ NO *(If "YES," please submit a VA Form 21-686c, Application Request to Add And/Or Remove Dependents, or VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)*

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

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

5P. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

5Q. DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)* START: __/__/____

5R. DATE OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)* END: __/__/____

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

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

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

5V. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER *(Explain)*

5W. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* START: __/__/____

5X. DATE OF VETERAN'S PREVIOUS MARRIAGE? *(MM/DD/YYYY)* END: __/__/____

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

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

6. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?
☐ YES ☐ NO *(If "YES," please submit a VA Form 21-686c, Application Request to Add And/Or Remove Dependents, or VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VI: CHILD OF THE VETERAN INFORMATION

(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)

(Skip to Section VII if you are NOT claiming benefits for a child(ren) of the veteran)

NOTE: Please refer to instructions page 2, under "*Special Circumstances*" for what is considered a dependent child. In most circumstances, children over the age of 23 are not considered dependent for VA purposes, unless the child is determined to be seriously disabled based on a condition that started before turning 18.

NOTE: When reporting place, if the country is the United States, VA needs city and state as well.

6A. HOW MANY DEPENDENT CHILDREN OF THE VETERAN ARE THERE?

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

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

6C. CHILD'S BIRTH DATE *(MM/DD/YYYY)* ___/___/____

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

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

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

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

☐ CHILD DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $

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

6H. CHILD'S BIRTH DATE *(MM/DD/YYYY)* ___/___/____

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

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

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

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

☐ CHILD DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $

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

6M. CHILD'S BIRTH DATE *(MM/DD/YYYY)* ___/___/____

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

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

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

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

☐ CHILD DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $

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

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

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

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

6S. PLEASE PROVIDE THE ADDRESS OF THE CHILD(RENS) CUSTODIAN BELOW:

MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VII: DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

(Skip to Section VIII if you are NOT claiming D.I.C.)

7A. WHAT BENEFIT ARE YOU CLAIMING? *(Check one) Please refer to the Instructions page 5 for guidance on 38 U.S.C. 1151)*
*(**Note**: Please refer to Instructions page 6 for guidance on PACT Act)*

☐ D.I.C. ☐ D.I.C. under U.S.C. 1151 *(**Note**: D.I.C. under 38 U.S.C. is a rare benefit.)* ☐ D.I.C. due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 *(PACT Act)*

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

NAME OF VA MEDICAL CENTER	LOCATION	START DATE(S) OF TREATMENT *(MM/DD/YYYY)*	END DATE(S) OF TREATMENT *(MM/DD/YYYY)*
		/ /	/ /
		/ /	/ /
		/ /	/ /

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY D.I.C. BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

☐ YES ☐ NO *(If "YES," please complete a VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP/CRNP), or Clinical Nurse Specialist (CNS))*

8B. ARE YOU NOW IN A NURSING HOME?

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

SECTION IX: INCOME AND ASSETS

(Skip to Section X if you are NOT claiming survivors pension but claiming any last expenses)

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

IMPORTANT:

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

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER $75,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?

☐ YES *(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.))*

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

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

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

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

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

9D. IS 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.)*
$

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

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

9G. HOW MANY INCOME SOURCES DOES YOUR FAMILY HAVE?

☐ NO INCOME ☐ 1-4 SOURCES OF INCOME

☐ 5+ SOURCES OF INCOME *(If 5+ please submit VA Form 21P-0969) and ONLY report your Social Security Income)*

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

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

SECTION IX: INCOME AND ASSETS *(Continued)*

(Skip to Section X if you are NOT claiming survivors pension but claiming any last expenses)

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

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim.

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9I(2) SPECIFY THE TYPE OF INCOME	9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CUSTODIAN ☐ CHILD *(Specify Name)* ☐ CUSTODIAN'S SPOUSE	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9I(4) CURRENT GROSS MONTHLY INCOME $
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9J(2) SPECIFY THE TYPE OF INCOME	9J(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CUSTODIAN ☐ CHILD *(Specify Name)* ☐ CUSTODIAN'S SPOUSE	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9J(4) CURRENT GROSS MONTHLY INCOME $
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9K(2) SPECIFY THE TYPE OF INCOME	9K(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CUSTODIAN ☐ CHILD *(Specify Name)* ☐ CUSTODIAN'S SPOUSE	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9K(4) CURRENT GROSS MONTHLY INCOME $
9L(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9L(2) SPECIFY THE TYPE OF INCOME	9L(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CUSTODIAN ☐ CHILD *(Specify Name)* ☐ CUSTODIAN'S SPOUSE	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9L(4) CURRENT GROSS MONTHLY INCOME $

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid.

Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child, educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

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

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

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

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider. **All in-home care fees or facility fees you pay must be reported on this form if you want VA to use them as a deductible expense.**

10B(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10B(2). NAME OF PROVIDER	10B(4). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER *(Specify Name)*	10B(3). TYPE OF CARE *(Select one)*: ☐ NURSING HOME ☐ RESIDENTIAL CARE FACILITY ☐ ADULT DAYCARE ☐ IN-HOME CARE ATTENDANT	Payment Rate (Per Hour) $ 10B(5). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE: Hours Worked (Per Month)

10B(6). PROVIDER START DATE *(MM/DD/YYYY)*	10B(8). PAYMENT FREQUENCY	10B(9). AMOUNT YOU PAY *(Based on frequency selected in Item 10B(8))*
10B(7). PROVIDER END DATE *(MM/DD/YYYY)* ☐ CONTINUING	☐ MONTHLY ☐ ANNUALLY	$

VETERAN'S SOCIAL SECURITY NUMBER ___ — ___ — ____

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

10C(1). WHOSE EXPENSES WERE PAID? *(Select One)*
- ☐ SURVIVING SPOUSE
- ☐ OTHER *(Specify Name)*

10C(2). NAME OF PROVIDER

10C(3). TYPE OF CARE
- ☐ NURSING HOME
- ☐ RESIDENTIAL CARE FACILITY
- ☐ ADULT DAYCARE
- ☐ IN-HOME CARE ATTENDANT

10C(4). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Payment Rate (Per Hour) $

10C(5). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Hours Worked (Per Month)

10C(6). PROVIDER START DATE *(MM/DD/YYYY)*

10C(7). PROVIDER END DATE *(MM/DD/YYYY)*
- ☐ CONTINUING

10C(8). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY

10C(9). AMOUNT YOU PAY *(Based on frequency selected in Item 10C(8))*
$

10D(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ OTHER *(Specify Name)*

10D(2). NAME OF PROVIDER

10D(3). TYPE OF CARE *(Select one)*:
- ☐ NURSING HOME
- ☐ RESIDENTIAL CARE FACILITY
- ☐ ADULT DAYCARE
- ☐ IN-HOME CARE ATTENDANT

10D(4). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Payment Rate (Per Hour) $

10D(5). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Hours Worked (Per Month)

10D(6). PROVIDER START DATE *(MM/DD/YYYY)*

10D(7). PROVIDER END DATE *(MM/DD/YYYY)*
- ☐ CONTINUING

10D(8). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY

10D(9). AMOUNT YOU PAY *(Based on frequency selected in Item 10D(8))*
$

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

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

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

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

10E(5). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY
- ☐ ONE-TIME

10E(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10E(5))*
$

10F(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

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

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

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

10F(5). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY
- ☐ ONE-TIME

10F(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10F(5))*
$

10G(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

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

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

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

10G(5). PAYMENT FREQUENCY
- ☐ MONTHLY
- ☐ ANNUALLY
- ☐ ONE-TIME

10G(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10G(5))*
$

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

10H(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

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

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

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

10H(5). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10H(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10H(5))*

$

10I(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

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

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

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

10I(5). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10I(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10I(5))*

$

10J(1). WHOSE EXPENSES WERE PAID? *(Select one)*
- ☐ SURVIVING SPOUSE
- ☐ VETERAN *(Last expense/burial)*
- ☐ CHILD *(Specify Name)*

10J(2). PAID TO *(Name of Provider, any medical Insurance company, etc.)*

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

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

10J(5). PAYMENT FREQUENCY
- ☐ MONTHLY ☐ ANNUALLY
- ☐ ONE-TIME

10J(6). AMOUNT YOU PAY *(Based on frequency selected in Item 10J(5))*

$

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. 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)*

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

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

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

Account No.:

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

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

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim.

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

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

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

SECTION XIII: WITNESSES TO SIGNATURE

(TWO (2) WITNESS SIGNATURES ARE REQUIRED ONLY IF ITEM 12A IS SIGNED WITH AN "X")

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

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

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

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

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

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside 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: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0004, and it expires 8/31/2028. Public reporting burden for this collection of information is estimated to average 40 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Pleaserefer to OMB Control No. 2900-0004 in any correspondence. Do not send your completed VA Form 21P-534EZ to this email address.

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) (First, Last)*

2. WHO IS COMPLETING THIS WORKSHEET? *(Name of Provider, either an Administrator or Licensed Medical Professional) (First, Last)*

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

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

9. FOR EACH STATEMENT BELOW, PLEASE CHECK THE APPROPRIATE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

YES	NO	
☐	☐	THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
☐	☐	THE FACILITY IS LICENSED
☐	☐	THE FACILITY IS RESIDENTIAL
☐	☐	THE FACILITY IS STAFFED 24 HOURS

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

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

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

11. DATE THE CARE RECIPIENT WAS ADMITTED TO THE FACILITY. *(MM/DD/YYYY)*

/ /

12. DO YOU EXPECT THIS CARE TO END? *(If "Yes, "provide the date the care is expected to end in question 13.)*

☐ YES ☐ NO

13. DATE YOU EXPECT CARE TO END. *(MM/DD/YYYY)*

/ /

14. 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.

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

16. 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) (First, Last)*

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

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)
☐ YES ☐ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?
☐ YES ☐ NO *(If "NO," skip to question 7)*

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

6. WHAT IS THE AGENCY TELEPHONE NUMBER?
– –

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code –

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.
☐ A. EATING ☐ B. BATHING/SHOWERING ☐ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
☐ D. DRESSING ☐ E. USING THE TOILET ☐ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
☐ A. SHOPPING ☐ B. FOOD PREPARATION ☐ C. NON-MEDICAL TRANSPORTATION
☐ D. LAUNDERING ☐ E. USING TELEPHONE ☐ F. MANAGING FINANCES
☐ G. HOUSEKEEPING ☐ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE?
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)
☐ YES ☐ NO

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

12. DO YOU EXPECT THIS CARE TO END? *(IF YES, PROVIDE THE DATE THE CARE IS EXPECTED TO END IN QUESTION 13.)*
☐ YES ☐ NO

13. DATE YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)*
/ /

14. MONTHLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$, . PER MONTH

15. 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.

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

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

8. Step-by-Step Application Guide

- Step 1 – **Confirm Service and Basic Eligibility.** Review wartime service dates, discharge status, and general medical and financial criteria.

- Step 2 – **Discuss Care Needs with a Healthcare Provider.** Schedule a visit with the Veteran's or surviving spouse's physician to review daily care needs and complete VA Form 21-2680.

- Step 3 – **Gather Financial Documents.** Collect bank statements, retirement account information, and income records. Prepare to complete VA Form 21P-0969 if needed.

- Step 4 – **Complete the Pension Application.** Fill out VA Form 21P-527EZ (Veteran) or 21P-534EZ (Surviving Spouse), ensuring all sections are complete and accurate.

- Step 5 – **Assemble Supporting Evidence.** Attach discharge paperwork, marriage and death certificates (if applicable), and care-related invoices or estimates from Comfort Keepers.

- Step 6 – **Submit Your Application.** You may submit by mail to the appropriate VA Pension Management Center, in person at a VA regional office, or online through VA.gov (if available).

- Step 7 – **Respond Promptly to VA Requests.** The VA may request additional information. Respond quickly and consider working with a VA-accredited representative or Veterans Service Officer (VSO).

- Step 8 – **Maintain Copies.** Keep a complete set of copies of all forms and documents submitted for your records.

9. How Comfort Keepers Supports Veterans

Comfort Keepers is proud to serve Veterans and surviving spouses by providing compassionate in-home care and practical support throughout the Aid & Attendance journey. While we are not part of the VA and do not make eligibility decisions, as a National VA Provider we can:

- Offer a complimentary in-home consultation to discuss needs and care options.
- Develop a personalized care plan that focuses on safety, independence, and quality of life.
- Provide written care summaries and visit logs that help demonstrate ongoing care needs.
- Generate detailed invoices and care statements that may be used as deductible medical expenses in VA pension calculations.
- Coordinate, at your request, with VA-accredited representatives or Veterans Service Organizations (VSOs).
- Adjust care schedules as needs change over time.

Comfort Keepers caregivers are carefully selected, trained, and supported to provide dignified, compassionate assistance that respects each Veteran's history, preferences, and goals.

10. Frequently Asked Questions

Do I need a service-connected disability rating to qualify for Aid & Attendance?
No. Aid & Attendance is based on wartime service, financial eligibility, and the need for regular personal care. A service-connected disability rating is not required for this pension benefit.

Can Aid & Attendance be used to pay for in-home care with Comfort Keepers?
Yes. When you qualify and receive the pension, the payments are made to you (the Veteran or surviving spouse). These funds can then be used to pay for in-home care services such as those provided by Comfort Keepers.

Can I start care before the VA approves my claim?
Many families begin care before a VA decision is made. Qualified in-home care expenses paid during the application process may be counted as medical expenses in the VA pension calculation. Always confirm details with a VA-accredited representative.

How long does it take to receive a decision?
Processing times vary depending on claim complexity and VA workload. Some claims may be processed in a few months, while others can take longer. Responding quickly to VA requests and working with an accredited representative may help avoid delays.

Who can help me complete these forms?
Free assistance is available from VA-accredited representatives, Veteran Service Officers, Veterans Service Organizations, county Veteran offices, and certain legal aid organizations. Comfort Keepers can help you organize care-related information and connect you with accredited resources.

11. Important Links & Disclaimers

Key VA and Support Resources

- VA main website: www.va.gov
- VA pension information and current rates: www.va.gov/pension/rates
- Aid & Attendance overview: www.va.gov/pension/aid-attendance-housebound
- Find VA forms: www.va.gov/find-forms
- Find a VA-accredited representative: www.va.gov/ogc/apps/accreditation

Disclaimer

This booklet is for general informational purposes only and is not legal, tax, medical, or financial advice. Comfort Keepers is a private home care provider and, while we are a National VA Provider, we are not affiliated with, endorsed by, or acting on behalf of the U.S. Department of Veterans Affairs. VA eligibility determinations, benefit amounts, and policies are governed solely by the VA and applicable law and are subject to change.

Veterans and surviving spouses are strongly encouraged to consult with a VA-accredited representative, Veteran Service Officer, Veterans Service Organization, or qualified professional when preparing and submitting claims.

Prepared by:

Comfort Keepers of Central and Southern New Jersey

(732) 530-3636