OMB Control Number: 2900-0867 Estimated Burden: 20 minutes Expiration Date: XX/XX/20XX

Department of Veterans Affairs

IRS/SSA SPOUSE REPORTED INCOME

PRIVACY ACT INFORMATION: Title 38, United States Code, Sections 501(a), 1705, 1710, 1722, 5317 and Public Law 101–508, the Omnibus Budget Reconciliation Act of 1990 grants the Department of Veterans Affairs (VA) the authority to verify Veterans' self-reported household income to determine eligibility for medical benefits. The VA also has the authority to verify Veterans' self-reported income with the Internal Revenue Service (IRS) and Social Security Administration (SSA). With the exception of Federal Tax Information (FTI), VA may make routine use disclosure under the authority of 45 CFR Parts 160 and 164 which permits such disclosures. The information being requested is voluntary, however failure to provide the information requested may delay or result in the denial of your health care benefits. Failure to furnish the information request will however not affect any benefits for which you are already deemed eligible due to service connection.

VA BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0867, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 20 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Please refer to OMB Control No. 2900-0867 in any correspondence. Do not send your completed VA Form 10-302 to this email address.

SECTION I - GENERAL INFORMATION							
1. VETERAN'S NAME (Last, First, Middle Name)				2. CASE NUMBER			3. INCOME YEAR (YYYY)
4. SPOUSE'S NAME (Last, First, Middle Name)							
	OPTION 1	I agree my reported total gross household income is above the VA National Income Threshold of I do not wish to submit documentation of allowable deductible expenses that may reduce my income below the threshold.					
	OPTION 2	I have enclosed documentation of allowable deductible expenses that may reduce my income below the threshold. Examples of allowable deductible expenses are unreimbursed medical expenses, such as prescription drugs, Medicare premiums, health insurance premiums, lab tests, eyeglasses, hearing aids, funeral/burial expenses, and educational expenses for the Veteran only.					
If you determine there is an error with any of the income year information listed below, please provide proof of the correct information. The following documents can be used as evidence of proof: • W-2 Form(s) from employer(s) • Form 1099 for any interest, stocks, bonds, dividends, etc. from financial institutions • End-of-Year statements from financial institutions Income may be reduced if any of the following documents are provided as evidence for the income year: • Copies of paid receipts or canceled checks for out-of-pocket medical expenses (physician, dentist, hospital, nursing home fees, health insurance premiums including Medicare premiums), prescription drugs and eye care not covered by health insurance • Copies of paid receipts or cancelled checks for funeral/burial expenses for spouse or dependent child(ren) • Copies of paid receipts or canceled checks for Veteran's tuition, fees, and book expenses for post-secondary or vocational training NOTE: If separated or divorced, please provide legal documentation. SECTION II - FINANCIAL INFORMATION							
	PAYER	RNAME	DOCUMENT TY	'E	TYPE OF INCOM	E _	AMOUNT (In US Dollars)
CERTIFICATION AND CONSENT: I certify the income listed above is correct or I have provided proof of the correct amounts. I understand the Department of Veterans Affairs (VA) will use this information to determine my Veteran spouse's eligibility for VA health care.							
5. SIGNATURE (Required)							. DATE SIGNED (MM/DD/YYYY)

XXX 2025

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