

2025

VETERAN

PENSION

PACKET

BRAZORIA COUNTY VETERANS SERVICE OFFICE
111 E. Locust, Bldg. A-29, Suite 120 • Angleton, Texas 77515
Telephone Number (979)864-1289 • Fax (979)864-1032

Sonya T. Broadway
Veteran Service Officer

Asst. Veteran Service Officer
Jose "JC" Cumpian

Administrative Assistant
Kimberly Westbrook

2025

Dear Veteran:

Please find enclosed VA Form 21P-527EZ-Application for Veteran Pension; VA Form 21-2680-Examination for Housebound Status or Permanent Need for Regular A&A; VA Form 21-0779 Request for Nursing Home information; Worksheets for Assisted Living/In-Home Attendant expenses; and VA Form 21P-0969-Income & Asset Statement. When you have gathered all necessary information on the enclosed checklist, please contact our office.

Respectfully,

Veteran Service Office
Brazoria County

Enclosures

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

The Brazoria County Veterans Service Office is a County Agency.

WE ARE NOT THE VA.

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

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

- ____ Certified Copy of veterans DD214
- ____ Full current name of veteran
- ____ Mailing address where VA correspondence will be properly received
- ____ Day and Evening telephone number
- ____ Best email address where your VA claim forms will be sent for your final review and signature
- ____ Social Security Number of Veteran
- ____ Date of Birth of Veteran
- ____ Place of Birth of veteran
- ____ VOIDED CHECK-for Direct Deposit Purposes-(If not already on VA record)
- ____ Does veteran currently get Medical Care through VA? – If yes, what VA facility?
- ____ Copy of Social Security Award Letter and 1099's from all other income sources
- ____ Copy of current Bank, Asset, Investment Account Statements
- ____ Amounts paid for reoccurring monthly Medical Expenses-Medicare, Private HI, Nursing Home...

Pension- FOR THE VETERAN

What Is VA Pension?

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

Who Is Eligible?

You may be eligible if:

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

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

FAMILY INCOME LIMITS (EFFECTIVE DECEMBER 1, 2024)		
If you are a...	Your income must be less than...	
	Year	Month
Veteran with no dependents	\$16,965	1,414
Veteran with a spouse or a child	\$22,216	1,851
(Veterans with additional children: add \$2,902 to the limit for EACH child)		
Housebound veteran with no dependents	\$20,732	1,728
Housebound veteran with one dependent	\$25,982	2,165
Veteran who needs aid and attendance and has no dependents	\$28,300	2,358
Veteran who needs aid and attendance and has one dependent	\$33,548	2,796

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

How Much Does VA Pay?

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

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

How Can You Apply?

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

Related Benefits

Vocational Rehabilitation Program
Medical Care

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

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

28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)

- YES
 NO

28B. CORRECTED VISION

LEFT EYE

RIGHT EYE

29. DOES THE PATIENT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

- YES
 NO

30. IN YOUR JUDGMENT, DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYMENTS, OR ARE THEY ABLE TO DIRECT SOMEONE TO DO SO?

- YES
 NO

(If "NO," provide the disability(ies) that prevent them from performing this function and any rationale to support your conclusion in the space provided)

31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE

33. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. (NOTE: If indicated, comment specifically on weight bearing, balance and propulsion of each lower extremity)

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

Veterans Pension Application Checklist

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

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

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

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

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

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

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

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

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

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

Claim for Fiduciary Assistance

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

Statement of Medical Care

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

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

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

Medical Expenses (Requested in Section X)

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



VA DATE STAMP
 (DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1B. VETERAN'S SOCIAL SECURITY NUMBER

____ - ____ - _____

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

____ / ____ / _____

1D. HAVE YOU EVER FILED A CLAIM WITH VA?

YES NO (If NO, skip question 1E)

1E. VA FILE NUMBER (If applicable)

SECTION II: VETERAN'S CONTACT INFORMATION

2A. MAILING ADDRESS

No. & Street _____

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

____ - _____

2B. TELEPHONE NUMBER (Include Area Code)

____ - ____ - _____

International Phone Number (If applicable)

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

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

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

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

____ / ____ / _____

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

____ / ____ / _____

3D. YOUR SERVICE NUMBER

3E. BRANCH OF SERVICE

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

3F. PLACE OF YOUR LAST SEPARATION

3G. HAVE YOU EVER BEEN A PRISONER OF WAR?

- YES NO (If "NO," skip to question 4A)

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

____ / ____ / _____
 ____ / ____ / _____

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

____ / ____ / _____
 ____ / ____ / _____

SECTION IV: PENSION INFORMATION

4A. ARE YOU OVER THE AGE OF 65 OR HAVE YOU BEEN DETERMINED TO BE DISABLED BY SOCIAL SECURITY ADMINISTRATION?

- YES NO (If "YES," skip question 4B)

4B. ARE YOU MEDICALLY INCAPABLE OF WORKING?

- YES NO (If "YES," you must submit medical evidence with this application)

4C. DO YOU LIVE IN A NURSING HOME?

- YES NO (If "NO," skip question 4D)

4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED FOR MEDICAID?

- YES NO (If "YES," please have an official from your nursing home complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance)

4E. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL IMPAIRMENT OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

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

4F. HAVE YOU RECEIVED TREATMENT FROM A VA MEDICAL CENTER? <input type="radio"/> YES <input type="radio"/> NO Specify Facility: _____	4G. HAVE YOU RECENTLY RECEIVED TREATMENT FROM ANY FEDERAL MEDICAL FACILITIES (Military base, etc.)? <input type="radio"/> YES <input type="radio"/> NO Specify Facility: _____
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SECTION V: EMPLOYMENT HISTORY

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

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

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

5D. WHEN DID YOU LAST WORK? (MM/DD/YYYY) ____/____/____	5E. HOW MANY HOURS PER WEEK DID YOU AVERAGE? _____
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5F. WHAT WAS YOUR JOB TITLE? _____

5G. WHAT KIND OF WORK DID YOU DO? _____

SECTION VI: MARITAL STATUS (MUST COMPLETE)

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

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

6C. SPOUSE'S BIRTH DATE (MM/DD/YYYY) ____/____/____	6D. SPOUSE'S SOCIAL SECURITY NUMBER ____ - ____ - ____
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6E. DATE AND PLACE OF MARRIAGE (MM/DD/YYYY) CITY AND STATE OR COUNTRY
 ____/____/____ _____

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

6G. IS YOUR SPOUSE ALSO A VETERAN? <input type="radio"/> YES <input type="radio"/> NO <i>(If "NO," skip question 6H)</i>	6H. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? <i>(If any)</i> _____
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6I. IF YOU ARE SEPARATED, PLEASE TELL US THE REASON YOU ARE SEPARATED *(Illness, work, etc.)*
 MEDICAL REASON MARITAL DISCORD WORK OTHER *(Specify)* _____

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

No. & Street _____

Apt./Unit Number _____ City _____

State/Province _____ Country _____ ZIP Code/Postal Code _____ - _____

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

SECTION VII: PRIOR MARITAL HISTORY

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

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

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

7B. HOW DID YOUR PREVIOUS MARRIAGE END? <i>(Death, divorce, etc.)</i> <input type="radio"/> DEATH <input type="radio"/> DIVORCE <input type="radio"/> OTHER <i>(Specify)</i> _____	7C. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY) START: ____/____/____ END: ____/____/____
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7D. PLACE OF MARRIAGE *(City and State or Country)*

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

VETERAN'S PRIOR MARRIAGES - CONTINUED (If None, skip to question 7L)	
7F. WHO WERE YOU MARRIED TO? (First, Middle Initial, Last)	
<input type="text"/>	
7G. HOW DID YOUR PREVIOUS MARRIAGE END? (Death, divorce, etc.) <input type="radio"/> DEATH <input type="radio"/> DIVORCE <input type="radio"/> OTHER (Specify) _____	7H. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> END: <input type="text"/> / <input type="text"/> / <input type="text"/>
7I. PLACE OF MARRIAGE (City and State or Country)	
7J. PLACE OF MARRIAGE TERMINATION (City and State or Country)	
7K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT? <input type="radio"/> YES <input type="radio"/> NO (If "YES," please submit a VA Form 21-686c, Declaration of Status of Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)	
SPOUSE'S PRIOR MARRIAGES (If "None," skip to Section VIII)	
7L. WHO WAS YOUR SPOUSE MARRIED TO? (First, Middle Initial, Last)	
<input type="text"/>	
7M. HOW DID THE PREVIOUS MARRIAGE END? (Death, divorce, etc.) <input type="radio"/> DEATH <input type="radio"/> DIVORCE <input type="radio"/> OTHER (Specify) _____	7N. WHAT ARE THE DATES OF THE PREVIOUS MARRIAGE? (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> END: <input type="text"/> / <input type="text"/> / <input type="text"/>
7O. PLACE OF MARRIAGE (City and State or Country)	
7P. PLACE OF MARRIAGE TERMINATION (City and State or Country)	
7Q. WHO WAS YOUR SPOUSE MARRIED TO? (First, Middle Initial, Last)	
<input type="text"/>	
7R. HOW DID THE PREVIOUS MARRIAGE END? (Death, divorce, etc.) <input type="radio"/> DEATH <input type="radio"/> DIVORCE <input type="radio"/> OTHER (Specify) _____	7S. WHAT ARE THE DATES OF THE PREVIOUS MARRIAGE? (MM/DD/YYYY) START: <input type="text"/> / <input type="text"/> / <input type="text"/> END: <input type="text"/> / <input type="text"/> / <input type="text"/>
7T. PLACE OF MARRIAGE (City and State or Country)	
7U. PLACE OF MARRIAGE TERMINATION (City and State or Country)	
7V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR YOUR SPOUSE? <input type="radio"/> YES <input type="radio"/> NO (If "YES", please submit a VA Form 21-686c, Declaration of Status of Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history.)	
SECTION VIII: DEPENDENT CHILDREN	
NOTE: Please refer to the Special Circumstances on the instructions page for information regarding dependents and the necessary forms if additional space is required to list all dependents. If None, skip to Section IX. In most circumstances, children over the age of 23 are not considered dependent for VA purposes.	
8A. HOW MANY DEPENDENT CHILDREN LIVE WITH YOU? (Please complete a VA Form 21-686c, Application Request to Add and/or Remove Dependents, if you need more space for additional dependents.)	
<input type="text"/>	
8B. CHILD'S NAME (First, Middle Initial, Last)	
<input type="text"/>	
8C. CHILD'S BIRTH DATE (MM/DD/YYYY)	8D. CHILD'S SOCIAL SECURITY NUMBER
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
8E. PLACE OF BIRTH (City and State or Country)	
8F. WHAT IS THE CHILD'S STATUS? (Select all that apply) <input type="radio"/> BIOLOGICAL <input type="radio"/> STEPCHILD <input type="radio"/> SERIOUSLY DISABLED <input type="radio"/> 18-23 YEARS OLD (in school) <input type="radio"/> PREVIOUSLY MARRIED <input type="radio"/> ADOPTED <input type="radio"/> DOES NOT LIVE WITH YOU BUT CONTRIBUTES \$ <input type="text"/> , <input type="text"/> . <input type="text"/>	
8G. CHILD'S NAME (First, Middle Initial, Last)	
<input type="text"/>	
8H. CHILD'S BIRTH DATE (MM/DD/YYYY)	8I. CHILD'S SOCIAL SECURITY NUMBER
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
8J. PLACE OF BIRTH (City and State or Country)	

SECTION VIII: DEPENDENT CHILDREN (CONTINUED)

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

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

8M. CHILD'S BIRTH DATE (MM/DD/YYYY) <input type="text"/> / <input type="text"/> / <input type="text"/>	8N. CHILD'S SOCIAL SECURITY NUMBER <input type="text"/> - <input type="text"/> - <input type="text"/>
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8O. PLACE OF BIRTH (City and State or Country)

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

8Q. DO ALL OF YOUR CHILDREN THAT ARE NOT LIVING WITH YOU AS ANSWERED ABOVE RESIDE AT THE SAME ADDRESS?
 YES NO (If "NO," Please submit a VA Form 21-4138, Statement in Support of Claim, with the following information: Who the child is currently living with, and the full address of where the child resides.)

8R. PLEASE PROVIDE THE NAME OF THE CUSTODIAN AND THE ADDRESS OF CHILDREN NOT LIVING WITH YOU
 NAME OF CUSTODIAN (First, Middle Initial, Last)

 No. & Street
 Apt./Unit Number City
 State/Province Country ZIP Code/Postal Code -

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS

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

9A. DO YOU AND YOUR DEPENDENTS HAVE OVER \$25,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?
 YES NO (If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.))
 \$, .00 (If "NO," please estimate the total value of your assets)

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)
 YES NO (If "YES," please submit VA Form 21P-0969)

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?
 YES NO (If "NO," skip to Item 9G)

9D. IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?
 YES NO (If "NO," skip to Item 9G)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES? (Do not include the value of the residence or the first 2 acres.)
 \$, .00

9F. IS THE LAND OVER 2 ACRES (87, 120 SQ FT) REPORTED IN QUESTION 9E MARKETABLE?
 YES NO (If "YES," please submit VA Form 21P-0969)

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?
 YES NO (If "YES," please submit VA Form 21P-0969 and ONLY report your Social Security Income below)

Please use the space below to report any income you currently receive.
IMPORTANT: If you have been directed to complete a VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C., by questions 9A through 9G, we only require Social Security income reported below. All other income should be reported on VA Form 21P-0969. Income will be counted as reported, do not duplicate.
NOTE: If reporting income in 9H through 9K, any items skipped or left blank will be considered as an unspecified income and could require a request for further information, potentially delaying your claim. If you leave the entire question blank, we will assume you have no income to report.

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

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

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

 9H(4) CURRENT GROSS MONTHLY INCOME
 \$,

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS (Continued)

9I(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i> <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD <i>(Specify)</i> _____	9I(2) SPECIFY THE TYPE OF INCOME <input type="radio"/> SOCIAL SECURITY <input type="radio"/> INTEREST/DIVIDENDS <input type="radio"/> CIVIL SERVICE <input type="radio"/> PENSION/RETIREMENT <input type="radio"/> OTHER <i>(Specify type of income)</i>	9I(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i> _____ 9I(4) CURRENT GROSS MONTHLY INCOME \$ _____,_____.____
9J(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i> <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD <i>(Specify)</i> _____	9J(2) SPECIFY THE TYPE OF INCOME <input type="radio"/> SOCIAL SECURITY <input type="radio"/> INTEREST/DIVIDENDS <input type="radio"/> CIVIL SERVICE <input type="radio"/> PENSION/RETIREMENT <input type="radio"/> OTHER <i>(Specify type of income)</i>	9J(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i> _____ 9J(4) CURRENT GROSS MONTHLY INCOME \$ _____,_____.____
9K(1) WHO IS THE INCOME RECIPIENT? <i>(Select one)</i> <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD <i>(Specify)</i> _____	9K(2) SPECIFY THE TYPE OF INCOME <input type="radio"/> SOCIAL SECURITY <input type="radio"/> INTEREST/DIVIDENDS <input type="radio"/> CIVIL SERVICE <input type="radio"/> PENSION/RETIREMENT <input type="radio"/> OTHER <i>(Specify type of income)</i>	9K(3) SPECIFY INCOME PAYER <i>(Name of business, financial institution, etc.)</i> _____ 9K(4) CURRENT GROSS MONTHLY INCOME \$ _____,_____.____

SECTION X: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

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

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?
 YES NO *(If "NO," skip to Section XI)*

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

IN-HOME CARE OR CARE FACILITY

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

10B(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i> <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD <i>(Specify)</i>	10B(2). NAME OF PROVIDER AND TYPE OF CARE <i>(Select one)</i> _____ <input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDANT	10B(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR? \$ _____ PER HOUR _____ HOURS WORKED PER WEEK
10B(4). PROVIDER START AND END DATE <i>(MM/DD/YYYY)</i> START: _____ / _____ / _____ END: _____ / _____ / _____ <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 \$ _____
10C(1). WHOSE EXPENSES WERE PAID? <i>(Select one)</i> <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD <i>(Specify)</i>	10C(2). NAME OF PROVIDER AND TYPE OF CARE <i>(Select one)</i> _____ <input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDANT	10C(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR? \$ _____ PER HOUR _____ HOURS WORKED PER WEEK
10C(4). PROVIDER START AND END DATE <i>(MM/DD/YYYY)</i> START: _____ / _____ / _____ END: _____ / _____ / _____ <input type="radio"/> NO END DATE	10C(5). PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY	10C(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED \$ _____

IN-HOME CARE OR CARE FACILITY (Continued)		
10D(1). WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10D(2). NAME OF PROVIDER AND TYPE OF CARE (Select one) <input type="radio"/> CARE FACILITY <input type="radio"/> IN-HOME CARE ATTENDANT	10D(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR? \$ [] [] [] [] PER HOUR [] [] HOURS WORKED PER WEEK
10D(4). PROVIDER START AND END DATE (MM/DD/YYYY) START: [] [] / [] [] / [] [] [] [] END: [] [] / [] [] / [] [] [] [] <input type="radio"/> NO END DATE	10D(5). PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY	10D(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED \$ [] [] [] [] [] []
OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES		
10E(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10E(2) PAID TO (Name of Provider, Insurance Company, etc.) 10E(3) PURPOSE (Insurance premium, medical supplies, etc.)	10E(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10E(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10E(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []
10F(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10F(2) PAID TO (Name of Provider, Insurance Company, etc.) 10F(3) PURPOSE (Insurance premium, medical supplies, etc.)	10F(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10F(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10F(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []
10G(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10G(2) PAID TO (Name of Provider, Insurance Company, etc.) 10G(3) PURPOSE (Insurance premium, medical supplies, etc.)	10G(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10G(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10G(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []
10H(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10H(2) PAID TO (Name of Provider, Insurance Company, etc.) 10H(3) PURPOSE (Insurance premium, medical supplies, etc.)	10H(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10H(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10H(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []
10I(1). WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10I(2) PAID TO (Name of Provider, Insurance Company, etc.) 10I(3) PURPOSE (Insurance premium, medical supplies, etc.)	10I(4) DATE COSTS INCURRED (MM/DD/YYYY) [] [] / [] [] / [] [] [] [] 10I(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10I(6) AMOUNT YOU PAY (Based on Frequency selected) \$ [] [] [] [] [] []

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

10J(1) WHOSE EXPENSES WERE PAID? (Select one) <input type="radio"/> VETERAN <input type="radio"/> SPOUSE <input type="radio"/> CHILD (Specify)	10J(2) PAID TO (Name of Provider, Insurance Company, etc.) 10J(3) PURPOSE (Insurance premium, medical supplies, etc.)	10J(4) DATE COSTS INCURRED (MM/DD/YYYY) / / 10J(5) PAYMENT FREQUENCY <input type="radio"/> MONTHLY <input type="radio"/> ANNUALLY <input type="radio"/> ONE-TIME 10J(6) AMOUNT YOU PAY (Based on Frequency selected) \$
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SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

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

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

11B. TYPE OF ACCOUNT (Check the appropriate box and provide the account number or simply write "Established," if you have a direct deposit with VA.)
 CHECKING SAVINGS I CERTIFY I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

11C. ROUTING NUMBER	11D. ACCOUNT NO.
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SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

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

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

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

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

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

12B. SIGNATURE OR MARK	12C. DATE SIGNED (MM/DD/YYYY) / /
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SECTION XIII: WITNESSES TO SIGNATURE
 (TWO (2) WITNESS SIGNATURES ARE REQUIRED IF THE CLAIMANT SIGNED ITEM 12B WITH AN "X")

13A. SIGNATURE OF THE FIRST WITNESS (If claimant signed above using an "X")	13B. PRINTED NAME AND ADDRESS OF FIRST WITNESS Name: Address:
-----------------------------------------------------------------------------	---------------------------------------------------------------------

13C. SIGNATURE OF THE SECOND WITNESS (If claimant signed above using an "X")	13D. PRINTED NAME AND ADDRESS OF SECOND WITNESS Name: Address:
------------------------------------------------------------------------------	----------------------------------------------------------------------

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

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

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

14A. ALTERNATE SIGNER SIGNATURE

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

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

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

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



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)

[Grid for name entry]

2. SOCIAL SECURITY NUMBER

[Grid for social security number]

3. VA FILE NUMBER

[Grid for VA file number]

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

[Grid for date of birth]

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)

[Grid for name entry]

6. SOCIAL SECURITY NUMBER

[Grid for social security number]

7. VA FILE NUMBER (If applicable)

[Grid for VA file number]

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

[Grid for date of birth]

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

[Grid for nursing home name]

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

No. & Street [Grid]
Apt./Unit Number [Grid] City [Grid]
State/Province [Grid] Country [Grid] ZIP Code/Postal Code [Grid]

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)

[Grid for date admitted]

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)

[Grid for date Medicaid plan began]

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

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)

[Grid for nursing home official's name]

18. NURSING HOME OFFICIAL'S TITLE

[Grid for nursing home official's title]

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

[Grid for office telephone number]
Enter International Phone Number (If applicable) [Grid]

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)

[Grid for signature]

21. DATE SIGNED (MM/DD/YYYY)

[Grid for date signed]

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)

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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)

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

No. & Street

--

Apt./Unit Number

--

 City

--

State/Province

--

 Country

--

 ZIP Code

--

 -

--

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

--

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

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

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

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

THE STATE OR COUNTRY REQUIRES THIS FACILITY TO BE LICENSED

THE FACILITY IS LICENSED

THE FACILITY IS RESIDENTIAL

THE FACILITY IS STAFFED 24 HOURS

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

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

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

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> </tr> </table>		/		/					12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> </tr> </table> <input type="radio"/> INDEFINITE		/		/				
	/		/														
	/		/														

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

\$

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 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) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align:center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; height: 20px;"></td> </tr> </table>		/		/				
	/		/						

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)*

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

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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

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

 -

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

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

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

A. SHOPPING B. FOOD PREPARATION C. NON-MEDICAL TRANSPORTATION
 D. LAUNDERING E. USING TELEPHONE F. MANAGING FINANCES
 G. HOUSEKEEPING H. HANDLING MEDICATIONS

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

YES NO

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

		/			/				
--	--	---	--	--	---	--	--	--	--

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

		/			/					<input type="radio"/> INDEFINITE
--	--	---	--	--	---	--	--	--	--	----------------------------------

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

\$

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--	--

 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)*

		/			/				
--	--	---	--	--	---	--	--	--	--



**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)		
<input type="checkbox"/> VETERAN <input type="checkbox"/> SURVIVING SPOUSE <input type="checkbox"/> SURVIVING CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> 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"/>
	(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"/>
	(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"/>
	(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"/> <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"/>
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"/> <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"/>
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"/> <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"/>

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS (Continued)
(See instructions on Page 2)

4E.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <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"/> <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"/>
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):	(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"/> <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"/>

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? <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, skip to Section VI)		
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):	(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"/>
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <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"/>
	(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	
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):	(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"/>
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other only)	(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <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"/>
	(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	
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):	(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"/>
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other only)	(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY \$ <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"/>
	(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	

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

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

YES NO (If NO, skip to Section VII)

6B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <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"/> <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"/> <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		
6C.	(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"/> <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"/> <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)

7B.	(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"/> <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"/> <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"/> <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)

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):	(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) [] [] - [] [] - [] [] [] []
	(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? \$ [] [] , [] [] [] , [] [] [] [] . [] []
	(4). WHO RECEIVED THE ASSET?	(10). WHAT WAS THE SALE PRICE? (If applicable) \$ [] [] , [] [] [] , [] [] [] [] . [] []
	(5). RELATIONSHIP TO NEW OWNER	(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ [] [] , [] [] [] , [] [] [] [] . [] []
	(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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):	(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) [] [] - [] [] - [] [] [] []
	(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? \$ [] [] , [] [] [] , [] [] [] [] . [] []
	(4). WHO RECEIVED THE ASSET?	(10). WHAT WAS THE SALE PRICE? (If applicable) \$ [] [] , [] [] [] , [] [] [] [] . [] []
	(5). RELATIONSHIP TO NEW OWNER	(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ [] [] , [] [] [] , [] [] [] [] . [] []
	(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

SECTION IX: ANNUITIES
(See instructions on Page 2)

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

YES NO (If NO, skip to Section X)

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

□□ - □□ - □□□□

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

\$ □□ . □□□□ . □□□□ . □□

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

YES NO

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

□□ - □□ - □□□□

9F. HOW MUCH DID YOU ADD?

\$ □□ . □□□□ . □□□□ . □□

9G. IS THE ANNUITY REVOCABLE OR IRREVOCABLE?

REVOCABLE IRREVOCABLE

9H. DO YOU RECEIVE INCOME FROM THE ANNUITY?

YES NO

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

\$ □□ . □□□□ . □□□□ . □□

9J. CAN THE ANNUITY BE LIQUIDATED?

YES NO

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

\$ □□ . □□□□ . □□□□ . □□

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

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

YES NO (If NO, skip to Section XI)

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

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

\$ □□ . □□□□ . □□□□ . □□

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

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

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

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

\$ □□ . □□□□ . □□□□ . □□

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

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

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

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

\$ □□ . □□□□ . □□□□ . □□

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

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

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

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

\$ □□ . □□□□ . □□□□ . □□

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

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

SECTION XI: DISCONTINUED OR IRREGULAR INCOME

(See instructions on Page 2)

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

YES NO (If NO, skip to Section XII)

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

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)

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

SECTION XIII: CERTIFICATION AND SIGNATURE

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

13A. SIGNATURE

13B. DATE SIGNED (MM/DD/YYYY)

[] [] - [] [] - [] [] [] []

SECTION XIV: WITNESS TO SIGNATURE

(Two witness signatures are required if the claimant signed item 13A with an "X")

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

14B. PRINTED NAME OF FIRST WITNESS

FIRST: MI: LAST:

14C. ADDRESS OF FIRST WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code -

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

14E. PRINTED NAME OF SECOND WITNESS

FIRST: MI: LAST:

14F. ADDRESS OF SECOND WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code -

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

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