Department of Veterans Affairs

NOTICE TO SURVIVOR OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION, AND/ORACCRUED BENEFITS

This notice is applicable to survivors claims for: Survivors Pension • Dependency Indemnity Compensation (DIC) • DIC under 38 U.S.C. 1151 • Increased Survivor Benefits Based on Need for Special Monthly Pension • Accrued Benefits • Benefits Based on a Veteran's Seriously Disabled Child.

Use this notice and the attached application to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. This notice informs you of the evidence necessary to substantiate your claim.

If you are ***not*** ready to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits, please complete a VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*, to protect your date of claim. If you complete the VA Form 21P-534EZ within one year of filing the VA Form 21-0966, your completed application will be considered filed as of the date of receipt of the VA Form 21-0966.

If you are a parent making a claim for parent's DIC or accrued benefits, use VA Form 21P-535, *Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation when Applicable)*. **If you are making a claim for veterans disability compensation or related compensation benefits**, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. **If you are claiming veterans Pension benefits**, use VA Form 21P-527EZ, *Application for Veterans Pension*. **If you are claiming accrued benefits only**, use VA Form 21P-601, *Application for Accrued Amounts Due a Deceased Beneficiary*.

VA forms are available at www.va.gov/vaforms.

FEES FOR CLAIMS: Generally, an accredited attorney or claims agent can **ONLY** charge claimants a fee after the VA has issued a decision on a claim. Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power of attorney and the fee agreement requirements.

The Application is comprised of 14 sections. Be sure to answer the question(s) in each section as required.	
Section I: Veteran's Identification Information	Section IX: Income and Assets
Section II: Claimant's Contact Information	Section X: Information about Your Medical or Other Expenses
Section III: Veteran's Service Information	Section XI: Direct Deposit Information
Section IV: Marital Information	Section XII: Claim Certification and Signature
Section V: Marital History	Section XIII: Witness to Signature
Section VI: Child of the Veteran Information	Section XIV: Alternate Signer Certification and Signature
Section VII: DIC	
Section VIII: Nursing Home or Increased Survivors Entitlement Based on a Claim For Special Monthly Pension	

NOTE: You may wish to contact an accredited Veterans Service Officer (VSO) to assist you with your application. For a list of accredited veteran's service organizations go to https://www.va.gov/vso/. You may also contact your state office of veterans affairs at https://www.www.va.gov/statedva.htm, should you need further assistance with the application process.

The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed, and there is no risk to participate! Participation in the FDC Program is optional and will not affect the quality of care you receive or the benefits to which you are entitled. If you file a claim in the FDC Program and it is determined that other non-federal records exist and VA needs the records to decide your claim, then VA will simply remove the claim from the FDC Program (Optional Expedited Process) and process it in the Standard Claim Process. See page 2 for more information. If you wish to file your claim in the FDC Program, see FDC Program (Optional Expedited Process). If you wish to file your claim under the process in which VA traditionally processes claims, see Standard Claim Process.

For more information on the FDC Program, visit our website at https://www.choose.va.gov/pensions.

FDC Criteria (Claim(s) for DIC, Survivors Pension, and/or Accrued Benefits)

1. Submit your claim on a signed and completed VA Form 21P-534EZ, Application for DIC, Survivors Pension, and/or Accrued Benefits (Attached).

2. Submit simultaneously with your claim:

A copy of the veteran's Death Certificate (unless he or she died on active duty); **AND**

If claiming Survivors Pension:

- All necessary income and asset information; **AND**
- **If claiming Survivors Pension with special monthly pension**, a completed VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance, **or** (if a patient in a) nursing home, a completed VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance.

If claiming DIC:

- All, if any, of the veteran's relevant, private medical treatment records and an identification of any of the veteran's treatment records available at a Federal facility, such as a VA medical center, that supports your claim that a service-connected disability caused the veteran's death or the veteran's death was caused by the VA.
- Any and all Service Treatment and Personnel Records in the custody of the veteran's Guard or Reserve Unit(s).
- **If claiming DIC with special monthly compensation,** a completed VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance, or (if a patient in a nursing home) a completed VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance.

Requirements for Certain Claimants:

- **If claiming benefits as the surviving spouse of the veteran**, a copy of your marriage certificate showing your marriage to the veteran.
- **If claiming benefits for a child of the veteran between the ages of 18 and 23**, a completed VA Form 21-674, Request for Approval of School Attendance.
- **If claiming benefits for a seriously disabled child of the veteran,** all, if any, relevant, private medical treatment records for the child's pertinent disabilities showing the child was incapable of self-support before age 18.

3. Report for any VA medical examinations VA determines are necessary to decide your claim.

WHAT YOU NEED TO DO

You must submit all relevant evidence in your possession and provide VA information sufficient to enable it to obtain all relevant evidence not in your possession. If your claim involves a disability the veteran had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before the veteran's entry into service.

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Submit your claim in accordance with the "FDC Criteria" (shown on this page)	You must: • If you know of evidence not in your possession and want VA to try to get it for you, give VA enough information about the evidence so that we can request it from the person or agency that has it **NOTE**: If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. **It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.**

HOW VA WILL HELP YOU OBTAIN EVIDENCE FOR YOUR CLAIM

FDC Program (Optional Expedited Process)	Standard Claim Process
VA will: • Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain	VA will: • Retrieve relevant records from a Federal facility that you adequately identify and authorize VA to obtain • Make every reasonable effort to obtain relevant records not held by a Federal facility that you adequately identify and authorize VA to obtain. These may include records from state or local governments and privately held evidence and information you tell us about, such as private doctor or hospital records or records from current or former employers

WHEN YOU SHOULD SEND WHAT WE NEED

FDC Program (Optional Expedited Process)	Standard Claim Process
You must: • Send the information and evidence simultaneously with your claim If you submit additional information or evidence after you submit your "fully developed" claim, then VA will remove the claim from the FDC Program expedited process and process it in the Standard Claim process. If we decide your claim before one year from the date we received the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.	We strongly encourage you to: • Send any information or evidence as soon as you can You have up to one year from the date we receive the claim to submit the information and evidence necessary to support your claim. If we decide the claim before one year from the date we received the claim, you will still have the remainder of the one year period to submit additional information or evidence necessary to support the claim.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

Military Service Verification

To support your claim for Survivors benefits, the veteran's military service must be verified. The following evidence can be submitted to verify the veteran's military service:

- A photocopy of the veteran's DD Form 214 (or equivalent) for all periods of military service. You may request a copy of the DD Form 214 through the National Archives' National Personnel Records Center (NPRC) using SF 180 (SEP 2021 version), *Request Pertaining to Military Records* (available at https://www.archives.gov/files/research/order/standard-form-180.pdf) or you can request a copy online at https://www.archives.gov/veterans/military-service-records

Fire Related Military Records:
There was a fire at the National Archives and Records Administration on July 12, 1973, which destroyed approximately

- 80 percent of the records NPRC held for veterans who were discharged from the Army between November 1,1912, and January 1, 1960, **AND**
- 75 percent of the records NPRC held for veterans with surnames beginning (alphabetically) with Hubbard and running through the end of the alphabet, and who were discharged from the Air Force between September 25, 1947, and January 1, 1964.

If the veteran's military records were stored there on that date, they may have been destroyed in the fire. If you believe the veteran's military records may have been destroyed in the fire, NA Form 13075, *Questionnaire About Military Service*, should be completed to avoid delays in processing your claim.

NA Form 13075 is available at: https://www.archives.gov/files/st-louis/military-personnel/na-13075-questionnaire-about-military-service.pdf.

NOTE: The Veterans Benefits Administration (VBA) is no longer able to retrieve or return original documents submitted. Please ***do not*** submit original documents to VA, since they will ***not be*** returned.

WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM *(Continued)*

If you are claiming...	See the evidence table titled...
Needs-based benefits based on the veteran's wartime service.	Survivors Pension
• The veteran's death was related to his or her service (DIC), or • DIC because the veteran was receiving or entitled to receive benefits for a service-connected disability rated totally disabling.	Dependency and Indemnity Compensation (DIC)
The veteran's death was a result of VA medical treatment, vocational rehabilitation, or compensated work therapy.	DIC under 38 U.S.C. 1151
DIC and it was previously denied by VA.	Reopened DIC
Special Monthly Pension.	Increased Survivor Benefits Based on Special Monthly Pension
You were entitled to the benefits that were due to the veteran at the time of the veteran's death.	Accrued Benefits
Benefits because the veteran's child is severely disabled.	Child Incapable of Self-Support

EVIDENCE TABLES

Survivors Pension

To support your claim for **Survivors Pension**, the evidence must show:

1. The veteran met certain minimum active service requirements during a period of war.

Generally, those requirements are:
- 90 days of service during a period of war; **OR**
- 90 days of consecutive service at least one day of which was during a period of war; **OR**
- 90 days of combined service during more than one period of war (**Note**: If the veteran's service began after September 7, 1980, additional length-of-service requirements may apply, typically requiring two years of continuous service or completion of active-duty obligations.); **OR**
- any length of active service during a period of war when:
  - at the time of death, the veteran was receiving (or entitled to receive) VA disability compensation or retirement pay for a service-connected disability; **OR**
  - the veteran was discharged from active service due to a service-connected disability.

2. Your income and assets do not exceed certain requirements.

Assets means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of the primary residence including the residential lot area that does not exceed 2 acres, unless the additional acreage is not marketable) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

Dependency and Indemnity Compensation (DIC)

To support a claim for **Dependency and Indemnity Compensation (DIC) based on a service-connected disability:**
- The veteran died while on active service; **OR**
- The veteran had a service-connected disability(ies) that was either the principal or contributory cause of the veteran's death; **OR**
- The veteran died from non-service-connected injury or disease **AND** was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling:
  - For at least 10 years immediately before death; **OR**
  - For at least 5 years after the veteran's release from active duty preceding death; **OR**
  - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999.

To support a claim for **DIC based on a disability that was not service-connected** or for which the veteran did not file a claim during his or her lifetime, the evidence must show:
- An injury or disease that was incurred or aggravated during active service, or an event in service that caused an injury or disease; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the disability associated with the cause of death and an injury, disease, or event in service. This may be shown by medical records or medical opinion or, in certain cases, by lay evidence.

To support your claim for **DIC based upon the service person's active duty for training**, the evidence must show:
- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty and the disease or injury caused or contributed to the service person's death.

Dependency and Indemnity Compensation (DIC) (Continued)

If VA granted service connection for a disease or injury during the service person's lifetime, evidence that the service-connected disease or injury caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **DIC based on a disability that was not service-connected** or for which the service person did not file a claim during their lifetime, the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty; **AND**
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the principal or contributory cause of death and the disability due to injury or disease, incurred in the line of duty. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support your claim for **DIC based upon the service person's inactive duty training**, the evidence must show:

- The service person died during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident during such training; **OR**
- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; and that injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

If VA granted service connection for an injury, acute myocardial infarction, or cerebrovascular accident during the service person's lifetime, evidence that the service-connected condition caused or contributed to the service person's death may satisfy this requirement.

To support a claim for **DIC based on a disability that was not service-connected** or for which the service person did not file a claim during his or her lifetime, the evidence must show:

- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; **AND**
- The injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

DIC under 38 U.S.C. 1151:

In order to support your claim for **DIC under 38 U.S.C. 1151**, the evidence must show:

- The deceased veteran died as a result of undergoing VA hospitalization, medical or surgical treatment, examination, or training; **AND**
- The death was:
  - the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment; **OR**
  - the direct result of an event that was not a reasonably expected result or complication of the VA care or treatment; **OR**
  - the direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program

Reopened DIC:

In order to reopen a claim previously denied by VA, we need new and material evidence. New and material evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.

- To qualify as new, the evidence must currently exist and be submitted to VA for the first time
- In order to be considered material, the additional existing evidence must pertain to the reason your claim was previously denied

Increased Survivor Benefits Based on Special Monthly Pension

In order to support your claim for **increased survivor benefits based on the need for aid and attendance**, the evidence must show:

- you have corrected vision of 5/200 or less in both eyes; **OR**
- you have concentric contraction of the visual field to 5 degrees; **OR**
- you are a patient in a nursing home due to mental or physical incapacity; **OR**
- you require the aid of another person to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment; **OR**
- you are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment; **OR**

In order to support your claim for **increased benefits based on being housebound**, the evidence must show:

- you are substantially confined to your immediate premises because of permanent disability

EVIDENCE TABLES (Continued)

Accrued Benefits:

To support a claim for **accrued benefits**, the evidence must show:

- Benefits were due the veteran based on existing ratings, decisions, or evidence in VA's possession at the time of death, but the benefits were not paid before the veteran's death; **AND**
- You are the surviving spouse, child, or dependent parent of the deceased veteran

VA pays accrued benefits in the following order of priority:

1. Spouse 2. Children of the veteran (in equal shares) 3. Dependent parents (in equal shares)

NOTE: Child means an unmarried child of the veteran who is under 18 years of age, or at least 18 but under 23 years of age and pursuing an approved course of education or became incapable of self-support prior to reaching age 18.

If there are no living persons who are entitled on the basis of relationship, accrued benefits may be used to reimburse the person or persons who paid for or are responsible to pay the expenses of last illness and burial of a beneficiary. The claim should be filed by the person or persons whose funds were or will be used to pay such expenses using VA Form 21P-601, *Application for Accrued Amounts Due a Deceased Beneficiary*.

Child Incapable of Self-Support:

To support a claim for benefits based on a veteran's child being incapable of self-support, the evidence must show that the child, before their 18th birthday became permanently incapable of self-support due to mental or physical disability.

IMPORTANT

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/.

HOW VA DETERMINES THE EFFECTIVE DATE

If we grant a claim for Survivors benefits, the beginning date of your entitlement will generally be the date we received your claim. However, if VA receives your claim within one year after the date of the veteran's death, entitlement will be from the first day of the month in which the veteran died. The veteran's death certificate is evidence relevant to determining the effective date of any benefits we award.

Special monthly pension may be available for a veteran's surviving spouse who is unable to perform certain activities of daily living, are a patient in a nursing home, or are substantially confined to their immediate premises. Special monthly pension may be effective from the date medical evidence first shows entitlement.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

When you have completed this application, you can either submit online or mail it to the Pension Intake Center listed below. Be sure to attach any materials that support and explain your claim. Also, make a photocopy of your application and any evidence you send to VA before submitting.

MAIL TO	SUBMIT ONLINE
Department of Veterans Affairs Pension Intake Center PO Box 5365 Janesville, WI 53547-5365	VA gov: www.va.gov Direct Upload via access.va.gov

SURVIVORS BENEFITS APPLICATION CHECKLIST

In addition to your application, VA may require some of the evidence described in this checklist. Failure to provide needed evidence, may delay the decision on your claim. This checklist does not apply to claims for Accrued benefits. Please carefully read pages 4 and 5 of the Instructions if you are claiming service-connected death (Dependency and Indemnity Compensation (DIC) only. Please note, the items marked with an asterisk (*) are required.

VERIFICATION OF VETERANS DEATH* *(Requested on page 2 of Instructions)*

- ☐ A Death certificate for the veteran, clearly showing the primary cause(s) of death and any contributing factors or conditions *(If the veteran's death certificate lists the cause of death as "Pending," please have the medical examiner submit evidence that shows the cause of death)*.

SERVICE VERIFICATION* *(Requested on page 3 of Instructions and Section III of the form)*

- ☐ Copy of the veteran's DD Form 214 (or equivalent) for all periods of military service. Must demonstrate military service dates, type of service and character of discharge.

INCOME AND NET WORTH *(Requested on page 2 of Instructions and Section IX of the form)*

- ☐ VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, is required if instructed in Section IX of this application form.
  NOTE: If you have specific types of income or assets the VA Form 21P-0969 requires additional evidence:
- ☐ Farm - VA Form 21P-4165, *Pension Claim Questionnaire for Farm Income*
- ☐ Business - VA Form 21P-4185, *Report of Income from Property or Business*
- ☐ Rental Property - VA Form 21P-4185, *Report of Income from Property or Business*
- ☐ Royalties - VA Form 21-4138, *Statement in Support of Claim,* (provide details, such as Royalty source, joint owners, etc.)
- ☐ Trust - submit complete trust documents to include the Schedule of Assets
- ☐ Interest, Dividends or Financial Investments - Current account statements from financial institutions (Bank, Investment, Annuity, etc.

SPECIAL CIRCUMSTANCES REGARDING YOUR MEDICAL CARE *(Requested on page 2 of Instructions and in Sections VIII and X of the form)*

Claim for Special Monthly Pension (SMP) - Aid and Attendance or Housebound Status

- ☐ VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Claim for Medicare Nursing Home and/or $90.00 Rate Reduction Request

- ☐ VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*

Claim for Fiduciary Assistance

- ☐ VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance*

Statement of Medical Care

- ☐ Care worksheets (found on pages **17** and **18** of the form).
- ☐ Proof of Payment from care provided (canceled checks, bank statements, etc.).
- ☐ Signed verification from care service provider.

Dependent Children* *(Requested on page 2 of Instructions and Section VI of the form)*

- ☐ A birth certificate must be included clearly showing the veteran as the parent if you do not reside within the U.S. or its territories. (A state includes the District of Columbia, Puerto Rico and other territories and possessions of the U.S.)
- ☐ If child(ren) is/are adopted the adoption decree or a revised birth certificate is required.
- ☐ If your child is over 18 but under 23 please submit VA Form 21-674, *Request for Approval of School Attendance.*
- ☐ Medical records for each seriously disabled child.

Medical Expenses *(Requested in Section X of the form)*

- ☐ If additional space is needed, submit VA Form 21P-8416, *Medical Expense Report.*

OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 16. Use this form to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. For additional information or questions contact us online at **https://www.va.gov/contact-us** or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at **www.va.gov/vaforms**. If submitting by mail, send completed form to: **Department of Veterans Affairs, Pension Intake Center, P.O. Box 5365, Janesville, WI 53547-5365**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

NOTE: You may *either* complete the form by typing the information in on the computer or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1A. VETERAN'S NAME (First, Middle Initial, Last)

1B. VETERAN'S SOCIAL SECURITY NUMBER — – –

1C. VETERAN'S DATE OF BIRTH (MM/DD/YYYY) / /

1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA? ◯ YES ◯ NO (If "YES," provide the file number in Item 1E)

1E. VA FILE NUMBER (If known)

1F. DID THE VETERAN DIE WHILE ON ACTIVE DUTY? ◯ YES ◯ NO

1G. VETERAN'S SERVICE NUMBER

1H. VETERAN'S DATE OF DEATH? (MM/DD/YYYY) / /

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

2A. YOUR NAME (First, Middle Initial, Last)

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)

◯ SURVIVING SPOUSE ◯ CHILD 18-24 IN SCHOOL ◯ CUSTODIAN FILING FOR CHILD UNDER 18 ◯ HELPLESS ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER — – –

2D. YOUR DATE OF BIRTH (MM/DD/YYYY) / /

2E. ARE YOU A VETERAN? ◯ YES ◯ NO

2F. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

2G. YOUR TELEPHONE NUMBER (Include Area Code) – – Enter International Phone Number (If applicable)

2H. E-MAIL ADDRESS (Optional)

2I. WHAT ARE YOU CLAIMING? (Check all that apply)

◯ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ◯ SURVIVORS PENSION ◯ ACCRUED BENEFITS

SECTION III: VETERAN'S SERVICE INFORMATION

(Skip to Section IV if the veteran was receiving VA compensation or pension benefits at the time of their death)

NOTE: Please refer to instructions page 3, Military Service Verification for more information pertaining to service information and relevant documents.

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME?

◯ YES ◯ NO (If "YES," list other names the veteran served under below)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)

3B. DATE VETERAN ENTERED ACTIVE DUTY (MM/DD/YYYY)

___/___/____

3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY)

___/___/____

3D. BRANCH OF SERVICE

◯ ARMY ◯ NAVY ◯ AIR FORCE ◯ MARINE CORPS

◯ COAST GUARD ◯ SPACE FORCE ◯ NOAA ◯ USPHS

3E. PLACE OF LAST SEPARATION

3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard)

◯ YES ◯ NO (If "NO," skip to Item 3J)

3G. DATE OF ACTIVATION (MM/DD/YYYY)

___/___/____

3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

___ – ___ – ____

3J. WAS THE VETERAN EVER A PRISONER OF WAR?

◯ YES ◯ NO (If "NO," skip to Section IV)

3K. DATES OF CONFINEMENT (MM/DD/YYYY)

START: ___/___/____

END: ___/___/____

SECTION IV: MARITAL INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

◯ YES ◯ NO (If "YES," provide explanation below)

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF HIS/HER DEATH?

◯ YES ◯ NO (If "NO," complete Item 4C)

4C. HOW DID YOUR MARRIAGE TO THE VETERAN END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain)

4D. DATES OF YOUR MARRIAGE TO THE VETERAN (MM/DD/YYYY)

START: ___/___/____

END: ___/___/____

4E. PLACE OF MARRIAGE (City/State or Country)

4F. PLACE OF MARRIAGE TERMINATION (City/State or Country)

4G. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.)

◯ CEREMONIAL ◯ OTHER (Explain):

4H. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

◯ YES ◯ NO

4I. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

◯ YES ◯ NO

4J. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?

◯ YES ◯ NO (If "YES," skip to Item 4L)

4K. WAS THE SEPARATION DUE TO MARITAL DISCORD?

◯ YES ◯ NO (If "YES," provide explanation in space provided)

NOTE: Give, the reason, date(s), and duration of the separation
(If the separation was by court order, attach a copy of the order)

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4L. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?

◯ YES ◯ NO (If "NO," skip to Item 5A)

4M. WHAT ARE THE DATES OF YOUR REMARRIAGE? (MM/DD/YYYY)

START: ___/___/____

END: ___/___/____

4N. HOW DID YOUR REMARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ DID NOT END ◯ OTHER (Explain)

4O. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH?

◯ YES ◯ NO (If "YES," please submit a VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for each marriage)

VETERAN'S SOCIAL SECURITY NUMBER

SECTION V: MARITAL HISTORY

TELL US ABOUT ANY OTHER MARRIAGES YOU AND/OR THE VETERAN HAD. IF YOU AND THE VETERAN DID NOT HAVE ANY ADDITIONAL MARRIAGES SKIP TO SECTION VI.

VETERAN'S PRIOR MARRIAGES (If none skip to Item 5L)

5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain below)

5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: / /

END: / /

5D. PLACE OF MARRIAGE (City/State or Country)

5E. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain below)

5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: / /

END: / /

5I. PLACE OF MARRIAGE (City/State or Country)

5J. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?

◯ YES ◯ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN (If none skip to Section VI)

5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5M. HOW DID THE YOUR PREVIOUS MARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain below)

5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: / /

END: / /

5O. PLACE OF MARRIAGE (City/State or Country)

5P. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5R. HOW DID THE YOUR PREVIOUS MARRIAGE END?

◯ DEATH ◯ DIVORCE ◯ OTHER (Explain below)

5S. WHAT ARE THE DATES OFTHE YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)

START: / /

END: / /

5T. PLACE OF MARRIAGE (City/State or Country)

5U. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?

◯ YES ◯ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VI: CHILD OF THE VETERAN INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)
(Skip to Section VII if you are NOT claiming benefits for a child(ren) of the veteran)

NOTE: Please refer to instructions page 2, under "*Requirements for Certain Claimants*" for what is considered a dependent child. In most circumstances, children over the age of 23 are not considered dependent for VA purposes.

6A. HOW MANY DEPENDENT CHILDREN DO YOU HAVE?

(**NOTE**: Please complete a VA Form 21-686c, *Application Request to Add and/or Remove Dependents*, if you need more space for additional dependents)

6B. CHILD'S NAME (First, Middle Initial, Last)

6C. CHILD'S DATE OF BIRTH (MM/DD/YYYY)

6D. CHILD'S SOCIAL SECURITY NUMBER

6E. PLACE OF BIRTH (City/State or Country)

6F. WHAT IS THE CHILD'S STATUS? (Check all that apply)

◯ BIOLOGICAL ◯ ADOPTED ◯ STEPCHILD ◯ 18-23 YEARS OLD (in school) ◯ SERIOUSLY DISABLED ◯ CHILD PREVIOUSLY MARRIED

◯ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___ , ___ .00

6G. CHILD'S NAME (First, Middle Initial, Last)

6H. CHILD'S DATE OF BIRTH (MM/DD/YYYY)

6I. CHILD'S SOCIAL SECURITY NUMBER

6J. PLACE OF BIRTH (City/State or Country)

6K. WHAT IS THE CHILD'S STATUS? (Check all that apply)

◯ BIOLOGICAL ◯ ADOPTED ◯ STEPCHILD ◯ 18-23 YEARS OLD (in school) ◯ SERIOUSLY DISABLED ◯ CHILD PREVIOUSLY MARRIED

◯ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___ , ___ .00

6L. CHILD'S NAME (First, Middle Initial, Last)

6M. CHILD'S DATE OF BIRTH (MM/DD/YYYY)

6N. CHILD'S SOCIAL SECURITY NUMBER

6O. PLACE OF BIRTH (City/State or Country)

6P. WHAT IS THE CHILD'S STATUS? (Check all that apply)

◯ BIOLOGICAL ◯ ADOPTED ◯ STEPCHILD ◯ 18-23 YEARS OLD (in school) ◯ SERIOUSLY DISABLED ◯ CHILD PREVIOUSLY MARRIED

◯ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT $ ___ , ___ .00

6Q. DO YOUR CHILDREN WHO DO NOT LIVE WITH YOU (If listed above) RESIDE AT THE SAME ADDRESS?

◯ YES ◯ NO (If "YES," please complete Item 6R) (If "NO," please complete a VA Form 21-4138, *Statement in Support of Claim*, with the following information. Name of person the child is currently living with, and the full address where the child resides)

6R. PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHILD(RENS) CUSTODIAN BELOW:

Custodian's Name (First, Middle Initial, Last)

Custodian's Mailing Address (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION VII: Dependency and Indemnity Compensation (DIC)
(Skip to Section VIII if you are NOT claiming DIC)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

◯ DIC ◯ DIC under U.S.C. 1151 (**Note**: DIC under 38 U.S.C. is a rare benefit. Please refer to the Instructions pages 4 & 5 for guidance on necessary evidence for DIC benefits)

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: __/__/____ END: __/__/____
	START: __/__/____ END: __/__/____
	START: __/__/____ END: __/__/____

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT BASED ON A CLAIM FOR SPECIAL MONTHLY PENSION

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

◯ YES ◯ NO (If "YES," please complete a VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA)*, Certified Nurse Practitioner (CNP/CRNP), or Clinical Nurse Specialist (CNS))

8B. ARE YOU NOW IN A NURSING HOME?

◯ YES ◯ NO (If "YES," complete VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance.* For additional information see Instructions, page 2 under "If Claiming Survivors Pension") (If "NO," skip to Item 9A)

SECTION IX: INCOME AND ASSETS
Skip to Section X if you are NOT claiming survivors pension benefits)

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 you or your dependents need for transportation.

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER $25,000.00 IN ASSETS? (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC))*

(If "No," provide an estimate of the total value of your assets below)

$ ___,___.__

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC))*

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

◯ YES ◯ NO (If "NO," skip to Item 9G)

9D. IS THE VALUE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

◯ YES ◯ NO (If "NO," skip to Item 9H)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF THE LAND OVER 2 ACRES? (Do **NOT** include the value of the residence or the first 2 acres)

$ _,___,___.__

9F. IS THE LAND OVER 2 ACRES (87,120 SQ FT) MARKETABLE?

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969*)*

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969, and ONLY report your Social Security income in Item 9I)

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

◯ YES ◯ NO (If "YES," please submit a VA Form 21P-0969*)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION IX: INCOME AND ASSETS (CONTINUED)
(Skip to Section X if you are not claiming survivors pension benefits)

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

NO.	(1) WHO IS THE INCOME RECIPIENT?	(2) WHAT IS THE TYPE/SOURCE OF INCOME?	(3) WHAT IS THE CURRENT GROSS MONTHLY INCOME?
9I	◯ SURVIVING SPOUSE ◯ CHILD (Provide name below)	◯ SOCIAL SECURITY ◯ PENSION/RETIREMENT ◯ CIVIL SERVICE ◯ INTEREST/DIVIDENDS ◯ OTHER (Specify Source i.e., inheritance, etc.)	$ ___,___.__
9J	◯ SURVIVING SPOUSE ◯ CHILD (Provide name below)	◯ SOCIAL SECURITY ◯ PENSION/RETIREMENT ◯ CIVIL SERVICE ◯ INTEREST/DIVIDENDS ◯ OTHER (Specify Source i.e., inheritance, etc.)	$ ___,___.__
9K	◯ SURVIVING SPOUSE ◯ CHILD (Provide name below)	◯ SOCIAL SECURITY ◯ PENSION/RETIREMENT ◯ CIVIL SERVICE ◯ INTEREST/DIVIDENDS ◯ OTHER (Specify Source i.e., inheritance, etc.)	$ ___,___.__
9L	◯ SURVIVING SPOUSE ◯ CHILD (Provide name below)	◯ SOCIAL SECURITY ◯ PENSION/RETIREMENT ◯ CIVIL SERVICE ◯ INTEREST/DIVIDENDS ◯ OTHER (Specify Source i.e., inheritance, etc.)	$ ___,___.__

SECTION X: INFORMATION ABOUT YOUR 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 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, 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 were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES OR OTHER EXPENSES?

◯ YES ◯ NO (If "NO," skip to Section XI)

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 17 and 18 for each provider.

10B (1). WHOSE EXPENSES WERE PAID?	10B (2). NAME OF PROVIDER AND TYPE OF CARE	10B (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
◯ SURVIVING SPOUSE ◯ OTHER (Specify below)	CHECK ONE: ◯ CARE FACILITY ◯ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $ ___.00 Hours Worked (Per Week) ___

10B (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10B (5). PAYMENT FREQUENCY	10B (6). AMOUNT YOU PAY (Based on frequency selected in Item 10B (5))
START: __/__/____ END: __/__/____ ◯ NO END DATE	◯ MONTHLY ◯ ANNUALLY	$ ___,___.__

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

IN-HOME CARE OR CARE FACILITY (Continued)

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 17 and 18 for each provider.

10C (1). WHOSE EXPENSES WERE PAID?
- ◯ SURVIVING SPOUSE
- ◯ OTHER (Specify below)

10C (2). NAME OF PROVIDER AND TYPE OF CARE

CHECK ONE:
- ◯ CARE FACILITY
- ◯ IN-HOME CARE ATTENDENT

10C (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
- Payment Rate (Per Hour) $ ___.00
- Hours Worked (Per Week) ___

10C (4). PROVIDER START AND END DATE (MM/DD/YYYY)
- START: __/__/____
- END: __/__/____
- ◯ NO END DATE

10C (5). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY

10C (6). AMOUNT YOU PAY (Based on frequency selected in Item 10C (5))
$ ___,___.__

10D (1). WHOSE EXPENSES WERE PAID?
- ◯ SURVIVING SPOUSE
- ◯ OTHER (Specify below)

10D (2). NAME OF PROVIDER AND TYPE OF CARE

CHECK ONE:
- ◯ CARE FACILITY
- ◯ IN-HOME CARE ATTENDENT

10D (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
- Payment Rate (Per Hour) $ ___.00
- Hours Worked (Per Week) ___

10D (4). PROVIDER START AND END DATE (MM/DD/YYYY)
- START: __/__/____
- END: __/__/____
- ◯ NO END DATE

10D (5). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY

10D (6). AMOUNT YOU PAY (Based on frequency selected in Item 10D (5))
$ ___,___.__

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10E (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10E (3). DATE COSTS INCURRED (MM/DD/YYYY)
- START: __/__/____
- END: __/__/____

10E (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10E (5). AMOUNT YOU PAY (Based on frequency selected in Item 10E (4))
$ ___,___.__

10F (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10F (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10F (3). DATE COSTS INCURRED (MM/DD/YYYY)
- START: __/__/____
- END: __/__/____

10F (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10F (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4))
$ ___,___.__

10G (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10G (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10G (3). DATE COSTS INCURRED (MM/DD/YYYY)
- START: __/__/____
- END: __/__/____

10G (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10G (5). AMOUNT YOU PAY (Based on frequency selected in Item 10G (4))
$ ___,___.__

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES (Continued)

10H (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10H (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10H (3). DATE COSTS INCURRED (MM/DD/YYYY)
- START: __/__/____
- END: __/__/____

10H (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10H (5). AMOUNT YOU PAY (Based on frequency selected in Item 10H (4))
$ ___,___.__

10I (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10I (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10I (3). DATE COSTS INCURRED (MM/DD/YYYY)
- START: __/__/____
- END: __/__/____

10I (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10I (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4))
$ ___,___.__

10J (1). WHOSE EXPENSES WERE PAID? (Check one)
- ◯ SURVIVING SPOUSE
- ◯ CHILD (Specify below)

10J (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
- Provider:
- Purpose:

10J (3). DATE COSTS INCURRED (MM/DD/YYYY)
- START: __/__/____
- END: __/__/____

10J (4). PAYMENT FREQUENCY
- ◯ MONTHLY ◯ ANNUALLY
- ◯ ONE-TIME

10J (5). AMOUNT YOU PAY (Based on frequency selected in Item 10J (4))
$ ___,___.__

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and** attach either a voided personal check **or** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. 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.

11A. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)

11B. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

11C. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

◯ CHECKING ◯ SAVINGS ◯ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.:

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. 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 except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled ***Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.***

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 12A, indicating that I **DO NOT** want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

12A. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

◯ **I DO NOT want my claim considered for paid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE) (Continued)

12B. CLAIMANT'S SIGNATURE **OR** MARK WITH AN "X" IF UNABLE TO SIGN **(REQUIRED)**	12C. DATE SIGNED (MM/DD/YYYY)
	__ __ / __ __ / __ __ __ __

SECTION XIII: WITNESSES TO SIGNATURE
(TWO (2) WITNESS SIGNATURES ARE REQUIRED ONLY IF ITEM 12B IS SIGNED WITH AN "X")

13A. SIGNATURE OF WITNESS (Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12B using an "X")	13B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:
13C. SIGNATURE OF WITNESS (Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12B using an "X")	13D. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED (MM/DD/YYYY)
	__ __ / __ __ / __ __ __ __

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: 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. Your response is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 40 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.

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from an assisted living facility, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WESITE ADDRESS?

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

◯ A. EATING ◯ B. BATHING/SHOWERING ◯ C. TRANSFERRING IN OR OUT OF BED OR CHAIR

◯ D. DRESSING ◯ E. USING THE TOILET ◯ F. AMBULATING WITHIN HOME OR LIVING AREA

9. DO BOTH OF THE FOLLOWING STATEMENTS APPLY TO THE FACILITY?

- The facility is licensed (if the State or Country requires it).
- The facility is residential, it is staffed 24 hours per day with caregivers.

◯ YES ◯ NO

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to his or her daily environment.)

◯ YES ◯ NO, Care is being provided by a third-party provider. ◯ NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY)

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

◯ INDEFINITE

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

$, . PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)

15. DATE SIGNED (MM/DD/YYYY)

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency Administrator, Provider)

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)

◯ YES ◯ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

◯ YES ◯ NO (If "NO," skip to question 7)

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

– –

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.

◯ A. EATING ◯ B. BATHING/SHOWERING ◯ C. TRANSFERRING IN OR OUT OF BED OR CHAIR

◯ D. DRESSING ◯ E. USING THE TOILET ◯ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

◯ A. SHOPPING ◯ B. FOOD PREPARATION ◯ C. NON-MEDICAL TRANSPORTATION

◯ D. LAUNDERING ◯ E. USING TELEPHONE ◯ F. MANAGING FINANCES

◯ G. HOUSEKEEPING ◯ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to his or her daily environment.)

◯ YES ◯ NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. (MM/DD/YYYY)

/ /

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

/ / ◯ INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

$. PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)

/ /