Department of Veterans Affairs

INFORMATION AND INSTRUCTIONS FOR COMPLETING THE VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

IMPORTANT - Please read the information below carefully to help you complete this form more quickly and accurately. Some parts of the form also contain notes or specific instructions for completing that part.

Frequently Asked Questions

What do I use VA Form 21-526 for?

Use VA Form 21-526 to apply for compensation and/or pension benefits.

Should I apply for compensation or pension benefits?

You should apply for **compensation** benefits if:

- You currently have a disability that is the result of an injury, disease, or an event in military service.

You should apply for **pension** benefits if *all* of the following are true:

- You are age 65 or older or are permanently and totally disabled. Your disabilities ***do not*** have to be related to your military service.
- You served on active duty with at least one day during a period of war. Visit the VA pension benefits web site at **http://www.benefits.va.gov/pension/vetpen.asp** for more specific information.
- Your income and assets ***do not*** exceed certain limits. Visit the VA pension rates web site at **http://www.benefits.va.gov/pension/rates.asp** for the maximum yearly income VA allows.

Note: Read the "Important" statement below and attach current medical evidence showing that you are permanently and totally disabled if necessary.

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

May I apply electronically?

You can apply for VA disability compensation and pension online through eBenefits at www.ebenefits.va.gov. For disability compensation claims, you can also upload all supporting evidence you may have and make your claim a Fully Developed Claim. To file a claim for VA disability compensation electronically, go to eBenefits, select Apply for Benefits and then select Apply for Disability Compensation. You will need to create an eBenefits account to apply for disability compensation online. To file a claim for VA pension electronically, go to eBenefits, select Apply for Benefits, and then select Apply for Veterans Benefits via VONAPP. Once you submit your claim, you can track the status using eBenefits.

NOTE: You can contact an accredited Veterans Service Officer to assist you with your application.

What parts of the form should I complete?

You should complete only the parts related to the benefit for which you are applying:

- If you are applying for compensation **ONLY**, skip parts VII, VIII, IX, X.
- If you are applying for pension, complete the **ENTIRE** form.
- If you need more space to answer a question or have a comment about a specific item on this form, please place it in Part XII, Item 46, "Remarks." Please identify your answer or comment by the part and item number.

Where can I get help?

You can ask VA to help you fill out the form by contacting a regional office or call center. Before you contact us, make sure you gather the necessary materials and complete as much of the form as you can. You can contact VA in the following ways:

- **By internet:** https://iris.va.gov
- **In person:** You can locate the address of the closest regional office at http://www.va.gov/directory or in your telephone book blue pages under **"United States Government, Veterans"**
- **By telephone:** Please call one of the following telephone numbers:
  1-800-827-1000
  Relay Number 711 (Hearing Impaired TDD line)
  1-412-395-6272 (If living outside the U.S.)

You can also contact a VA-accredited veterans service organization (VSO) representative to help you with your claim. If you want to use a representative to help you, consult your local telephone book to contact a particular VSO or contact the closest VA office. You may also seek the assistance of a VA-accredited attorney or claims agent. Depending on the type of representative you want to designate, we will send you one of the following forms:

- VA Form 21-22, Appointment of Veterans Service Organization as Claimant's Representative
- VA Form 21-22A, Appointment of Individual as Claimant's Representative

What should I do when I have finished my application?

- You should provide your signature in Part XI, Item 43A. Be sure to sign every form you fill out before you send it to us. If you don't sign the form, VA will return it for you to sign, and it will take longer for us to process.
- Attach any materials that support and explain your claim.
- Mail or take your application to the closest VA regional office. VA regional office addresses are available on the internet at http://www.va.gov/directory

Do I need to keep a copy of my application?

It is important that you keep a copy of all completed forms and materials you give to VA.

Social Security Disability and Supplemental Security Income Benefits

Social Security Disability and Supplemental Security Income are two Federal programs that help people with disabilities. While these programs are different in many ways, the Social Security Administration (SSA) administers both programs. If you think you have a disabling condition, you may qualify for benefits under one or both of these programs and should contact Social Security.

How can I contact SSA if I have questions?

You can find answers to most questions and file a claim online at **www.socialsecurity.gov**. Specific information is available for active duty military, veterans, and their families at **www.socialsecurity.gov/woundedwarriors**.

You can also contact SSA in the following ways:

- **By phone:** (Monday-Friday, 7 a.m. - 7 p.m. EST) at one of the following toll-free numbers:
  1-800-772-1213
  Relay Number 711 (TDD if you are deaf or hard of hearing)
- **By mail or in person:** You can locate the address of the Social Security office nearest to you in your telephone book blue pages under **"United States Government, Social Security Administration".**

SPECIFIC INSTRUCTIONS FOR VA FORM 21-526

Part II - Nature and History of Service-Related Disability(ies)

What disabilities should I list?
List the disease(s) or medical condition(s) that form the basis of your claim for service connected compensation. Be as specific as you can. Indicate the approximate date the disability began and the place of treatment.

Do I have to include any records with this claim form?
If you have records that support your claim, you should attach them to this form. VA will help you obtain records by requesting them from the person, company, or agency that has them. On this form you must tell us the name and address of the person, company or agency that has these records, the approximate time frame covered by them, and the condition for which you were treated. If you received treatment from a non VA health care provider complete and return VA Form 21-4142, *Authorization to Disclose Information to the Department of Veterans Affairs (VA)* and VA Form 21-4142a, *General Release for Medical Provider Information to the Department of Veterans Affairs (VA)*, in order for VA to obtain your treatment records. Additional VA Forms 21-4142a can be obtained from the VA forms web site at www.va.gov/vaforms.

Part III - Active Duty Service Information

Do I need to include my active duty service information?
Please provide the information for each period of active duty (provide a copy of your DD214 or other separation papers for all periods of active duty service).

Part IV - Reserve and National Guard Service Information

What If I have Reserve or National Guard Service?
This section tells us if you were a member of the Reserve or National Guard. Complete information for each period of Reserve and National Guard service. Provide a copy of your DD214 or other separation papers for all periods of active service.

Part V - Military Retired/Severance Pay

What If I have received or will receive military pay?
This section asks about your military severance or separation pay, the type, and the amount. If you currently receive military retired pay, we may reduce your retired pay by the amount of any compensation that we award. It is to your advantage because VA compensation is not taxable while retired pay is taxable. However, if you wish to receive military retired pay rather than VA compensation, you must check the box in Item 25. Some veterans receive various readjustment, separation, or severance pay from service departments which may be recouped in full or in part from VA benefit payments.

Part VI - Marital and Dependency Information

Who can I count as a dependent spouse?
A spouse is a person who is married to the veteran (authority: 38 U.S.C. subsection 101(31)). If you are certifying that you are married for the purpose of VA benefits, your marriage must be recognized by the place where you and/or your spouse resided at the time of marriage, or where you and/or your spouse resided when you filed your claim (or a later date when you became eligible for benefits) (38 U.S.C. § 103(c)). Additional guidance on when VA recognizes marriages is available at http://www.va.gov/opa/marriage/.

Note: It is important that you provide your marital history and that of your spouse.

Who can be recognized as a dependent child?
VA recognizes the veteran's biological child, adopted child, and stepchild. However, the child must be unmarried and:

- under the age of 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- permanently incapable of self support before reaching the age of 18.

SPECIFIC INSTRUCTIONS FOR VA FORM 21-526 (Continued)

Part VII - Veterans Pension

This section asks you to provide information about the disabilities that prevent you from working. We also ask you to tell us if you require the regular assistance of another person, if you are housebound, if you are in a nursing home, if you are in receipt of Social Security Disability or Supplemental Security Income, or if you have applied for Medicaid.

Part VIII - Income and Asset Information

This section asks you to provide specific information about the Social Security benefits you and your dependants receive. Report the gross amount you and your dependents receive monthly before deductions are taken out. If you have a copy of your most recent Social Security award letter, please include a copy of the letter with your application.

This section also asks you to tell us if you or your dependents receive or received income from sources other than Social Security. VA also needs to know if you or your dependents own your primary residence and we ask you other questions about the value of your assets and your dependents' assets. Your assets ***do*** include your spouse's assets. Although your assets ***do not*** include your child's assets, you must tell us if your child has significant assets. Your assets include all the money and the fair market value of any property you and your spouse own. Assets ***do not*** include your primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

This section also asks if you have transferred assets in the past three calendar years.

IMPORTANT: If you receive or received income in addition to Social Security benefits ***or*** you have significant assets or have transferred assets, we will require you to complete VA Form 21P-0969, *Income and Asset Statement*, in addition to this application.

Part IX - Information about Your Unreimbursed Medical or Other Expenses

When determining your eligibility for pension, we may be able to deduct unreimbursed medical expenses from your income for the year in which the expenses are paid. Report the amount of unreimbursed medical expenses, including the Medicare deductions you paid (out-of-pocket) for yourself or relatives you are under an obligation to support. **Do not** report any expenses you did not pay or expenses for which you were or will be reimbursed.

OMB Control No. 2900-0001
Respondent Burden: 1 hour
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

VETERAN'S APPLICATION FOR COMPENSATION AND/OR PENSION

IMPORTANT - Read information and instructions carefully before completing the form. Type, print, or write plainly.

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

PART I - VETERAN'S INFORMATION

1. FOR WHAT BENEFIT ARE YOU APPLYING?
☐ COMPENSATION ☐ PENSION ☐ BOTH COMPENSATION AND PENSION

2. HAVE YOU PREVIOUSLY APPLIED FOR ANY VA BENEFIT(S)? *(Check applicable box)*
☐ PENSION ☐ COMPENSATION ☐ OTHER *(Specify)* ____________

3. FIRST, MIDDLE, LAST NAME OF VETERAN

4A. VETERAN'S SOCIAL SECURITY NO.	4B. VA FILE NUMBER *(If applicable)*	4C. SPOUSE'S SOCIAL SECURITY NO.

4D. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NO.

5. MAILING ADDRESS *(Number and street or rural route, city or P.O., State and ZIP Code)*

6. TELEPHONE NUMBER(S) *(Include Area Code)*

A. DAYTIME	B. EVENING	C. CELL

7. E-MAIL ADDRESS *(If applicable)*

8A. DATE OF BIRTH *(Month, day, year)*

8B. PLACE OF BIRTH

9. SEX
☐ MALE ☐ FEMALE

10A. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? *(Formerly the U.S. Bureau of Employees Compensation)*
☐ YES ☐ NO *(If "Yes," complete Items 10B & 10C)*

10B. WHEN WAS THE CLAIM FILED? *(Mo., day, yr.)*

10C. FOR WHAT DISABILITY ARE YOU RECEIVING BENEFITS?

PART II - NATURE AND HISTORY OF SERVICE-RELATED DISABILITY(IES) *(If you need more space please use Item 46, "Remarks")*

11. PLEASE PROVIDE NATURE OF SICKNESS, DISEASE, OR INJURIES FOR WHICH THIS CLAIM IS MADE; DATE EACH BEGAN; AND PLACE OF TREATMENT

A. LIST DISABILITY(IES)	B. DATE BEGAN	C. PLACE OF TREATMENT

12A. ARE YOU NOW OR HAVE YOU RECEIVED TREATMENT OR DOMICILIARY CARE AT A VA MEDICAL FACILITY?
☐ YES ☐ NO *(If "Yes,"complete Items 12B &12C)*

12B. DATES OF TREATMENT/CARE

Month	Day	Year

12C. NAME AND ADDRESS OF VA MEDICAL FACILITY *(If you need more space use Item 46, "Remarks")*

13A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES ☐ NO *(If "Yes," complete Items 13B and 13C)*

13B. NAME OF COUNTRY

13C. DATES OF CONFINEMENT

FROM	TO

14. ARE YOU CLAIMING A DISABILITY RELATED TO AGENT ORANGE OR OTHER HERBICIDE EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☐ NO ____________

15. ARE YOU CLAIMING A DISABILITY RELATED TO ASBESTOS EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☐ NO ____________

16. ARE YOU CLAIMING A DISABILITY RELATED TO MUSTARD GAS EXPOSURE? *(If "Yes," list disability(ies) below)*
☐ YES ☐ NO ____________

17. ARE YOU CLAIMING A DISABILITY RELATED TO IONIZING RADIATION EXPOSURE? *(If 'Yes," list disability(ies) below)*
☐ YES ☐ NO ____________

18. ARE YOU CLAIMING A DISABILITY RELATED TO AN ENVIRONMENTAL HAZARD EXPOSURE DURING THE GULF WAR? *(If "Yes," list disability(ies) below)*
☐ YES ☐ NO ____________

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 43A THRU 43C ON PAGE 10.

PART III - ACTIVE DUTY SERVICE INFORMATION

NOTE: Please complete the information for each period of active duty. Attach DD214 or other separation papers for all periods of active duty. If you do not have your DD214 form or other separation papers, check the box. ☐

19A. ENTERED INTO SERVICE		19B. SERVICE NUMBER	19C. SEPARATED FROM SERVICE		19D. BRANCH OF SERVICE	19E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

PART IV - RESERVE AND NATIONAL GUARD SERVICE INFORMATION

NOTE: Enter complete information for each period of Reserves and National Guard service. Attach any separation papers you have.

20A. ENTERED INTO SERVICE		20B. SERVICE NUMBER	20C. SEPARATED FROM SERVICE		20D. SERVICE STATUS *(Reserve, National Guard)*	20E. GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

21. IF DISABILITY OCCURRED DURING ACTIVE OR INACTIVE DUTY FOR TRAINING, GIVE BRANCH OF SERVICE AND DATE OF OCCURRENCE

22A. ARE YOU NOW A MEMBER OF THE RESERVES OR NATIONAL GUARD? IF SO, GIVE THE BRANCH OF SERVICE

☐ YES ☐ NO BRANCH ________________

22B. RESERVE STATUS

☐ ACTIVE ☐ RESERVE OBLIGATION

☐ INACTIVE

22C. NAME, ADDRESS AND PHONE NO. OF RESERVE OR NATIONAL GUARD UNIT *(If additional space is needed, use Item 46 "Remarks")*

PART V - MILITARY RETIRED/SEVERANCE PAY

IMPORTANT - Unless you check the box in Item 25 below, you are telling us that you are choosing to receive VA compensation instead of military retired pay, if it is determined you are entitled to both benefits. If you are awarded military retired pay prior to compensation, we will reduce your retired pay by the amount of any compensation that you are awarded. VA will notify the Military Retired Pay Center of all benefit changes. If you receive both military retired pay and VA compensation, some of the amount you receive may be recouped by VA, or, in the case of Voluntary Separation Incentive (VSI), by the Department of Defense.

23A. ARE YOU RECEIVING MILITARY RETIRED PAY? *(If "Yes," complete Items 23C & 23D)*

☐ YES ☐ NO

23B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE? *(If "Yes," explain, i.e. Future Reserve/National Guard Retirement, Pending MEB/PEB)*

☐ YES ☐ NO ________________

23C. BRANCH OF SERVICE

23D. MONTHLY AMOUNT

$

24. RETIRED STATUS

☐ RETIRED ☐ TEMPORARY DISABILITY RETIRED LIST ☐ DISABLED RETIRED LIST

25. NO, I DO NOT WANT VA COMPENSATION IN LIEU OF MILITARY RETIRED PAY *(Check box, if applicable)* ☐

26. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE/SEPARATION PAY, OR ANY OTHER LUMP SUM PAYMENT FROM THE ARMED FORCES? *(If "Yes," list type, amount, date it was received, and the branch of service below)*

☐ YES ☐ NO ________________

PART VI - MARITAL AND DEPENDENCY INFORMATION

27A. MARITAL STATUS *(If married, complete Items 27B thru 29D)*

☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ NEVER MARRIED *(If never married, skip to Item 30)*

27B. SPOUSES'S BIRTHDATE *(Mo., day, yr.)*

27C. NUMBER OF TIMES YOU HAVE BEEN MARRIED *(To include current marriage)*

27D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED *(To include current marriage)*

27E. IS YOUR SPOUSE ALSO A VETERAN?

☐ YES ☐ NO *(If "Yes,"complete Item 27F)*

27F. SPOUSE'S VA FILE NUMBER *(If any)*

C-

27G. DO YOU LIVE TOGETHER?

☐ YES ☐ NO *(If "No,"complete Items 27H thru 27J)*

27H. REASON FOR SEPARATION *(For example, marital problems, job requirements, health, etc.)*

27I. PRESENT ADDRESS OF SPOUSE

27J. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S MONTHLY SUPPORT

$

27K. HOW WERE YOU MARRIED?

☐ CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL ☐ TRIBAL ☐ OTHER *(Explain)*

☐ COMMON-LAW ☐ PROXY ________________

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 43A THRU 43C ON PAGE 10.

PART VI - MARITAL AND DEPENDENCY INFORMATION - CONTINUED *(If you need additional space, use Item 46 "Remarks")*

FURNISH THE FOLLOWING INFORMATION ABOUT EACH OF YOUR MARRIAGES *(IF NOT APPLICABLE, WRITE "N/A")*

28A. DATE AND PLACE OF MARRIAGE		28B. TO WHOM MARRIED	28C. TERMINATED *(Death, Divorce)*	28D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE *(IF NOT APPLICABLE, WRITE "N/A")*

29A. DATE AND PLACE OF MARRIAGE		29B. TO WHOM MARRIED	29C. TERMINATED *(Death, Divorce)*	29D. DATE AND PLACE TERMINATED	
MONTH, YEAR	CITY, STATE			MONTH, YEAR	CITY, STATE

DEPENDENCY - Dependent Children Information *(If you need additional space, use Item 46 "Remarks")*

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN

30A. NAME OF CHILD *(First, middle initial, last)*	30B. DATE & PLACE OF BIRTH *(City, state or country)*	30C. SOCIAL SECURITY NUMBER	30D. CHECK EACH APPLICABLE CATEGORY					
			BIOLOGICAL	ADOPTED	STEPCHILD	18-23 YRS. OLD AND IN SCHOOL	SERIOUSLY DISABLED BEFORE AGE 18	CHILD PREVIOUSLY MARRIED
	(Month, day, year) Place:		☐	☐	☐	☐	☐	☐
	(Month, day, year) Place:		☐	☐	☐	☐	☐	☐
	(Month, day, year) Place:		☐	☐	☐	☐	☐	☐

FURNISH THE FOLLOWING INFORMATION FOR EACH OF YOUR DEPENDENT CHILDREN WHO DO NOT LIVE WITH YOU

31A. NAME(S) OF ANY CHILD(REN) NOT IN YOUR CUSTODY	31B. NAME AND ADDRESS OF PERSON HAVING CUSTODY	31C. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
		$
		$

PART VII - VETERANS PENSION *(If you need additional space use Item 46 "Remarks")*

NOTE: If you are a veteran who is claiming pension and you are age 65 or older, or determined disabled by the Social Security Administration, you ***DO NOT*** have to submit medical evidence with your application unless you are claiming special monthly pension.

32. WHAT DISABILITIES PREVENT YOU FROM WORKING? *(List below)*

33. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR HOME?

☐ 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 ensure that each item on the form is complete and that it is signed by a physician, physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialist (CNA))

NURSING HOME INFORMATION

NOTE: If you are in a nursing home, please submit a statement from an official of the nursing home that tells VA that you are a patient in the nursing home due to a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care.

34A. ARE YOU NOW IN A NURSING HOME?

☐ YES ☐ NO *(If "YES,"complete Items 34B thru 34D)*

34B. NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY

34C. HAVE YOU APPLIED FOR MEDICAID?

☐ YES ☐ NO

34D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED AND NOT RECEIVED A DECISION?

☐ YES ☐ NO ☐ APPLIED - NOT RECEIVED DECISION

34E. ARE YOU RECEIVING SOCIAL SECURITY DISABILITY (SSD) OR SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI) OR HAVE YOU APPLIED FOR SSD OR SSI BUT NO DECISION HAS BEEN MADE:

☐ YES ☐ NO ☐ APPLIED - NOT RECEIVED DECISION

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 43A THRU 43C ON PAGE 10.

PART VIII - INCOME AND ASSET INFORMATION *(If you need more space, attach a separate sheet)*

35. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

☐ YES ☐ NO (If "NO," skip to Item 36) (If "YES," complete Items 35A and 35B)

A. SOCIAL SECURITY RECIPIENT	B. GROSS MONTHLY AMOUNT
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$

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

☐ YES ☐ NO (If "NO," skip to Item 38A after reading the "Important Information" below) (If "YES," complete Items 37A and 37B)

37A. WHAT IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS?

_________________ Square Feet

37B. COULD ANY PART OF THE LOT BE SOLD WITHOUT SELLING THE RESIDENCE?

☐ YES ☐ NO (If "YES," also complete VA Form 21P-0969, *Income and Asset Statement*)

IMPORTANT INFORMATION

VA MATCHES INCOME INFORMATION REPORTED WITH FEDERAL TAX INFORMATION. REPORT ***ALL*** INCOME YOU AND YOUR DEPENDENTS RECEIVE ON THE APPROPRIATE SECTIONS OF THIS FORM AND VA FORM 21P-0969, *INCOME AND ASSET STATEMENT*, IF APPROPRIATE.

38A. *OTHER THAN SOCIAL SECURITY*, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?

☐ YES ☐ NO

38B. *OTHER THAN SOCIAL SECURITY*, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?

☐ YES ☐ NO

38C. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN $10,000.00 IN 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 your or your dependents need for transportation)

☐ YES ☐ NO

38D. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving them away, selling them, purchasing an annuity, or using them to establish a trust)

☐ YES ☐ NO

38E. DID YOU ANSWER "YES" TO ***ANY*** OF THE ITEMS 38A THRU 38D?

☐ YES ☐ NO (If "YES," you ***must*** also complete VA Form 21P-0969, *Income and Asset Statement*)

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 43A THRU 43C ON PAGE 10.

PART IX - INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself, dependents you are under obligation to support, or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child 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 be sure to complete all 6 criteria below (if applicable).

If more space is needed, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: If you are claiming expenses for in-home care or an assisted living facility, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 11 and 12.

39A. AMOUNT YOU PAID	39B. DATE PAID (*Month, year*)	39C. HOURLY RATE/HOURS (In-home attendant only)	39D. PURPOSE (*Doctor's fees, hospital charges, attorney fees, etc.*)	39E. PAID TO (*Name of doctor, hospital, pharmacy, attorney, etc.*)	39F. PERSON FOR WHOM EXPENSE PAID (*Self, spouse, child*)

PART X - DIRECT DEPOSIT

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 40, 41 and 42 to enroll in direct deposit. If you do not have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

40. ACCOUNT NUMBER *(Please check the appropriate box and provide the account number, if applicable)*

☐ CHECKING ____________________ (Account Number)

☐ SAVINGS ____________________ (Account Number)

☐ I certify that I do not have an account with a financial institution or certified payment agent

41. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit to go)*

42. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check or savings deposit slip)*

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 43A THRU 43C ON PAGE 10.

PART XI - CERTIFICATION, AUTHORIZATION, AND SIGNATURE(S)

I certify that the statements in this document are true and complete to the best of my knowledge and belief. 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 I waive any privilege which makes the information confidential.

IMPORTANT - If you sign with an "X", then you must have 2 people witness your signature. They must then print their names and addresses and sign the form.

43A. VETERAN'S SIGNATURE *(Do not print) (Please sign in ink)*	43B. VETERAN'S PRINTED NAME	43C. DATE SIGNED

44A. SIGNATURE OF WITNESS *(Do not print)*	44B. PRINTED NAME AND ADDRESS OF WITNESS
45A. SIGNATURE OF WITNESS *(Do not print)*	45B. PRINTED NAME AND ADDRESS OF WITNESS

PART XII - REMARKS

(Use this space for any additional statements that you would like to make concerning your application for Compensation and/or Pension)

46. REMARKS *(If you need more space you may attach a separate sheet of paper)*

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

YOU MUST SIGN AND PRINT YOUR NAME AND DATE THIS FORM IN ITEMS 43A THRU 43C ON THIS PAGE.

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

☐ YES ☐ NO

(If "NO," continue to Step 2)

(If "YES," ***all*** payments to the facility qualify as medical expenses in Items 39A thru 39F. You are finished completing this worksheet)

STEP 2. Do ***all*** of the following apply to the facility?
- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with caregivers

☐ YES ☐ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the veteran) the disabled person?

☐ YES ☐ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension on Page 7, Item 33 of the attached form?

☐ YES ☐ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 39A thru 39F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the ***primary reason*** you live in the facility (or attend day care in the facility)?

☐ YES ☐ NO

(If "YES," all payments to this facility ***may*** qualify as medical expenses in Items 39A thru 39F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 39A thru 39F applicable amounts you pay the facility for: (1) lodging and meals, (2) ***health care services or assistance with ADLs provided by a health care provider***, and (3) custodial care. Skip to Step 8)

(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 39A thru 39F applicable amounts you pay the facility for: (1) ***health care services or assistance with ADLs provided by a health care provider***; and (2) ***custodial care***. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

☐ YES ☐ NO

(If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disabilty)

(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 39A thru 39F. Skip to Step 8)

STEP 7. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the ***primary reason*** the disabled person lives in the facility (or attends day care in the facility)?

☐ YES ☐ NO

(If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 39A thru 39F)

(If "NO," ***only*** claim payments you pay the facility for assistance with ***health care and/or assistance with custodial care*** as medical expenses in Items 39A thru 39F. Payment to this facility for meals and lodging ***do not*** qualify)

STEP 8. Facility Certification: Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received.

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to ______________________________
(Name of person staying at your facility)

and his or her care at this facility______________________________.
(Name and address of facility)

______________________________ (Name, Signature and Title of Person Certifying for the Facility)

______________ (Date Certified)

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: Only complete this worksheet if you are claiming expenses for in-home care.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.

Follow the steps below to determine whether or not:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care

STEP 1. Are you (the veteran) the disabled person?

☐ YES ☐ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Page 7, Item 33 of the attached form?

☐ YES ☐ NO (If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 39A thru 39F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

☐ YES ☐ NO

(If "YES," payments to this in-home attendant ***may*** qualify as medical expenses in Items 39A thru 39F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 39A thru 39F amounts you pay an in-home attendant for: (1) health-care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs, and (3) custodial care. Skip to Step 6)

(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 39A thru 39F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

☐ YES ☐ NO

(If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," the attendant ***must be a health care provider***. Only report payments to the in-home attendant for ***health care services or assistance with ADLs*** provided by the health care provider as medical expenses in Items 39A thru 39F. Payments for assistance with IADLs do not qualify as medical expenses. Skip to Step 6)

STEP 5. Is the ***primary responsibility*** of the in-home attendant to provide the disabled person with health care or custodial care?

☐ YES ☐ NO

(If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 39A thru 39F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 39A thru 39F. Payment for assistance with IADLs ***do not*** qualify as a medical expense)

STEP 6. Check all activities below that the attendant assists the veteran or disabled person with:

ADLs: ☐ EATING ☐ BATHING/SHOWERING ☐ DRESSING ☐ TRANSFERRING ☐ USING THE TOILET

IADLs: ☐ SHOPPING ☐ FOOD PREPARATION ☐ HOUSEKEEPING ☐ LAUNDERING ☐ MANAGING FINANCES ☐ HANDLING MEDICATIONS ☐ USING THE TELEPHONE ☐ TRANSPORTANTION FOR NON-MEDICAL PURPOSES

STEP 7. In-Home Attendant Certification: Please submit a current breakdown of the time the attendant spends assisting the veteran or disabled person with health care services, ADLs and IADLs.

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and

reflects the current environment pertaining to ______________________________
(Name of Person Requiring Care)

and his or her care from ______________________________.
(Name of Attendant)

______________________________ (Name, Signature and Title of Certifying Official)

______________ (Date Certified)