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

F		
Department of Veterans Affairs	Veteran - Income	Verification Response
Name of Veteran:	Income Year:	Case Number:
Before completing this form, please refer to the en out-of-pocket non-reimbursed expenses. Please s response to our attempt to verify your income informathe processing of your case. Your gross household will assist us in determining your copay responsibilities determination is made on your case, a decision letter of the complete responsibilities.	elect one of the Options belo tion. An incomplete form wi n income including income of s s and eligibility for VA health c	w which best represents your Il be returned which may delay pouse and dependent child(ren) are benefits. Once a
Option 1. Agree		
I agree with the financial information provided the health care received during ~CalendarYear~. I date on the decision letter regarding any un	understand I may be billed	
Option 2. Agree/Deductible Expens	ses	
I agree with the financial information provided to deductible out-of-pocket non-reimbursed exper Requirement section that may reduce my inco	ises for ~Income Year~ as en	tered in the Additional
If you select Option 2 and do not provide the information proceeds our income verification using information production letter notifying you of your copay status and date on the decision letter regarding any unpaid to	ovided by IRS/SSA. After our revresponsibilities. You may be bill	view is completed, you will receive a
Option 3. Disagree		
I disagree with the financial information provide documentation for any disputed IRS/SSA in determine my eligibility for health care benefits employers.	formation. I understand VA r	nay use this information to
If you select Option 3 and do not provide the informa not provide copies of supporting documentation for the verification using information provided by IRS/SSA at and responsibilities. You may be billed within 60 da health care copays.	ne disputed IRS/SSA information, and you will receive a decision lette	we will complete our income r notifying you of your copay status
Additional Requirement: (Fill in appropriate	e circle and complete, where	applicable)
I attest that the household deductible out are as follows:	-of-pocket non-reimbursed ex	penses paid in ~IncomeYear~
Medical: \$ Medical N	fileage: miles	Burial: \$
(Total)	(Total)	(Spouse, Dependent Child(ren))

Department of Veterans A	veteran - Incor	ne Verification Respons Case Number:
ame of Veteran:	income rear:	Case Number:
Educational: \$	Gambling Losses: \$	
(Veteran only)	(Deducted from gambling winnings only)	
I attest that the listed sale of r	real estate was my primary resi	dence.
O I attest that I have been sepa	rated from my spouse since	
	(M	M/DD/YYYY of separation)
derstand that I may be required to pro- termine the final decision regarding m		CalendarYear~.
ignature:		Date:
'A Health Eligibility Center, Income Verif	fication Division, 2957 Clairmont	Road, Atlanta, GA 30329-1647
YA Health Eligibility Center, Income Verification you sign with an "X", two people you kn	fication Division, 2957 Clairmont	Road, Atlanta, GA 30329-1647
Sign and date this form. Return the form /A Health Eligibility Center, Income Verify you sign with an "X", two people you kneir names and sign and date the form the Witness' Name (Please Print)	fication Division, 2957 Clairmont	Road, Atlanta, GA 30329-1647
YA Health Eligibility Center, Income Verity you sign with an "X", two people you known the sign and date the form be	fication Division, 2957 Clairmont now must witness your signatur pelow.	e as you sign. They must prin
you sign with an "X", two people you kneir names and sign and date the form to Witness' Name (Please Print) Witness' Name (Please Print) The more information about VA health care elements.	now must witness your signatur pelow. Signature Signature	e as you sign. They must prin Date Date
Witness' Name (Please Print) Witness' Name (Please Print) word information about VA health care elements.	now must witness your signatur pelow. Signature Signature	e as you sign. They must prin Date Date
Va Health Eligibility Center, Income Verification you sign with an "X", two people you know the property of t	now must witness your signatur pelow. Signature Signature	e as you sign. They must prin Date Date
you sign with an "X", two people you known beir names and sign and date the form between the work of t	now must witness your signatur pelow. Signature Signature	e as you sign. They must prin Date Date
Va Health Eligibility Center, Income Verification you sign with an "X", two people you know the sign and date the form the sign and date	now must witness your signatur pelow. Signature Signature	e as you sign. They must prin Date Date
Va Health Eligibility Center, Income Verification you sign with an "X", two people you know the sign and date the form the sign and date	now must witness your signatur pelow. Signature Signature	e as you sign. They must prin Date Date

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.