Department of Veterans Affairs

INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

VA may be able to pay you a higher benefit rate if you identify expenses VA can deduct from your income. Your benefit rate is based on your income. Your out-of-pocket payments for medical and dental expenses may be deductible.

Report any medical or dental expenses that you paid for yourself or for a relative who is a member of your household (spouse, grandchild, parent, etc.) for which you were not reimbursed and do not expect to be reimbursed. Below are examples of expenses you should include, if applicable:

- Hospital expenses
- Doctor's office fees
- Dental fees
- Prescription/non-prescription drug costs
- Vision care costs
- Medical insurance premiums
- Nursing home costs
- Hearing aid costs
- Home health service expenses
- Expenses related to transportation to a hospital, doctor, or other medical facility
- Monthly Medicare deduction

IMPORTANT NOTES

- Do not include any expenses for which you were or will be reimbursed. If you receive reimbursement after you have filed this claim, promptly notify the VA office handling your claim.
- If you are a veteran, VA can deduct allowable expenses paid by either you or your spouse.
- If you are not sure whether VA can deduct a payment for a particular expense, furnish a complete description of the purpose of the payment. We will let you know if we cannot deduct an expense.
- If you are claiming expenses for an in-home care provider or for care in a facility other than a nursing home, you ***must*** complete the appropriate worksheet to determine whether VA may deduct all or some of your payments to the provider or facility and whether additional evidence is required. If the expenses are for your care, you are not in receipt of special monthly benefits, and you want to make a claim, please attach a completed VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance.*
- VA may require you to verify the amounts you paid, so keep all receipts or other documentation of payments for at least 3 years after we make a decision on your medical expense claim. If you are unable to provide documentation of your claimed medical expenses when VA asks you to do so, your benefits may be retroactively reduced or discontinued.
- If you need more space to report expenses, attach a separate sheet of paper with columns corresponding to those on this form. Be sure to write your VA file number on any attachments.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits provided under law. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine whether medical expenses you paid may be used to reduce the amount of income we count in determining eligibility to benefits (38 U.S.C. 1503). 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 suggestions about this form.

OMB Control No. 2900-0161
Respondent Burden: 30 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

FOR VA USE ONLY

MEDICAL EXPENSE REPORT

1. FIRST NAME OF VETERAN	2. MIDDLE NAME OF VETERAN	3. LAST NAME OF VETERAN	4. SUFFIX NAME OF VETERAN
5. VETERAN'S SOCIAL SECURITY NO.			6. VA FILE NUMBER
7. FIRST NAME OF CLAIMANT	8. MIDDLE NAME OF CLAIMANT	9. LAST NAME OF CLAIMANT	10. SUFFIX NAME OF CLAIMANT
11. STREET ADDRESS OF CLAIMANT			12. APT. NO.
13. CITY		14. STATE	15. ZIP CODE
16. DAYTIME TELEPHONE NO. OF CLAIMANT *(Include Area Code)*		17. EVENING TELEPHONE NO. OF CLAIMANT *(Include Area Code)*	
18. CHANGE OF ADDRESS *(Check box if address in Items 11-15 is different from last address furnished to VA)* ☐ ____________	19. E-MAIL ADDRESS OF CLAIMANT *(If applicable)*		

20. MILEAGE FOR PRIVATELY OWNED VEHICLE TRAVEL FOR MEDICAL PURPOSES

Report miles traveled to a hospital, doctor, or other medical facility in a privately owned vehicle (POV) such as a car, truck, or motorcycle. Itemize travel occurring between the dates ______________ and ________________. If no dates appear on this line, refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis. We will calculate the allowable deduction for your mileage based on the current POV mileage reimbursement rate for automobiles specified by the United States General Services Administration (GSA). You may locate the current amount at **www.gsa.gov** or on VA's website at **www.benefits.va.gov/pension**.

NOTE: You may also claim deductions for other payments related to travel for medical purposes, such as taxi fares, buses, or other forms of public transportation. Report these types of medical travel expenses in Item 22.

A. MEDICAL FACILITY TO WHICH TRAVELED	B. TOTAL ROUNDTRIP MILES TRAVELED	C. AMOUNT REIMBURSED FROM ANOTHER SOURCE *(Such as a VA Medical Center)*	D. DATE TRAVELED *(Month/Day/Year)*	E. WHO NEEDED TO TRAVEL? *(Self, spouse, child)*

IMPORTANT: Be sure to sign and date this form in Items 23A & 23B on page 4. Unsigned reports will be returned.

21. IN-HOME ATTENDANT EXPENSES

IMPORTANT - You must complete the attached In-Home Attendant Worksheet (page 6) to claim in-home attendant expenses.
Report amounts paid between the dates __ and __. If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis.

A. NAME OF PROVIDER	B. HOURLY RATE/ NUMBER OF HOURS	C. AMOUNT PAID	D. DATE PAID *(Month/Day/Year)*	E. FOR WHOM PAID *(Self, spouse, child, etc.)*

22. ITEMIZATION OF MEDICAL EXPENSES

IMPORTANT - If you are claiming expenses for care in a facility that is not a nursing home, you must complete the appropriate worksheet (page 5).
Report medical expenses that you paid between the dates __________________ and _________________. If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis.

A. MEDICAL EXPENSE *(Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)*	B. AMOUNT PAID	C. DATE PAID *(Month/Day/Year)*	D. NAME OF PROVIDER *(Name of doctor, dentist, hospital, lab, etc.)*	E. FOR WHOM PAID *(Self, spouse, child, etc.)*
MEDICARE (PART B)				
MEDICARE (PART D)				
PRIVATE MEDICAL INSURANCE				

22. ITEMIZATION OF MEDICAL EXPENSES *(Continued)*

IMPORTANT - If you are claiming expenses for care in a facility that is not a nursing home, you must complete the appropriate worksheet (page 5).
Report medical expenses that you paid between the dates __________________ and _________________. If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis.

A. MEDICAL EXPENSE *(Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)*	B. AMOUNT PAID	C. DATE PAID *(Month/Day/Year)*	D. NAME OF PROVIDER *(Name of doctor, dentist, hospital, lab, etc.)*	E. FOR WHOM PAID *(Self, spouse, child, etc.)*
MEDICARE (PART B)				
MEDICARE (PART D)				
PRIVATE MEDICAL INSURANCE				

CERTIFICATION: I have not and will not receive reimbursement for these expenses. I certify that the above information is true.

23A. SIGNATURE OF CLAIMANT *(Do NOT print)*	23B. DATE

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 is false, or fraudulent acceptance of any payment to which you are not entitled.

WORKSHEET: EXPENSES FOR CARE IN A FACILITY OTHER THAN A NURSING HOME

IMPORTANT: VA recognizes the following six 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

(6) Ambulating within the home or living area

Custodial Care is regular -

- supervision because a person with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to be protected from hazards or dangers incident to his or her daily environment, ***or***
- assistance with two or more ADLs.

INSTRUCTIONS: Use this worksheet if you are claiming your or your relative's care in a facility other than a nursing home. Follow the steps below to determine what expenses to claim and any additional evidence to provide. If you are not in receipt of special monthly benefits and wish to make a claim, please attach a completed VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* with this report.

STEPS 1 THROUGH 6	YES	NO
STEP 1. Are the expenses you wish to claim due to your or your relative's treatment in a hospital, inpatient treatment center, nursing home, or VA-approved medical foster home? NOTE: If "YES," ***all*** payments to the facility qualify as medical expenses. You may claim them in Items 30A through 30F)	☐ *(See **"Note"** then stop)*	☐ ***(Continue)***
STEP 2. Do ***both*** of the following apply to the facility? • The facility is licensed (if the State or country requires it) • If the facility is residential, it is staffed 24 hours per day with care providers (the providers do not have to be licensed). NOTE: If "NO," payments to the facility do ***not*** qualify as medical expenses)	☐ ***(Continue)***	☐ *(See **"Note"** then stop)*
STEP 3. Are you the person who needs care?	☐ ***(Continue)***	☐ *(Continue)*
STEP 4. Do you or your relative receive **health care and/or custodial care** in the facility? NOTE 1: If "YES," you must attach a statement that (1) states you or your relative needs to be in a protected environment because of a physical, mental, developmental, or cognitive disorder; and (2) describes the disorder. A physician; physician assistant (PA); certified nurse practitioner (CNP), or clinical nurse specialist (CNS) may sign the statement. NOTE 2: If "NO," you may only claim health care expenses provided by a licensed health care provider in Items 22A through 22E.	☐ *(See **"Note 1"** then continue)*	☐ *(See **"Note 2"** then stop)*
STEP 5. Do you want to claim meals and lodging (and other facility expenses not directly related to health care or custodial care)?	☐ *(See **"Note 1"in Step 4 then** continue)*	☐ ***(Continue)***

STEP 6. 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: Expenses for Care in a Facility Other than a Nursing Home"* is accurate and reflects the current and projected future environment pertaining to:

____ and his or her care in this

(Name of Person Receiving Care in Facility)

facility____.

(Name and Address of Facility)

________________________________ ________________

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

WORKSHEET: EXPENSES FOR IN-HOME ATTENDENT CARE

IMPORTANT: VA recognizes the following six 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

(6) Ambulating within the home or living area

Custodial Care is regular -
- supervision because a person with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to be protected from hazards or dangers incident to his or her daily environment, ***or***
- assistance with two or more ADLs.

IMPORTANT: For VA medical expense purposes, "health care providers" include persons who are -

- licensed by a state or country to provide health care. Examples: physicians, physician assistants, psychologists, chiropractors, clinical nurse specialists, licensed practical nurses, and physical or occupational therapists, ***and***
- nursing assistants or home health aides who are supervised by a licensed health care provider.

INSTRUCTIONS: Use this worksheet if you are claiming payments to your or your relative's in-home attendant as an unreimbursed medical expense. You must complete a separate worksheet for each person whose care expenses you are claiming.

Follow the steps below to determine whether or not the in-home attendant must be a health care provider.

STEPS 1 THROUGH 5	YES	NO
STEP 1. Are you the person who needs care?	☐ ***(Continue)***	☐ *(Skip to **step 3**)*
STEP 2. Do you or your relative require custodial care? NOTE 1: If "YES," you must attach a statement that (1) states you or your relative requires custodial care because of a physical, mental, developmental, or cognitive disorder; and (2) describes the disorder. A physician; physician assistant (PA); certified nurse practitioner (CNP), or clinical nurse specialist (CNS) may sign the statement. NOTE 2: If "NO," the in-home attendant must be a health care provider.	☐ *(See **"Note 1"** then skip to **step 4**)*	☐ *(See **"Note 2"** then continue)*

STEP 3. Health Care Provider Certification (When Required):

I CERTIFY that I am a health care provider as defined above:

______________________________ (Name, Signature and Title of Health Care Provider or Supervisor)

______________ (Date Certified)

STEP 4. Check all activities below with which the attendant assists the veteran or relative:

☐ EATING ☐ BATHING/SHOWERING ☐ DRESSING ☐ TRANSFERRING ☐ USING THE TOILET ☐ AMBULATING WITHIN THE HOME OR LIVING AREA

☐ SHOPPING ☐ FOOD PREPARATION ☐ HOUSEKEEPING ☐ LAUNDERING ☐ MANAGING FINANCES ☐ HANDLING MEDICATIONS

☐ USING THE TELEPHONE ☐ TRANSPORTATION FOR NON-MEDICAL PURPOSES ☐ OTHER______________

STEP 5. In-Home Attendant Certification: Please submit a current breakdown of the time the attendant spends assisting the veteran or relative with health care services, ADLs and other personal services.

I CERTIFY that the information stated within this *"Worksheet For In-Home Attendant Expenses"* is accurate and

reflects the current and projected future environment pertaining to______________________________
(Name of Person Requiring Care)

and his or her care from______________________________.
(Name of Attendant)

______________________________ (Name, Signature and Title of Attendant or Agency Certifying Official)

______________ (Date Certified)