DEPARTMENT OF VETERANS AFFAIRS

# SURVIVORS PENSION BENEFITS 2026

Our staff of VA trained and accredited County Veteran Service Officers can answer your questions, assist in completing the necessary VA forms, and act as the claimant's advocate through the claim process.

**ALL SERVICES ARE PROVIDED FREE OF CHARGE.**


**LAKE COUNTY VETERANS SERVICE OFFICE**

An Office of Lake County Government
Located in Building C of the Lake County Administration Center

**105 Main St.,**
**Painesville, OH 44077**
**(440) 350-2904/2567**
**Fax (440) 350-5980**


If you are the surviving spouse of a deceased veteran with low income or overwhelmed with the high cost of medical care, such as paying for assisted living facilities, home care aids, adult daycare, or skilled nursing, the VA Survivors benefit could be the solution to help pay for this care or other needs.

**There are three levels of VA Survivors Pensions:**

**Basic Pension**—for surviving spouses with low income

**Aid & Attendance (A&A)** – for surviving spouses that require assistance with their activities of daily living

**Housebound** – for surviving spouses with a permanent disability that prevents them from leaving their home

**You may be eligible if:**

- the deceased veteran was discharged from military service under other than dishonorable conditions; ***AND***
- the veteran served 90 days of active duty or more with at least 1 day during a war time period*; ***AND***
- your annual household income and net worth** meet certain limits set by law.

While an un-remarried spouse is eligible at any age, a child of a deceased wartime Veteran must be: under 18, ***OR*** under age 23 if attending a VA-approved school, ***OR*** permanently incapable of self-support due to a disability before age 18.

*To find the dates of service considered as war time periods, visit: www.va.gov/pension/wartime period. Veterans who enlisted after September 7, 1980 generally must have served at least 24 months of active duty OR the full period for which called or ordered to active duty.

| PENSION RATES effective 12/1/2025 | MAXIMUM MONTHLY BENEFIT | (MAPR) MAXIMUM ANNUAL INCOME** |
|---|---|---|
| Basic Pension with no dependents* | $974.00 | $11,699.00 |
| With Housebound benefits with no dependents* | $1,191.00 | $14,298.00 |
| With Aid and Attendance with no dependents* | $1,621.00 | $19,453.00 |
| In Nursing Home receiving Medicaid benefits | $90.00 | N/A |

*Additional benefits are available for dependent children. Ask for details.

****OUT OF POCKET MEDICAL EXPENSES PAID BY THE HOUSEHOLD ARE USED TO REDUCE THE HOUSEHOLD INCOME.** **You may deduct only the amount that's above 5% of your MAPR amount . Please see the examples on page 2.**

*****HOUSEHOLD NET WORTH LIMIT MUST BE UNDER $163,699.00**

(as of 12/01/2023–changes annually) Net worth is the sum of household assets and annual income. It does NOT include a primary residence and lot under 2 acres, automobile, or personal effects. As of 10/18/2018 the VA instituted a **"look back" period of 3 years**. Any assets transferred to reduce net worth after this date must be reported and may prohibit qualifying for the pension benefit for up to 5 years.

## DETERMINING THE MONTHLY BENEFIT AMOUNT:

**The amount of the possible benefit can be determined by totaling the amount of monthly GROSS household income and then subtracting the monthly total of continuing out of pocket medical expenses which equals the countable income. The countable income is then subtracted from the maximum monthly income limit for the veteran's situation. (See the chart on page 1.) The examples below can help you to understand how the VA calculates the amount. All amounts are monthly figures.**

**The Pension Worksheet on page 3 can be used to determine the possible benefit.**

**1.PENSION EXAMPLE:**

The surviving spouse is 81 years old. Her monthly income is $800 (GROSS) in Social Security (SS) benefits. She is still able to live alone in her home which is paid off. She has no savings or any other assets. $185.00 is withheld from her SS benefits for Medicare and she pays $75.00 per month for a supplemental health insurance.

| **Medical Expenses:** | | **Income:** | | **Possible Benefit:** | |
|---|---|---|---|---|---|
| Medicare Part B | $ 202.00 | Social Security | $800.00 | VA Income Limit | $974.00 |
| Health insurance | 75.00 | Less med expenses | 272.00 | Less countable income | 528.00 |
| **Total med exps** | **$272.00** | **Countable income** | **$528.00** | **VA benefit** | **$446.00** |

**2. PENSION WITH AID AND ATTENDANCE EXAMPLE:**

Surviving spouse is 70 years old. His monthly income consists of $825.00 (GROSS) in Railroad Retirement (RR) and $1,370.00 in State Teachers Retirement. His doctor stated that he could no longer live alone, and it was a medical necessity to move into an assisted living facility but did not need full nursing home care. The monthly cost of the assisted living facility is $3,500 per month, $185.00 is withheld from his RR for Medicare, and he pays $100 for supplemental health insurance.

| **Medical Expenses:** | | **Income:** | | **Possible Benefit:** | |
|---|---|---|---|---|---|
| Assisted Living | $3,500.00 | RR | $ 825.00 | VA Income Limit | $1,621.00 |
| Medicare Part B | 202.00 | State Teachers | 1,370.00 | Because the claimant's income is | |
| Health insurance | 100.00 | **Total income** | $2,195.00 | less than his medical expense, his | |
| **Total med exps** | **$3,802.00** | Less med exps | 3,802.00 | countable income is zero. He would | |
| | | **Countable income** | **0.00** | receive the full benefit **$1,621.00.** | |

**3. NURSING HOME WITH MEDICAID EXAMPLE:**

The widow in example #1 becomes ill and the doctors determine she must be placed into a nursing home. Medicaid begins to pay the cost of her care and she receives just a small portion of her Social Security benefit. The VA will reduce her monthly pension benefit to **$90 per month** which can be used for her personal needs such as clothing, haircuts, etc.

## VA SURVIVOR PENSION WORKSHEET * This worksheet helps to determine only a *POSSIBLE* VA benefit amount.

**All claims for benefits must be processed through the VA to determine eligibility and benefit amount.**

**PLEASE PROVIDE STATEMENTS DOCUMENTING ALL AMOUNTS.**

| ***GROSS*** **MONTHLY INCOME** | **SURVIVOR** | **DEPENDENT** | **DEPENDENT** | **SOURCE** |
|---|---|---|---|---|
| SOCIAL SECURITY | | | | |
| US CIVIL SERVICE | | | | |
| RAILROAD RETIREMENT | | | | |
| BLACK LUNG BENS | | | | |
| ANY RETIREMENT OR PENSIONS | | | | |
| SSI/PUBLIC ASSISTANCE | | | | |
| LONG TERM CARE INSUR BENEFITS RECEIVED | | | | |
| WAGES FROM EMPLOYMENT | | | | |
| OTHER (PROVIDE SOURCE) | | | | |
| OTHER (PROVIDE SOURCE) | | | | |
| OTHER (PROVIDE SOURCE) | | | | |
| **TOTALS** | | | (A) | |

TOTAL HOUSEHOLD INCOME

| ***CONTINUING ***** **MTHLY MED EXPENSES** | **SURVIVOR** | **DEPENDENT** | **DEPENDENT** | **SOURCE** |
|---|---|---|---|---|
| MEDICARE PART B | | | | |
| HEALTH INSUR PREMIUM | | | | |
| HEALTH INSUR PREMIUM | | | | |
| RX INSUR PREMIUM | | | | |
| NURSING HOME | | | | |
| ASSISTED LIVING | | | | |
| HOME HEALTH AIDES | | | | |
| LONG TERM CARE INSUR PREMIUMS PAID | | | | |
| OTHER (PROVIDE TYPE) | | | | |
| OTHER (PROVIDE TYPE) | | | | |
| **TOTALS** ** List only medical expenses which are the same every month **(B)** | | | | |

TOTAL HOUSEHOLD MEDICAL EXPENSES

| | |
|---|---|
| **TOTAL HOUSEHOLD INCOME(A)** | |
| **LESS TOTAL HOUSEHOLD MEDICAL EXPENSES (B)** | |
| **EQUALS COUNTABLE INCOME ( C )** | |
| If household income is less than medical expenses, the countable income is "0" | (A-B=C) |
| **VA INCOME LIMIT for your situation** (from pg 1-i.e. survivor w/aid & attendance is $1,388.00) | |
| **LESS COUNTABLE INCOME( C )** (from above) | |
| **EQUALS POSSIBLE* VA BENEFIT** | |

**LIST BALANCES OF ALL BANK ACCOUNTS, IRAS, MUTUAL FUNDS, STOCKS, TRUSTS, ETC. ****

| **ACCOUNT** | **CURRENT BALANCES** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| TOTAL NET WORTH | |

****TOTAL NET WORTH MUST BE UNDER $155,356.00**



DO YOU OWN A HOME? ADDRESS: IS THERE ANY RENTAL INCOME?

## CHECKLIST OF DOCUMENTATION NEEDED TO COMPLETE THE VA FORMS FOR SURVIVORS PENSION:

The average processing time for VA **Survivors** Pension is an average of 6 to 9 months. Therefore, it is best to submit all supporting documentation with the original claim forms to expedite the process as much as possible.
**FAILURE TO PROVIDE ALL DOCUMENTATION WILL DELAY THE FILING OF THE CLAIM AND A DECISION FROM THE VA.**

____ **DD 214/Military Separation Record.** We can assist with obtaining this document if necessary or you can request it FREE OF CHARGE on-line at: www.archives.gov/veterans/military-service-records.

____ **Social Security numbers for claimant, veteran, and dependents**. Please also provide VA Claim number if available.

____ **Marriage Licenses and Death Certificates.**

____ **Proof of all income.** Please provide statements showing the **GROSS* amounts** (before any deductions such as Medicare, health insurance, etc.) of all monthly income including Social Security, pensions, income from investments, rental or business income, long term care insurance benefits received, etc. *This amount can generally be found on annual statements from Social Security and other benefits.

____ **Current statements for all assets.** All checking, savings accounts, stocks, bonds, mutual funds, trusts, annuities, long term care insurance, savings bonds, etc.

____ **Direct deposit information and/or voided check.**

____ **Documentation regarding any transfer of assets you or your dependents have made in the last 3 tax years.** Assets transfers include gifts, selling them, purchasing an annuity, or using them to establish a trust.

____ **Amounts of CONTINUING monthly medical expenses.** When initially filing for the VA Pension benefit, we will report household "out of pocket" medical expenses which are the same every month. These include:

- Medicare deductions withheld from Social Security or other benefits for Parts B, C, or D.
- Supplemental insurance premiums for health, dental, prescriptions, vision plans, etc. (sometimes withheld from pension/retirement benefits)
- Prescriptions/over the counter medications/medical supplies (i.e. incontinence supplies) which are the same every month
- Long term care insurance premiums
- Final funeral/burial expenses paid by the veteran for spouse in the last year
- Amounts paid for in home health care, adult day care, assisted living, and nursing home

____ **Documentation from the Ohio Department of Jobs and Family Services (ODJFS) regarding Medicaid.**
____**Any Guardianship Appointments or Power of Attorneys.**

**If the claimant is in a Nursing Home:**
____ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician **AND** signed by the veteran/claimant. ***AND***
____ **VA Form 21-0779 included in this packet** (Request for Nursing Home Information)

**If the claimant is in an Assisted Living, Adult Day Care, or similar facility:**
____**VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician **AND** signed by the veteran/claimant. ***AND***
____ **VA Form 21P-534EZ, page 19 included in this packet** (Worksheet for Residential Care, etc.)

**If the claimant receives medical care from an In-Home Care Attendant:**
____ **VA Form 21-2680 included in this packet** (Examination for Housebound Status or Permanent Need for Regular Aid and Attendance) Must be completed by a physician **AND** signed by the veteran/claimant. ***AND***
____ **VA Form 21P-534EZ, page 20 included in this packet** (Worksheet for an In-Home Attendant)

 ***ENTER SURVIVING SPOUSE'S NAME AS CLAIMANT OR BENEFICIARY ON ALL VA FORMS

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

Department of Veterans Affairs

**VA DATE STAMP**
(DO NOT WRITE IN THIS SPACE)

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

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

## SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER – –

3. VA FILE NUMBER (If applicable)

4. VETERAN'S SERVICE NUMBER (If applicable)

5. DATE OF BIRTH (MM/DD/YYYY) – –

## SECTION II: CLAIMAINT'S IDENTIFICATION INFORMATION

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

7. CLAIMANT'S SOCIAL SECURITY NUMBER – –

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

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

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

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

11. TELEPHONE NUMBER (Optional) (Include Area Code) – –

Enter International Phone Number (If applicable)

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

## SECTION III: CLAIM INFORMATION

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

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

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

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

## SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

14A. IS THE CLAIMANT HOSPITALIZED?

☐ 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.

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

Department of Veterans Affairs

**VA DATE STAMP**
(Do Not Write In This Space)

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

**INSTRUCTIONS**: Before completing this form, read the Privacy Act and Respondent Burden on page 2. VA uses this form to determine eligibility for pension and aid and attendance benefits based on nursing home status. For more information you can contact us online through **Ask VA:** https://ask.va.gov, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI, 53547- 4444.**

## SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER — — 

3. VA FILE NUMBER

4. DATE OF BIRTH (MM/DD/YYYY) — — 

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

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

6. SOCIAL SECURITY NUMBER — — 

7. VA FILE NUMBER (If applicable)

8. DATE OF BIRTH (MM/DD/YYYY) — — 

## SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

10. ADDRESS OF NURSING HOME (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number  City

State/Province  Country  ZIP Code/Postal Code —

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

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

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

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

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

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

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

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

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

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

18. NURSING HOME OFFICIAL'S TITLE

19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER (Include Area Code) — —
Enter International Phone Number (If applicable)

## SECTION V - CERTIFICATION AND SIGNATURE

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

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

21. DATE SIGNED (MM/DD/YYYY) — — 

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

**PRIVACY ACT NOTICE**: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

**RESPONDENT BURDEN**: VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

## WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

**NOTE**: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

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

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

3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

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

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

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

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

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

- ○ YES
- ○ NO, Care <u>is</u> being provided by a third-party provider.
- ○ NO, Care <u>is not</u> being provided to this claimant.

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

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

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

○ INDEFINITE

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

$ , . PER MONTH

### FACILITY CERTIFICATION

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

14. SIGNATURE OF PROVIDER (From question 2)

15. DATE SIGNED (MM/DD/YYYY)

# WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

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

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

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

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

○ YES ○ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

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

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

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

– –

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

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

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

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

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

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

○ D. LAUNDERING ○ E. USING TELEPHONE ○ F. MANAGING FINANCES

○ G. HOUSEKEEPING ○ H. HANDLING MEDICATIONS

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

○ YES ○ NO

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

/ /

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

/ / ○ INDEFINITE

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

$ . PER HOUR

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

HOURS PER MONTH

## CERTIFICATION

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

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)

/ /