Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATION FOR HEALTH BENEFITS

Step 1: Before You Start…

What is VA Form 10-10EZ used for?

- To apply for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits.
- To update your personal, insurance, or financial information.

Where can I get help filling out the form?

- Contact a National or State Veterans Service Organization.
- Ask VA to help you fill out the form by calling or visiting a VA health care facility. Before you call or go to the VA health care facility, gather the necessary materials identified in Step 2 of the instructions and complete as much of the form as you can.

How can I contact VA if I have questions?

- Look in your telephone book blue pages under "United States Government, Veterans" to locate your local VA health care facility.
- Call VA's Health Benefits Service Center toll-free at 1-877-222-VETS (8387).
- Access our website at http://www.va.gov and select "Contact the VA."
- If you desire a health care appointment, contact the Enrollment Coordinator at your local VA health care facility for assistance in scheduling an appointment.

Definitions of terms used on this form

- SERVICE-CONNECTED (SC): A veteran with a VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A determination by VA that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A determination by VA that a service-connected disability is not severe enough to warrant monetary compensation.
- NONSERVICE-CONNECTED (NSC): A veteran who does not have a VA determined service-related condition.

Which sections of VA Form 10-10EZ should you complete?

If you are applying for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits, look at the table below to find out which sections of VA Form 10-10EZ you should complete. The shaded sections should be completed only if you answer "Yes" to Section VI agreeing to provide income and asset information to establish eligibility for care. You may agree to copayments without providing this detailed financial information.

If you are...	Complete the sections marked with an X …						
	I-IV	VI	VII	VIII	IX	X	XII
Service-connected 50% to 100%.	X						X
Service-connected 30-40%. ***Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications for treatment of your nonservice-connected conditions assessed.***	X	X	X	X	X		X
Service-connected 0% (compensable) or service-connected 10-20%. ***Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel for treatment of your nonservice-connected conditions assessed.***	X	X	X	X	X		X
A Former POW. ***Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for beneficiary travel assessed. Also, complete Section X if applying for long-term care.***	X	X	X	X	X		X
A veteran discharged from the military due to a disability incurred or aggravated in service, Purple Heart Medal recipient or WWI veteran. ***Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel assessed. Also, complete Section X if applying for long-term care.***	X	X	X	X	X		X
Receiving nonservice-connected VA Pension, Aid and Attendance or Housebound benefits. ***Answer YES in Section VI and complete Sections VII-X to have your financial eligibility for long-term care assessed. Unmarried VA Pensioners are excluded from this requirement.***	X	X	X	X	X	X	X
Service-connected 0% (noncompensable), nonservice-connected with no special eligibilities listed above or veterans with combat service discharged within the last two years. ***Answer YES in Section VI and complete Sections VII-X to have your priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of your nonservice-connected conditions assessed.***	X	X	X	X	X	X	X

Complete only the sections that apply to you and sign and date the form.

Step 2: Completing your application ...

Review the table in Step 1 to find out what sections you should complete. Answer all questions in those sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. For each question that you need more room, write "Continuation of Item" and write the section and question number.

Section II - Insurance Information. Include information for all health insurance policies that cover you. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

Section IV - Military Service Information. If you are not currently receiving benefits from VA, you should attach a copy of your discharge or separation papers from the military (such as DD 214 or, for WWII veterans, a "WD" Form), with your signed application to expedite processing of your application.

If you indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your status as a Purple Heart Medal recipient, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating you were awarded the medal. To reduce processing time, you may submit a copy of this documentation with your signed application.

Section VI - Financial Disclosure. The financial assessment is used to determine whether certain veterans qualify for cost-free health care services for their nonservice-connected conditions and to assign their priority for enrollment. You should review the table in Step 1 to see if your eligibility for health care benefits requires or may be based on a financial assessment.

If your financial information is used to determine your priority for enrollment and you choose not to disclose this information, you must agree to make copayments. However, please be aware that even if you agree to pay copayments, you may not be eligible for enrollment and other health care benefits for your nonservice-connected conditions, if you are placed in a priority group that is not eligible for enrollment.

If a financial assessment is not used to determine your priority for enrollment, you may choose not to disclose your information and agree to make copayments for treatment of your nonservice-connected conditions. If a financial assessment is used to determine your eligibility for travel assistance, and you do not disclose your financial information, you will not be eligible for this benefit for your nonservice-connected conditions.

Section VII - Dependent Information. Use a separate sheet of paper for additional dependent children.

- You may count your spouse as your dependent even if you did not live together, as long as you contributed $600 or more in support last calendar year.
- You may count your biological children, adopted children, and stepchildren as dependents. But these children must be unmarried and under the age of 18, or be at least 18 but under 23 and attending high school, college or vocational school on a full or part-time basis, or have become permanently unable to support themselves before reaching the age of 18.
- Count child support contributions even if not paid in regular set amounts. Contributions can include tuition payments or payments of medical bills.

Section VIII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Use a separate sheet of paper for additional dependent children.

- Report: gross annual income from employment, except for income from your farm, ranch, property or business, including information about your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses
- Report: net income from your farm, ranch, property or business.
- Report: other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities
- Do Not Report: Welfare, Supplemental Security Income (SSI) and need-based payments from a government agency, profit from the occasional sale of property, income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs), scholarships and grants for school attendance, disaster relief payment or proceeds of casualty insurance, loans, Agent Orange and Alaska Native Claim Settlement Acts Income and payments to foster parents.

Section IX - Previous Calendar Year Deductible Expenses. Report nonreimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources.

Section X - Previous Calendar Year Net Worth. Use a separate sheet of paper for additional dependent children.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

Step 3: Submitting your application ...

What do I do when I have finished my application?

- Read Section V, Paperwork and Privacy Act Information , Section XI Consent to Copayments and Section XII, Assignment of Benefits.
- Make sure you sign and date VA Form 10-10EZ in Section XII. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", then you must have 2 people you know witness you as you sign. They must then sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete. This will result in a delay in processing your application.
- Attach any continuation sheets and necessary material to your application.

Where do I send my application? Mail the original application with a copy of your supporting materials to your local VA care facility. You can find the address in your local telephone book, by calling toll-free 1-877-222-VETS (8387), or on the Internet at http://www.va.gov.

OMB Approved No. 2900-0091
Estimated Burden Avg. 45 min.

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

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

2. OTHER NAMES USED

3. MOTHER'S MAIDEN NAME

4. GENDER ☐ MALE ☐ FEMALE

5. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO

6. WHAT IS YOUR RACE? ***(You may check more than one.) (Information is required for statistical purposes only.)***
☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

7. SOCIAL SECURITY NUMBER

9. DATE OF BIRTH ***(mm/dd/yyyy)***

10. RELIGION

8. CLAIM NUMBER

9A. PLACE OF BIRTH ***(City and State)***

11. PERMANENT ADDRESS ***(Street)***

11A. CITY

11B. STATE

11C. ZIP CODE ***(9 digits)***

11D. COUNTY

11E. HOME TELEPHONE NUMBER ***(Include area code)***

11F. E-MAIL ADDRESS

11G. CELLULAR TELEPHONE NUMBER ***(Include area code)***

11H. PAGER NUMBER ***(Include area code)***

12. TYPE OF BENEFIT(S) APPLIED FOR ***(You may check more than one)***
☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL

13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?

14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE?
☐ YES ☐ NO I am only enrolling in case I need care in the future.

15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY?
☐ YES, **LOCATION:** ☐ NO

16. CURRENT MARITAL STATUS ***(Check one)***
☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN

17A. NEXT OF KIN'S HOME TELEPHONE NUMBER ***(Include area code)***

17B. NEXT OF KIN'S WORK TELEPHONE NUMBER ***(Include area code)***

18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT

18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER ***(Include area code)***

18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER ***(Include area code)***

19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE ***(Check one)***
☐ EMERGENCY CONTACT ☐ NEXT OF KIN

APPLICATION FOR HEALTH BENEFITS, Continued

VETERAN'S NAME *(Last, First, Middle)* | SOCIAL SECURITY NUMBER

SECTION II - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ARE YOU COVERED BY HEALTH INSURANCE? *(Including coverage through a spouse or another person)* ☐ YES ☐ NO

2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

3. NAME OF POLICY HOLDER

4. POLICY NUMBER

5. GROUP CODE

	YES	NO	
6. ARE YOU ELIGIBLE FOR MEDICAID?	☐	☐	
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	☐	☐	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	☐	☐	8A. EFFECTIVE DATE *(mm/dd/yyyy)*

9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD

10. MEDICARE CLAIM NUMBER

11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? *(Check one)* ☐ YES ☐ NO

12. IS NEED FOR CARE DUE TO ACCIDENT? *(Check One)* ☐ YES ☐ NO

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(Check one)*
If employed or retired, complete item 1A
☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED
Date of retirement (mm/dd/yyyy)

1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

2. SPOUSE'S EMPLOYMENT STATUS *(Check one)*
If employed or retired, complete item 2A
☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED
Date of retirement (mm/dd/yyyy)

2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER

2. CHECK YES OR NO	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	☐	☐
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	☐	☐
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE? %			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☐	J. DO YOU HAVE A SPINAL CORD INJURY?	☐	☐

SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA may be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

Failure to disclose your previous year's financial information may affect your eligibility for health care benefits. Your financial information is used by VA to accurately determine if you should be responsible for copayments for office visits, pharmacy, inpatient, nursing home and long term care, and for some veterans, priority for enrollment. You are not required to provide this information. However, completing the financial disclosure section results in a more accurate determination of your eligibility for health care services/benefits.

☐ **NO**, I DO NOT WISH TO PROVIDE INFORMATION IN SECTIONS VII THROUGH X. ***I understand that VA is currently not enrolling veterans who decline to provide financial information unless other special eligibility factors exist.*** However, if I am enrolled, I agree to pay the applicable VA copayments. Sign and date the application in Section XII.

☐ **YES**, I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO ESTABLISH MY ELIGIBILITY FOR CARE. Complete all sections below that apply to you with last calendar year's information. Sign and date the application in Section XII.

SECTION VII - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*		2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S MAIDEN NAME		2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ *Son* ☐ *Daughter* ☐ *Stepson* ☐ *Stepdaughter*	
1B. SPOUSE'S SOCIAL SECURITY NUMBER		2B. CHILD'S SOCIAL SECURITY NUMBER	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	1D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO 2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT. SPOUSE $ CHILD $		2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $	

SECTION VIII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(eg., Social Security, compensation, pension interest, dividends)*. EXCLUDING WELFARE.	$	$	$

SECTION IX - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VII.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION X - PREVIOUS CALENDAR YEAR NET WORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second homes and non-income producing property. Do not count your primary home.)*	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION XI - CONSENT TO COPAYMENTS

If you are a 0% service-connected veteran and do not receive VA monetary benefits or a nonservice-connected veteran (and you are not an Ex-POW, Purple Heart Recipient, WWI veteran or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your nonservice-connected conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayment as required by law.**

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT	DATE