Department of Veterans Affairs

INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

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

This form is used to report any medical expenses that you paid for yourself or for a relative who is a dependent member of your household (spouse, child, grandchild, parent, etc.), for which you were not reimbursed and do not expect to be reimbursed. Below are examples of expenses you may 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

THE FORM IS COMPRISED OF 8 SECTIONS. BE SURE TO ANSWER THE QUESTION(S) IN EACH SECTION AS REQUIRED.	
SECTION I: VETERAN'S IDENTIFICATION INFORMATION	SECTION V: OTHER MEDICAL EXPENSES
SECTION II: CLAIMANT'S CONTACT INFORMATION	SECTION VI: MILEAGE
SECTION III: REPORTING PERIOD	SECTION VII: CERTIFICATION AND SIGNATURE
SECTION IV: IN-HOME CARE AND CARE FACILITY EXPENSES	SECTION VIII: WITNESS TO SIGNATURE

This form contains the following addendums and worksheets that may be required to support your application:

Addendum:
- A: In-Home Care or Care Facility Expenses
- B: Other Medical Expenses Continued
- C: Mileage Traveled for Medical Purposes Using Privately Owned Vehicle

Worksheet:
- Residential Care, Adult Daycare, or a Similar Facility
- In-Home Attendant Expenses

IMPORTANT INFORMATION

- All medical expenses must be reported on VA Form 21P-8416, *Medical Expense Report*. This form contains optional addendums that you may submit to supplement this form without the need to submit multiple copies of VA Form 21P-8416. You may submit as many copies of each addendum as you need. If you leave the questions on the addendum blank, VA will assume you are not submitting any additional medical expenses beyond the pages received.

- 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 VA by submitting a completed VA Form 21-4138, *Statement in Support of Claim,* or by contacting our call center at 1-800-827-1000.

- VA can deduct allowable expenses paid by either you, your spouse (for Veterans) or other relative that is a constructive member of the household.

  NOTE: ***Constructive member*** means the expenses can be for a spouse in a nursing home, a child away at school, or a similar situation. The expenses were incurred on behalf of the claimant or a relative of the claimant (not necessarily a dependent for VA purposes) who is a member or constructive member of the claimant's household.

- If you are unsure whether VA can deduct a payment for a particular expense, furnish a complete description including the purpose of the payment. VA will inform you if an expense cannot be deducted.

- If you are claiming vitamins, food supplements and/or herbal remedies, VA may allow these expense deductions on a limited basis (per household member and calendar year). If the deductions are over the limit per household member, VA requires evidence from a healthcare provider instructing the claimant or other dependent member of the household to purchase vitamins, food supplements, and/or herbal remedies. Please ensure these expenses are listed separately per household member.

IMPORTANT INFORMATION *(Continued)*

- **DO NOT** submit receipts for medical expenses you paid. VA may require you to verify the amounts you paid in some circumstances. Therefore, please keep all receipts or other documentation of payments for at least 3 years after receiving 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.

- Submitting a new VA Form 21P-8416 without reporting a previously counted medical expense may result in removal of the medical expense from the date of receipt of the form.

- If reporting expenses for a nursing home facility, please also submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*. **Important** - This only applies if your care facility is found under the "Nursing homes including rehab services" section of the following website address: https://www.medicare.gove/care-compare.

- If you are claiming expenses for an in-home care provider or for assisted living or similar care, each care provider should complete the applicable worksheet for VA to determine whether all or some of your payments to the provider or facility are deductible. The applicable worksheets are:

    - Residential Care, Adult Daycare, or a Similar Facility **- OR -**
    - In-Home Attendant Expenses

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)

You may wish to contact an accredited Veterans Service Officer to assist you with your application. For a list of accredited Veterans service organizations go to https://www.va.gov/vso/. You may also contact your state office of Veterans Affairs at https://www.va.gov/statedva.htm, should you need further assistance with the application process. To assign a VSO as your power of attorney for the claims process, please submit a VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents

Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veteran Affairs, go to: https://www.va.gov/ogc/apps/accreditation/index.asp. To assign a private attorney or claims agent as your power of attorney for the claims process, please submit VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims

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 claims agent can ONLY charge claimants a fee after the VA has issued an initial decision on a claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

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 Veteran Readiness 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 their 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

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

MEDICAL EXPENSE REPORT

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

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

FIRST: MI: LAST:

1B. VETERAN'S SOCIAL SECURITY NUMBER

1C. VA FILE NUMBER (If applicable)

SECTION II: CLAIMANT'S CONTACT INFORMATION

2A. NAME OF CLAIMANT (First, Middle Initial, Last - if different from veteran)

FIRST: MI: LAST:

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

No. and Street Apt./Unit Number

City State/Province Country Zip Code/Postal Code

2C. PRIMARY TELEPHONE NUMBER (Include Area Code)

☐☐☐ – ☐☐☐ – ☐☐☐☐ International Telephone Number *(If applicable)* _____

2D. CLAIMANT'S EMAIL ADDRESS (Optional)

Email Address

SECTION III: REPORTING PERIOD

This form is designed to provide VA with your medical expenses paid during a specific date range to determine or adjust your benefits. If you are submitting an initial application, please only report medical expenses paid on or after your effective date. Your effective date is typically one of the following dates:

- Date VA receives your initial application
- Date VA receives your VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*
- Date of the Veteran's death (for Survivors Pension, if within one year of the Veteran's death)

If you are already in receipt of Pension benefits, report medical expenses you paid on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX). If you are responding to a letter that identifies a specific date range, please report medical expenses you paid during the requested period(s).

Note: Submit separate VA Form 21P-8416's if reporting information for additional date ranges beyond a 1-year period.

3. THE INFORMATION SHOWN BELOW REPRESENTS MEDICAL EXPENSES PAID DURING THE FOLLOWING DATE RANGE:

Report amounts paid between the dates _____ and _____ - OR- ☐ DATE RECEIVED BY VA (For initial applications only)

SECTION IV: IN-HOME CARE AND CARE FACILITY EXPENSES

IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on **pages 9 and 10,** in addition to completion of this section. If you are reporting a nursing home found under the "Nursing homes including rehab services" section of the **https://www.medicare.gov/care-compare**" website, you must submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*, instead of a worksheet.

4A (1). WHOSE EXPENSES WERE PAID?

☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)

Specify Name of Child or Other:_____

4A (2). NAME OF PROVIDER

4A. (3) PROVIDER START AND END DATE (MM/DD/YYYY)

START: ☐☐/☐☐/☐☐☐☐

NOTE: If ongoing leave end date blank.

END: ☐☐/☐☐/☐☐☐☐

4A (4). AMOUNT PAID MONTHLY

$☐☐☐,☐☐☐.☐☐

4A (5). IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW:

Payment Rate (Per Hour) $☐☐☐.00 Average Hours Worked (Per Week) ☐☐☐

4B (1). WHOSE EXPENSES WERE PAID?

☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)

Specify Name of Child or Other:_____

4B (2). NAME OF PROVIDER

4B. (3) PROVIDER START AND END DATE (MM/DD/YYYY)

START: ☐☐/☐☐/☐☐☐☐

NOTE: If ongoing leave end date blank.

END: ☐☐/☐☐/☐☐☐☐

4B (4). AMOUNT PAID MONTHLY

$☐☐☐,☐☐☐.☐☐

4B (5). IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW:

Payment Rate (Per Hour) $☐☐☐.00 Average Hours Worked (Per Week) ☐☐☐

NOTE: If you have additional in-home care or care facility expenses, complete Addendum A: In-Home Care or Care Facility Expenses on page 6.

SECTION V: OTHER MEDICAL EXPENSES

DO NOT report your monthly recurring expenses on multiple lines; rather, report recurring expenses on one line. For recurring expenses include the specific dates the recurring expense started and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. If a recurring expense has already terminated, please treat the expense as non-recurring.
Non-recurring expenses must be reported individually on separate lines. Prescription medications are generally not considered recurring.

Note: A new VA Form 21P-8416 submitted without reporting a previously counted medical expense may result in removal of the medical expense from the date of receipt of the form.

5A (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

5A (2). DATE COSTS INCURRED (MM/DD/YYYY)	5A. (3). FREQUENCY	5A. (4). AMOUNT YOU PAY
☐☐/☐☐/☐☐☐☐	☐ MONTHLY ☐ ANNUALLY	$ ☐☐☐,☐☐☐.☐☐

5A. (5). PAID TO (Name of provider, insurance company, etc.)	5A. (6). PURPOSE (Insurance premium, medical supplies, etc.)

5B (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

5B (2). DATE COSTS INCURRED (MM/DD/YYYY)	5B. (3). FREQUENCY	5B. (4). AMOUNT YOU PAY
☐☐/☐☐/☐☐☐☐	☐ MONTHLY ☐ ANNUALLY	$ ☐☐☐,☐☐☐.☐☐

5B. (5). PAID TO (Name of provider, insurance company, etc.)	5B. (6). PURPOSE (Insurance premium, medical supplies, etc.)

5C (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

5C (2). DATE COSTS INCURRED (MM/DD/YYYY)	5C. (3). FREQUENCY	5C. (4). AMOUNT YOU PAY
☐☐/☐☐/☐☐☐☐	☐ MONTHLY ☐ ANNUALLY	$ ☐☐☐,☐☐☐.☐☐

5C. (5). PAID TO (Name of provider, insurance company, etc.)	5C. (6). PURPOSE (Insurance premium, medical supplies, etc.)

5D (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

5D (2). DATE COSTS INCURRED (MM/DD/YYYY)	5D. (3). FREQUENCY	5D. (4). AMOUNT YOU PAY
☐☐/☐☐/☐☐☐☐	☐ MONTHLY ☐ ANNUALLY	$ ☐☐☐,☐☐☐.☐☐

5D. (5). PAID TO (Name of provider, insurance company, etc.)	5D. (6). PURPOSE (Insurance premium, medical supplies, etc.)

5E (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

5E (2). DATE COSTS INCURRED (MM/DD/YYYY)	5E. (3). FREQUENCY	5E. (4). AMOUNT YOU PAY
☐☐/☐☐/☐☐☐☐	☐ MONTHLY ☐ ANNUALLY	$ ☐☐☐,☐☐☐.☐☐

5E. (5). PAID TO (Name of provider, insurance company, etc.)	5E. (6). PURPOSE (Insurance premium, medical supplies, etc.)

5F (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

5F (2). DATE COSTS INCURRED (MM/DD/YYYY)	5F. (3). FREQUENCY	5F. (4). AMOUNT YOU PAY
☐☐/☐☐/☐☐☐☐	☐ MONTHLY ☐ ANNUALLY	$ ☐☐☐,☐☐☐.☐☐

5F. (5). PAID TO (Name of provider, insurance company, etc.)	5F. (6). PURPOSE (Insurance premium, medical supplies, etc.)

5G (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

5G (2). DATE COSTS INCURRED (MM/DD/YYYY)	5G. (3). FREQUENCY	5G. (4). AMOUNT YOU PAY
☐☐/☐☐/☐☐☐☐	☐ MONTHLY ☐ ANNUALLY	$ ☐☐☐,☐☐☐.☐☐

5G. (5). PAID TO (Name of provider, insurance company, etc.)	5G. (6). PURPOSE (Insurance premium, medical supplies, etc.)

NOTE: If you have additional mileage reimbursement to report, complete Addendum B: Other Medical Expenses on page 7.

SECTION VI: MILEAGE

Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in question 3.

Note: Please report your monthly travel to the same facility on one line. Specific dates for the same facility are not necessary when reported monthly.

6A. (1). WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)	6A. (3). TOTAL MILES TRAVELED	6A. (4). DATE TRAVELED (MM/DD/YYYY
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)		Month / Day / Year
Specify Name of Child or Other:_____		
6A. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6A. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .

6B. (1). WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)	6B. (3). TOTAL MILES TRAVELED	6B. (4). DATE TRAVELED (MM/DD/YYYY
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)		Month / Day / Year
Specify Name of Child or Other:_____		
6B. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6B. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .

6C. (1). WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)	6C. (3). TOTAL MILES TRAVELED	6C. (4). DATE TRAVELED (MM/DD/YYYY
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)		Month / Day / Year
Specify Name of Child or Other:_____		
6C. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6C. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .

6D. (1). WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.)	6D. (3). TOTAL MILES TRAVELED	6D. (4). DATE TRAVELED (MM/DD/YYYY
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)		/ /
Specify Name of Child or Other:_____		
6D. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6D. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .

NOTE: if you have additional mileage reimbursement to report, complete Addendum C: Mileage for Privately Owned Vehicle Travel for Medical Purposes on page 8.

SECTION VII: CERTIFICATION AND SIGNATURE

CERTIFICATION: I **have not** and **will not** receive reimbursement for these expenses. I certify the information contained on this form and the attached addendums is a true representation of expenses I have paid.

7A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE (Sign in ink)	7B. DATE SIGNED (MM/DD/YYYY)
	/ /

SECTION VIII: WITNESS TO SIGNATURE
(Two (2) witness signatures are required if claimant signed Item 7A with an "X"

8A. PRINTED NAME OF FIRST WITNESS (**Note**: Only to be used if claimant signed in Item 7A using an "X")	8B. SIGNATURE OF FIRST WITNESS (NOTE: Only used if claimant signed in 7A using an "X")

8C. MAILING ADDRESS OF FIRST WITNESS

No. and Street | Apt../Unit Number

City | State/Province | Country | Zip Code/Postal Code

8D. PRINTED NAME OF SECOND WITNESS (**Note**: Only to be used if claimant signed in Item 7A using an "X")	8E. SIGNATURE OF SECOND WITNESS (NOTE: Only used if claimant signed in 7A using an "X")

8F. MAILING ADDRESS OF SECOND WITNESS

No. and Street | Apt../Unit Number

City | State/Province | Country | Zip Code/Postal Code

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any payment you are not entitled to.

ADDENDUM A: IN-HOME CARE OR CARE FACILITY EXPENSES

If you are not claiming expenses related to a care facility or from an in-home care provider, completion of Addendum A is not required.

IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on **pages 9 and 10,** in addition to completion of this section. If you are reporting a nursing home, you must submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*.

1A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)

Specify Name of Child or Other:_____

1B. NAME OF PROVIDER

1C. PROVIDER START AND END DATE (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐

NOTE: If ongoing leave end date blank.

END: ☐☐/☐☐/☐☐☐☐

1D. AMOUNT PAID MONTHLY
$ ☐☐☐,☐☐☐.☐☐

1E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) $ ☐☐☐.00 Average Hours Worked (Per Week) ☐☐☐

2A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)

Specify Name of Child or Other:_____

2B. NAME OF PROVIDER

2C. PROVIDER START AND END DATE (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐

NOTE: If ongoing leave end date blank.

END: ☐☐/☐☐/☐☐☐☐

2D. AMOUNT PAID MONTHLY
$ ☐☐☐,☐☐☐.☐☐

2E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) $ ☐☐☐.00 Average Hours Worked (Per Week) ☐☐☐

3A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)

Specify Name of Child or Other:_____

3B. NAME OF PROVIDER

3C. PROVIDER START AND END DATE (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐

NOTE: If ongoing leave end date blank.

END: ☐☐/☐☐/☐☐☐☐

3D. AMOUNT PAID MONTHLY
$ ☐☐☐,☐☐☐.☐☐

3E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) $ ☐☐☐.00 Average Hours Worked (Per Week) ☐☐☐

4A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)

Specify Name of Child or Other:_____

4B. NAME OF PROVIDER

4C. PROVIDER START AND END DATE (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐

NOTE: If ongoing leave end date blank.

END: ☐☐/☐☐/☐☐☐☐

4D. AMOUNT PAID MONTHLY
$ ☐☐☐,☐☐☐.☐☐

4E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) $ ☐☐☐.00 Average Hours Worked (Per Week) ☐☐☐

5A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)

Specify Name of Child or Other:_____

5B. NAME OF PROVIDER

5C. PROVIDER START AND END DATE (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐

NOTE: If ongoing leave end date blank.

END: ☐☐/☐☐/☐☐☐☐

5D. AMOUNT PAID MONTHLY
$ ☐☐☐,☐☐☐.☐☐

5E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) $ ☐☐☐.00 Average Hours Worked (Per Week) ☐☐☐

6A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)

Specify Name of Child or Other:_____

6B. NAME OF PROVIDER

6C. PROVIDER START AND END DATE (MM/DD/YYYY)
START: ☐☐/☐☐/☐☐☐☐

NOTE: If ongoing leave end date blank.

END: ☐☐/☐☐/☐☐☐☐

6D. AMOUNT PAID MONTHLY
$ ☐☐☐,☐☐☐.☐☐

6E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) $ ☐☐☐.00 Average Hours Worked (Per Week) ☐☐☐

ADDENDUM B: OTHER MEDICAL EXPENSES

If you are not claiming additional expenses, completion of Addendum B is not required.

Please report your monthly recurring expenses that are not reported in other sections on one line, including the specific dates the recurring expense started, and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. Prescription medications are generally not considered recurring. If a recurring expense has already stopped, please treat the expense as non-recurring and report a total amount paid during the designated time period.

Note: A new VA Form 21P-8416 submitted without reporting a previously counted medical expense may result in removal of the medical expense from the date of receipt of the form.

1A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

1B. DATE COSTS INCURRED (MM/DD/YYYY) / /

1C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING

1D. AMOUNT YOU PAY $, .

1E. PAID TO (Name of provider, insurance company, etc.)

1F. PURPOSE (Insurance premium, medical supplies, etc.)

2A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

2B. DATE COSTS INCURRED (MM/DD/YYYY) / /

2C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING

2D. AMOUNT YOU PAY $, .

2E. PAID TO (Name of provider, insurance company, etc.)

2F. PURPOSE (Insurance premium, medical supplies, etc.)

3A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

3B. DATE COSTS INCURRED (MM/DD/YYYY) / /

3C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING

3D. AMOUNT YOU PAY $, .

3E. PAID TO (Name of provider, insurance company, etc.)

3F. PURPOSE (Insurance premium, medical supplies, etc.)

4A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

4B. DATE COSTS INCURRED (MM/DD/YYYY) / /

4C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING

4D. AMOUNT YOU PAY $, .

4E. PAID TO (Name of provider, insurance company, etc.)

1F. PURPOSE (Insurance premium, medical supplies, etc.)

5A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

5B. DATE COSTS INCURRED (MM/DD/YYYY) / /

5C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING

5D. AMOUNT YOU PAY $, .

5E. PAID TO (Name of provider, insurance company, etc.)

5F. PURPOSE (Insurance premium, medical supplies, etc.)

6A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

6B. DATE COSTS INCURRED (MM/DD/YYYY) / /

6C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING

6D. AMOUNT YOU PAY $, .

6E. PAID TO (Name of provider, insurance company, etc.)

6F. PURPOSE (Insurance premium, medical supplies, etc.)

7A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____

7B. DATE COSTS INCURRED (MM/DD/YYYY) / /

7C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING

7D. AMOUNT YOU PAY $, .

7E. PAID TO (Name of provider, insurance company, etc.)

7F. PURPOSE (Insurance premium, medical supplies, etc.)

ADDENDUM C: MILEAGE FOR PRIVATELY OWNED VEHICLE TRAVEL FOR MEDICAL PURPOSES

Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in question 3 of VA Form 21P-8416, *Medical Expense Report* submitted with this addendum.

Note: Please report your monthly travel to the same facility on one line. Specific dates for the same facility are not necessary when reported monthly.

1A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____ 1B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	1C. TOTAL MILES TRAVELED	1D. DATE TRAVELED (MM/DD/YYYY Month / Day / Year 1E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .
2A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____ 2B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	2C. TOTAL MILES TRAVELED	2D. DATE TRAVELED (MM/DD/YYYY Month / Day / Year 2E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .
3A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____ 3B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	3C. TOTAL MILES TRAVELED	3D. DATE TRAVELED (MM/DD/YYYY Month / Day / Year 3E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .
4A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____ 4B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	4C. TOTAL MILES TRAVELED	4D. DATE TRAVELED (MM/DD/YYYY / / 4E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .
5A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____ 5B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	5C. TOTAL MILES TRAVELED	5D. TRAVELED (MM/DD/YYYY Month / Day / Year 5E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .
6A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____ 6B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	6C. TOTAL MILES TRAVELED	6D. DATE TRAVELED (MM/DD/YYYY Month / Day / Year 6E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .
7A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____ 7B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	7C. TOTAL MILES TRAVELED	7D. DATE TRAVELED (MM/DD/YYYY Month / Day / Year 7E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .
8A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other:_____ 8B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	8C. TOTAL MILES TRAVELED	8D. DATE TRAVELED (MM/DD/YYYY / / 8E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $, .

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, 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 WEBSITE 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. FOR EACH STATEMENT BELOW PLEASE CHECK THE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

☐ THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED

☐ THE FACILITY IS LICENSED

☐ THE FACILITY IS RESIDENTIAL

☐ THE FACILITY IS STAFFED 24 HOURS

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 their 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 A RESIDENTIAL CARE, 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 their 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)

/ /