

**2025
SURVIVOR'S
PENSION
PACKET**

BRAZORIA COUNTY VETERANS SERVICE OFFICE
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Sonya T. Broadway
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2025

Dear Surviving Spouse:

Please find enclosed VA Form 21P-534EZ-Application for Survivor's Pension; VA Form 21-2680-Examination for Housebound Status or Permanent Need for A&A; VA Form 21-0779-Request for Nursing Home Information; Worksheets for Assisted Living/In-Home Attendant expenses; and VA Form 21P-0969-Income & Asset Statement. When you have gathered all necessary information on the enclosed checklist, please contact our office.

Respectfully,

Veteran Service Office
Brazoria County

Enclosures

***** PLEASE NOTE *****

The Brazoria County Veterans Service Office is a County Agency.

WE ARE NOT THE VA.

The (DVA) Department of Veterans Affairs is a Federal Agency,
which has the POWER to Grant or Deny VA Claims.

Checklist to file Survivor's Pension- Brazoria County VSO 2025:

- ___ Certified Copy of veterans DD214
- ___ Copy of Death Certificate of Veteran
- ___ Copy of marriage certificate to Veteran
- ___ Date and place of prior marriages of self and veteran
- ___ Date and place of dissolution of prior marriages of self and veteran
- ___ Mailing address where VA correspondence will be properly received
- ___ Day and Evening telephone number
- ___ Best email address where your VA claim forms will be sent for your final review and signature
- ___ **VOIDED CHECK**-for Direct Deposit Purposes
- ___ Full name of veteran
- ___ Social Security Number of veteran
- ___ Date of Birth of Veteran
- ___ Place of Birth of veteran
- ___ Your Date of Birth
- ___ Your Social Security Number
- ___ Are you currently expecting a child of the veteran? -yes or no
- ___ Did you live with the veteran at the time of the veteran's death? -If no, reason for separation
- ___ Copy of Social Security Award Letter and 1099's from all other income sources
- ___ Copy of current Bank, Asset, Investment Account Statements
- ___ If In-home Care-Proof of payment from care provider (canceled checks, bank statements, etc.)
- ___ Receipts showing paid in full for all Funeral/Burial related expenses of veteran

Survivors Pension Benefits-FOR THE SURVIVING SPOUSE/CHILD

What Is Survivors Pension?

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

Who Is Eligible?

You may be eligible if:

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

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

INCOME LIMITS (EFFECTIVE DECEMBER 1, 2024)		
If you are a...	Your income must be less than...	
	Year	Month
Surviving spouse with no dependent children	\$11,380	948
Surviving spouse with one dependent child (add \$2,902 to the limit for EACH child)	\$14,893	1,241
Housebound surviving spouse with no dependents	\$13,908	1,159
Housebound surviving spouse with one dependent	\$17,414	1,451
Surviving spouse who needs aid and attendance-no dependents	\$18,187	1,516
Surviving spouse who needs aid and attendance-one dependent	\$21,696	1,808
Surviving child (no eligible parent)	\$ 2,902	242

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

How Much Does VA Pay?

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

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

How Can You Apply?

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

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

VETERAN'S SOCIAL SECURITY NUMBER - -

SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?	
14A. IS THE CLAIMANT HOSPITALIZED? <input type="checkbox"/> YES (If "YES," complete Items 14B, 14C & 14D) <input type="checkbox"/> NO (If "NO," skip to Section V)	14B. DATE ADMITTED (MM/DD/YYYY) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION VI: EXAMINATION INFORMATION (IMPORTANT: Remainder of form MUST be filled out by Examiner)	
NOTE: Examiner <u>must be</u> a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.	
16. DATE OF EXAMINATION (MM/DD/YYYY) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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 <input type="text"/> <input type="text"/>	19B. WEIGHT ACTUAL LBS. <input type="text"/> <input type="text"/> ESTIMATED LBS. <input type="text"/> <input type="text"/>	19C. HEIGHT FEET <input type="text"/> INCHES <input type="text"/> <input type="text"/>
20. NUTRITION		21. GAIT
22. BLOOD PRESSURE <input type="text"/> <input type="text"/> <input type="text"/>	23. PULSE RATE <input type="text"/> <input type="text"/>	24. RESPIRATORY RATE <input type="text"/> <input type="text"/>
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: <input type="text"/> <input type="text"/> <input type="text"/> From 9 AM to 9 PM: <input type="text"/> <input type="text"/> <input type="text"/>		
27. DOES THE PATIENT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply)		
<input type="checkbox"/> BATHING/SHOWERING	<input type="checkbox"/> TENDING TO HYGIENE NEEDS	<input type="checkbox"/> ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below)
<input type="checkbox"/> EATING OR SELF-FEEDING	<input type="checkbox"/> TRANSFERRING IN OR OUT OF BED/CHAIR	
<input type="checkbox"/> DRESSING	<input type="checkbox"/> TOILETING	
<input type="checkbox"/> AMBULATING WITHIN THE HOME OR LIVING AREA	<input type="checkbox"/> MEDICATION MANAGEMENT	
28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)	28B. CORRECTED VISION	
<input type="checkbox"/> YES <input type="checkbox"/> NO	LEFT EYE <input type="text"/> <input type="text"/> <input type="text"/>	RIGHT EYE <input type="text"/> <input type="text"/> <input type="text"/>
29. DOES THE PATIENT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)		
<input type="checkbox"/> YES <input type="checkbox"/> 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?		
<input type="checkbox"/> YES <input type="checkbox"/> 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		

SECTION VII: DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
 (Skip to Section VIII if you are NOT claiming DIC)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

- DIC DIC under 38 U.S.C. 1151 (Note: DIC under 38 U.S.C. 1151 is a rare benefit. Please refer to Instructions page 5 for guidance on 38 U.S.C 1151) DIC due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 (PACT Act) (Note: Please refer to Instructions page 6 for guidance on PACT Act)

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

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: [] [] / [] [] / [] [] [] [] END: [] [] / [] [] / [] [] [] []
	START: [] [] / [] [] / [] [] [] [] END: [] [] / [] [] / [] [] [] []
	START: [] [] / [] [] / [] [] [] [] END: [] [] / [] [] / [] [] [] []

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

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

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

8B. ARE YOU NOW IN A NURSING HOME?

- YES NO (If "YES," complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance. For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC") (If "NO," skip to Item 9A)

SECTION IX: INCOME AND ASSETS
 (Skip to Section X if you are NOT claiming survivors pension benefits)

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

IMPORTANT:

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

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

- YES NO (If "YES," please submit a VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC))

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

\$ [] [] [] , [] [] [] . [] [] [] []

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

- YES NO (If "YES," please submit a VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC))

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

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

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

- YES NO (If "NO," skip to Item 9H)

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

\$ [] [] [] , [] [] [] , [] [] [] . [] [] [] []

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

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

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

- YES NO (If "YES," please submit a VA Form 21P-0969, and ONLY report your Social Security income in Item 9I)

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

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

SECTION IX: INCOME AND ASSETS (CONTINUED)
 (Skip to Section X if you are not claiming survivors pension benefits)

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

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

NO.	(1) WHO IS THE INCOME RECIPIENT?	(2) WHAT IS THE TYPE/SOURCE OF INCOME?	(3) WHAT IS THE CURRENT GROSS MONTHLY INCOME?
9I	<input type="radio"/> SURVIVING SPOUSE <input type="radio"/> CHILD (Provide name below)	<input type="radio"/> SOCIAL SECURITY <input type="radio"/> PENSION/RETIREMENT <input type="radio"/> CIVIL SERVICE <input type="radio"/> INTEREST/DIVIDENDS <input type="radio"/> OTHER (Specify Source i.e., inheritance, etc.)	\$ <input type="text"/> , <input type="text"/> . <input type="text"/>
9J	<input type="radio"/> SURVIVING SPOUSE <input type="radio"/> CHILD (Provide name below)	<input type="radio"/> SOCIAL SECURITY <input type="radio"/> PENSION/RETIREMENT <input type="radio"/> CIVIL SERVICE <input type="radio"/> INTEREST/DIVIDENDS <input type="radio"/> OTHER (Specify Source i.e., inheritance, etc.)	\$ <input type="text"/> , <input type="text"/> . <input type="text"/>
9K	<input type="radio"/> SURVIVING SPOUSE <input type="radio"/> CHILD (Provide name below)	<input type="radio"/> SOCIAL SECURITY <input type="radio"/> PENSION/RETIREMENT <input type="radio"/> CIVIL SERVICE <input type="radio"/> INTEREST/DIVIDENDS <input type="radio"/> OTHER (Specify Source i.e., inheritance, etc.)	\$ <input type="text"/> , <input type="text"/> . <input type="text"/>
9L	<input type="radio"/> SURVIVING SPOUSE <input type="radio"/> CHILD (Provide name below)	<input type="radio"/> SOCIAL SECURITY <input type="radio"/> PENSION/RETIREMENT <input type="radio"/> CIVIL SERVICE <input type="radio"/> INTEREST/DIVIDENDS <input type="radio"/> OTHER (Specify Source i.e., inheritance, etc.)	\$ <input type="text"/> , <input type="text"/> . <input type="text"/>

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

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

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

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

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

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

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10B (1). WHOSE EXPENSES WERE PAID? <input type="radio"/> SURVIVING SPOUSE <input type="radio"/> OTHER (Specify below)	10B (2). NAME OF PROVIDER AND TYPE OF CARE CHECK ONE: <input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDENT	10B (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE: Payment Rate (Per Hour) \$ <input type="text"/> .00 Hours Worked (Per Week) <input type="text"/>
10B (4). PROVIDER START AND END DATE (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> END: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="radio"/> NO END DATE	10B (5). PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY	10B (6). AMOUNT YOU PAY (Based on frequency selected in Item 10B (5)) \$ <input type="text"/> , <input type="text"/> . <input type="text"/>

IN-HOME CARE OR CARE FACILITY (Continued)

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

<p>10C (1). WHOSE EXPENSES WERE PAID? <input type="radio"/> SURVIVING SPOUSE <input type="radio"/> OTHER (Specify below)</p>	<p>10C (2). NAME OF PROVIDER AND TYPE OF CARE</p> <p>CHECK ONE: <input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDANT</p>	<p>10C (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE: Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Hours Worked (Per Week) <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>10C (4). PROVIDER START AND END DATE (MM/DD/YYYY)</p> <p>START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p><input type="radio"/> NO END DATE</p>	<p>10C (5). PAYMENT FREQUENCY</p> <p><input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY</p>	<p>10C (6). AMOUNT YOU PAY (Based on frequency selected in Item 10C (5))</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>

<p>10D (1). WHOSE EXPENSES WERE PAID? <input type="radio"/> SURVIVING SPOUSE <input type="radio"/> OTHER (Specify below)</p>	<p>10D (2). NAME OF PROVIDER AND TYPE OF CARE</p> <p>CHECK ONE: <input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDANT</p>	<p>10D (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE: Payment Rate (Per Hour) \$ <input type="text"/> <input type="text"/> <input type="text"/> .00 Hours Worked (Per Week) <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>10D (4). PROVIDER START AND END DATE (MM/DD/YYYY)</p> <p>START: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>END: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p><input type="radio"/> NO END DATE</p>	<p>10D (5). PAYMENT FREQUENCY</p> <p><input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY</p>	<p>10D (6). AMOUNT YOU PAY (Based on frequency selected in Item 10D (5))</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

<p>10E (1). WHOSE EXPENSES WERE PAID? (Check one) <input type="radio"/> SURVIVING SPOUSE <input type="radio"/> CHILD (Specify below)</p>	<p>10E (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)</p> <p>Provider: <input style="width:100%;" type="text"/></p> <p>Purpose: <input style="width:100%;" type="text"/></p>	
<p>10E (3). DATE COSTS INCURRED (MM/DD/YYYY)</p> <p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>10E (4). PAYMENT FREQUENCY</p> <p><input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME</p>	<p>10E (5). AMOUNT YOU PAY (Based on frequency selected in Item 10E (4))</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>

<p>10F (1). WHOSE EXPENSES WERE PAID? (Check one) <input type="radio"/> SURVIVING SPOUSE <input type="radio"/> CHILD (Specify below)</p>	<p>10F (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)</p> <p>Provider: <input style="width:100%;" type="text"/></p> <p>Purpose: <input style="width:100%;" type="text"/></p>	
<p>10F (3). DATE COSTS INCURRED (MM/DD/YYYY)</p> <p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>10F (4). PAYMENT FREQUENCY</p> <p><input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME</p>	<p>10F (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4))</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>

<p>10G (1). WHOSE EXPENSES WERE PAID? (Check one) <input type="radio"/> SURVIVING SPOUSE <input type="radio"/> CHILD (Specify below)</p>	<p>10G (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)</p> <p>Provider: <input style="width:100%;" type="text"/></p> <p>Purpose: <input style="width:100%;" type="text"/></p>	
<p>10G (3). DATE COSTS INCURRED (MM/DD/YYYY)</p> <p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>10G (4). PAYMENT FREQUENCY</p> <p><input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME</p>	<p>10G (5). AMOUNT YOU PAY (Based on frequency selected in Item 10G (4))</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>



VA DATE STAMP
(Do Not Write In This Space)

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

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

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

4. DATE OF BIRTH (MM/DD/YYYY)

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

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

6. SOCIAL SECURITY NUMBER

7. VA FILE NUMBER (If applicable)

8. DATE OF BIRTH (MM/DD/YYYY)

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

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

No. &
Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

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

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

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

12. IS THE NURSING HOME A MEDICAID APPROVED FACILITY?

YES NO

13. HAS THE PATIENT APPLIED FOR MEDICAID?

YES NO

14A. IS THE PATIENT COVERED BY MEDICAID?

YES NO (If "YES," complete Item 14B)

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

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

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

SKILLED NURSING CARE INTERMEDIATE NURSING CARE

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

18. NURSING HOME OFFICIAL'S TITLE

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

Enter International Phone Number (If applicable)

SECTION V - CERTIFICATION AND SIGNATURE

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

20. SIGNATURE OF NURSING HOME OFFICIAL (REQUIRED)

21. DATE SIGNED (MM/DD/YYYY)

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

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

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

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

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

--	--	--	--

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

--	--	--	--

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

--	--	--	--

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

--	--	--	--

5. WHAT IS THE FACILITY TELEPHONE NUMBER?

International Phone Number (If applicable)

--	--	--	--	--	--	--	--	--	--

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

No. & Street

--	--	--	--

Apt./Unit Number

--	--	--	--

City

--	--	--	--

State/Province

--	--	--	--

Country

--	--	--	--

ZIP Code

--	--	--	--

-

--	--	--	--

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

--	--	--	--

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

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

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

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

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

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

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

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

--	--	--	--	--	--	--	--	--	--

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

--	--	--	--	--	--	--	--	--	--

 INDEFINITE

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

\$

--	--	--	--	--	--	--	--

 PER MONTH

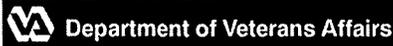
FACILITY CERTIFICATION

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

14. SIGNATURE OF PROVIDER (From question 2)

15. DATE SIGNED (MM/DD/YYYY)

--	--	--	--	--	--	--	--



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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME (First, Middle Initial (M.I.), Last)		
First:	MI:	Last:
1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VETERAN'S FILE NUMBER (If known)	

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

2A. CLAIMANT'S NAME (First, Middle Initial (M.I.), Last)		
First:	MI:	Last:
2B. CLAIMANT'S SOCIAL SECURITY NUMBER	2C. CLAIMANT'S TELEPHONE NUMBER (If known)	

2D. TYPE OF CLAIMANT (Check only one box)

VETERAN
 SURVIVING SPOUSE
 SURVIVING CHILD
 PARENT
 CUSTODIAN OF CHILD BENEFICIARY

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

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

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

3A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS FROM SOURCES NOT RELATED TO AN ACCOUNT OR YOUR ASSETS?

YES
 NO (If NO, skip to Section IV)

3B. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify): _____	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify): _____	(4). GROSS MONTHLY INCOME \$ <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/> . <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/> . <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/>
(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	

3C. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify): _____	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify): _____	(4). GROSS MONTHLY INCOME \$ <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/> . <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/> . <input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/>
(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (Continued)

(See instructions on Page 2)

3D.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
	(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):	(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	
3E.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
	(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):	(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	
3F.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)
	(3). SPECIFY THE TYPE OF INCOME <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):	(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
	(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS

(See instructions on Page 2)

4A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS THAT IS RELATED TO FINANCIAL ACCOUNTS? <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, skip to Section V)		
4B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
4C.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
4D.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/>
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)	(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS (Continued)

(See instructions on Page 2)

<p>4E. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):</p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)</p>	<p>(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)</p>	<p>(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>

<p>4F. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). SPECIFY THE TYPE OF INCOME EARNED <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):</p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)</p>	<p>(5). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)</p>	<p>(6). VALUE OF ACCOUNT \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>

SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS

(See instructions on Page 2)

5A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS GENERATED BY OWNED PROPERTY OR OTHER PHYSICAL ASSETS?
 YES NO (If NO, skip to Section VI)

<p>5B. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)</p>	<p>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185</p>	

<p>5C. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other only)</p>	<p>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185</p>	

<p>5D. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other only)</p>	<p>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/></p>
<p>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185</p>	

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

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

YES NO (If NO, skip to Section VII)

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> 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 <input type="checkbox"/> BENEFITS FROM INTELLECTUAL PROPERTY <input type="checkbox"/> EXTRACTION OF MINERALS/LUMBER <input type="checkbox"/> USE OF LAND <input type="checkbox"/> OTHER (Specify):		
(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	(6). CAN THE ASSET BE SOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO
(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET		

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> 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 <input type="checkbox"/> BENEFITS FROM INTELLECTUAL PROPERTY <input type="checkbox"/> EXTRACTION OF MINERALS/LUMBER <input type="checkbox"/> USE OF LAND <input type="checkbox"/> OTHER (Specify):		
(4). GROSS MONTHLY INCOME \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	(6). CAN THE ASSET BE SOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO
(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET		

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

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

YES NO (If NO, skip to Section VIII)

(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
(2). SPECIFY HOW THE ASSET WAS TRANSFERRED <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify):	(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE? <input type="checkbox"/> YES <input type="checkbox"/> NO
(3). WHAT ASSET WAS TRANSFERRED?	(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED? \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
(4). WHO RECEIVED THE ASSET?	(10). WHAT WAS THE SALE PRICE? (If applicable) \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
(5). RELATIONSHIP TO NEW OWNER	(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

<p>7C. (1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) [] [] - [] [] - [] [] [] []</p>
<p>(2). SPECIFY HOW THE ASSET WAS TRANSFERRED <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify):</p>	<p>(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(3). WHAT ASSET WAS TRANSFERRED?</p>	<p>(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED? \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(4). WHO RECEIVED THE ASSET?</p>	<p>(10). WHAT WAS THE SALE PRICE? (If applicable) \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(5). RELATIONSHIP TO NEW OWNER</p>	<p>(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

<p>7D. (1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p>	<p>(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) [] [] - [] [] - [] [] [] []</p>
<p>(2). SPECIFY HOW THE ASSET WAS TRANSFERRED <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify):</p>	<p>(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(3). WHAT ASSET WAS TRANSFERRED?</p>	<p>(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED? \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(4). WHO RECEIVED THE ASSET?</p>	<p>(10). WHAT WAS THE SALE PRICE? (If applicable) \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(5). RELATIONSHIP TO NEW OWNER</p>	<p>(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>
<p>(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

SECTION VIII: TRUSTS
(See instructions on Page 2)

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

<p>8B. DATE TRUST ESTABLISHED (MM/DD/YYYY) [] [] - [] [] - [] [] [] []</p>	<p>8C. SPECIFY MARKET VALUE OF ALL ASSETS WITHIN THE TRUST AT TIME OF ESTABLISHMENT \$ [] [] , [] [] [] , [] [] [] [] . [] []</p>	<p>8D. SPECIFY TYPE OF TRUST ESTABLISHED <input type="checkbox"/> REVOCABLE <input type="checkbox"/> IRREVOCABLE <input type="checkbox"/> BURIAL TRUST</p>
<p>8E. HAVE YOU ADDED FUNDS TO THE TRUST AFTER IT WAS ESTABLISHED? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8F. WHEN DID YOU ADD FUNDS? (MM/DD/YYYY) (If more than one date, submit a VA Form 21-4138 with all dates and amounts) [] [] - [] [] - [] [] [] []</p>	<p>8G. HOW MUCH DID YOU ADD? \$ [] [] [] , [] [] [] [] . [] []</p>
<p>8H. ARE YOU RECEIVING INCOME FROM THE TRUST? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8I. HOW MUCH DO YOU RECEIVE ANNUALLY? \$ [] [] [] , [] [] [] [] . [] []</p>	
<p>8J. IS THE TRUST BEING USED TO PAY FOR OR TO REIMBURSE SOMEONE ELSE FOR YOUR MEDICAL EXPENSES? (Such as a guardian, family member or other service provider) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8K. HOW MUCH IS BEING REIMBURSED MONTHLY? \$ [] [] [] , [] [] [] [] . [] []</p>	
<p>8L. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>8M. DO YOU HAVE ANY ADDITIONAL AUTHORITY OR CONTROL OF THE TRUST? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

SECTION IX: ANNUITIES
(See instructions on Page 2)

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

YES NO (If NO, skip to Section X)

9B. SPECIFY DATE ANNUITY WAS ESTABLISHED (MM/DD/YYYY)

□□ - □□ - □□□□

9C. SPECIFY MARKET VALUE OF ASSET AT TIME OF ANNUITY PURCHASE

\$ □□, □□□□, □□□□. □□

9D. HAVE YOU ADDED FUNDS TO THE ANNUITY IN THE CURRENT OR PRIOR THREE YEARS?

YES NO

9E. WHEN DID YOU ADD FUNDS? (MM/DD/YYYY)

□□ - □□ - □□□□

9F. HOW MUCH DID YOU ADD?

\$ □□, □□□□, □□□□. □□

9G. IS THE ANNUITY REVOCABLE OR IRREVOCABLE?

REVOCABLE IRREVOCABLE

9H. DO YOU RECEIVE INCOME FROM THE ANNUITY?

YES NO

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

\$ □□, □□□□, □□□□. □□

9J. CAN THE ANNUITY BE LIQUIDATED?

YES NO

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

\$ □□, □□□□, □□□□. □□

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

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

YES NO (If NO, skip to Section XI)

10B. (1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN
 VETERAN SPOUSE CUSTODIAN OF CHILD CHILD
 PARENT OTHER (Specify):

(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY
 \$ □□, □□□□, □□□□. □□

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

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

10C. (1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN
 VETERAN SPOUSE CUSTODIAN OF CHILD CHILD
 PARENT OTHER (Specify):

(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY
 \$ □□, □□□□, □□□□. □□

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

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

10D. (1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN
 VETERAN SPOUSE CUSTODIAN OF CHILD CHILD
 PARENT OTHER (Specify):

(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY
 \$ □□, □□□□, □□□□. □□

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

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

10E. (1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN
 VETERAN SPOUSE CUSTODIAN OF CHILD CHILD
 PARENT OTHER (Specify):

(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY
 \$ □□, □□□□, □□□□. □□

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

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

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

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

YES NO (If NO, skip to Section XII)

11B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(5). SPECIFY FREQUENCY OF INCOME RECEIVED <input type="checkbox"/> RECURRING <input type="checkbox"/> IRREGULAR <input type="checkbox"/> ONE TIME PAYMENT
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(6). DATE INCOME LAST PAID (MM/DD/YYYY) [] [] - [] [] - [] [] [] []
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS? \$ [] [] [] , [] [] [] . [] []
	(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)	

11C.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(5). SPECIFY FREQUENCY OF INCOME RECEIVED <input type="checkbox"/> RECURRING <input type="checkbox"/> IRREGULAR <input type="checkbox"/> ONE TIME PAYMENT
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(6). DATE INCOME LAST RECEIVED (MM/DD/YYYY) [] [] - [] [] - [] [] [] []
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS? \$ [] [] [] , [] [] [] . [] []
	(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)	

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

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

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

12B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE? \$ [] [] [] , [] [] [] . [] []
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY) [] [] - [] [] - [] [] [] [] <input type="checkbox"/> This income will not resume
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(6). WAIVED GROSS MONTHLY INCOME \$ [] [] [] , [] [] [] . [] []

12C.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE? \$ [] [] [] , [] [] [] . [] []
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY) [] [] - [] [] - [] [] [] [] <input type="checkbox"/> This income will not resume
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(6). WAIVED GROSS MONTHLY INCOME \$ [] [] [] , [] [] [] . [] []

SECTION XIII: CERTIFICATION AND SIGNATURE

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

13A. SIGNATURE	13B. DATE SIGNED (MM/DD/YYYY) [] [] - [] [] - [] [] [] []
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SECTION XIV: WITNESS TO SIGNATURE
(Two witness signatures are required if the claimant signed Item 13A with an "X")

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

14B. PRINTED NAME OF FIRST WITNESS

FIRST: _____ MI: _____ LAST: _____

14C. ADDRESS OF FIRST WITNESS

No. & Street _____ Apt./Unit Number _____

City _____

State/Province Country ZIP Code/Postal Code -

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

14E. PRINTED NAME OF SECOND WITNESS

FIRST: _____ MI: _____ LAST: _____

14F. ADDRESS OF SECOND WITNESS

No. & Street _____ Apt./Unit Number _____

City _____

State/Province Country ZIP Code/Postal Code -

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

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