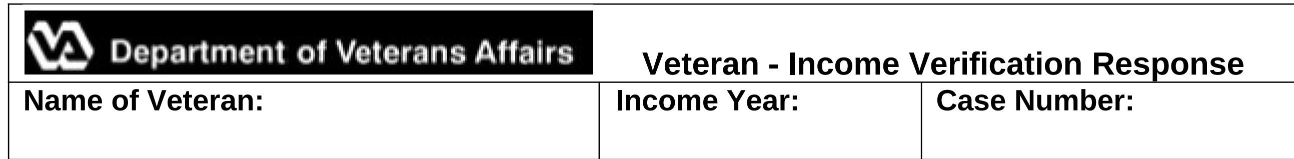
OMB Control Number: 2900-XXXX
Estimate Burden: 30 minutes



Department of Veterans Affairs	Veteran - Income Verification Response	
Name of Veteran:	**Income Year:**	**Case Number:**

Before completing this form, please refer to the enclosed instructions which include examples of deductible out-of-pocket non-reimbursed expenses. Please select **one** of the **Options** below which best represents your response to our attempt to verify your income information. ***An incomplete form will be returned which may delay the processing of your case.*** Your gross household income including income of spouse and dependent child(ren) will assist us in determining your copay responsibilities and eligibility for VA health care benefits. Once a determination is made on your case, a decision letter will be mailed to you. ***(Fill−in appropriate circle)***

○ **Option 1. Agree**

I agree with the financial information provided by IRS/SSA and agree to make the applicable copays for health care received during ~CalendarYear~**. I understand I may be billed within 60 days following the date on the decision letter regarding any unpaid health care copays.**

○ **Option 2. Agree/Deductible Expenses**

I agree with the financial information provided by IRS/SSA and have indicated the total amount of deductible out-of-pocket non-reimbursed expenses for ~Income Year~ as entered in the **Additional Requirement** section that may reduce my income below the VA National Income Threshold.

*If you select **Option 2** and do not provide the information requested below in the **Additional Requirement** section, we will complete our income verification using information provided by IRS/SSA. After our review is completed, you will receive a decision letter notifying you of your copay status and responsibilities. **You may be billed within 60 days following the date on the decision letter regarding any unpaid health care copays**.*

○ **Option 3. Disagree**

I disagree with the financial information provided by IRS/SSA. **I have enclosed copies of supporting documentation for any disputed IRS/SSA information.** I understand VA may use this information to determine my eligibility for health care benefits and may obtain verification from financial institutions and/or employers.

*If you select **Option 3** and do not provide the information requested below in the **Additional Requirement** section and/or do not provide copies of supporting documentation for the disputed IRS/SSA information, we will complete our income verification using information provided by IRS/SSA and you will receive a decision letter notifying you of your copay status and responsibilities. **You may be billed within 60 days following the date on the decision letter regarding any unpaid health care copays.***

Additional Requirement: ***(Fill in appropriate circle and complete, where applicable)***

○ I attest that the **household** deductible out-of-pocket non-reimbursed expenses paid in ~IncomeYear~ are as follows:

Medical: $ __________ (Total)   Medical Mileage: __________ miles (Total)   Burial: $ __________ (Spouse, Dependent Child(ren))

Department of Veterans Affairs

Veteran - Income Verification Response

Name of Veteran:	Income Year:	Case Number:

Educational: $ ___________ Gambling Losses: $ ____________
(Veteran only) (Deducted from gambling winnings only)

○ I attest that the listed sale of real estate was my primary residence.

○ I attest that I have been separated from my spouse since ____________________.
(MM/DD/YYYY of separation)

I declare to the best of my knowledge and belief that the information stated is true and correct and I understand that I may be required to provide supporting documentation as proof which may be used to determine the final decision regarding my health care benefits during ~CalendarYear~.

Signature:	Date:
Sign and date this form. Return the form and any copies of your supporting documentation to: **VA Health Eligibility Center, Income Verification Division, 2957 Clairmont Road, Atlanta, GA 30329−1647**	

If you sign with an "X", two people you know must witness your signature as you sign. They must print their names and sign and date the form below.

Witness' Name (Please Print)	Signature	Date

Witness' Name (Please Print)	Signature	Date

For more information about VA health care eligibility and enrollment, visit VA's website at **www.va.gov/healthbenefits**.

Document Contains Federal Tax Information

End of Reported Federal Tax Information

If you have additional earned or unearned income information for ***~IncomeYear~*** that is not listed, please provide it on a separate sheet of paper. **Be sure to write your case number on each page of correspondence you mail or fax to our office.**