INFORMATION ON FILING AN APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.), SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

When to Use This Form:

Use this form, VA Form 21P-534EZ, *APPLICATION FOR D.I.C., SURVIVORS PENSION, AND/OR ACCRUED BENEFITS,* to submit a new and original claim for Survivors Pension, and/or D.I.C. and Accrued Benefits. You may also complete and submit the form online at: **https://www.va.gov/family-and-caregiver-benefits/survivor-compensation/apply-for-dic-survivors-pension-accrued-benefits-form-21p-534ez/introduction**.

Submit a copy of proof of Veteran's death when you file your application.

If you disagree with a prior decision, **do not use this form**. Review the decision notice for available options. For additional information, visit **https://www.va.gov/decision-reviews/.**

Other Benefit Forms:

Certain **claim types** (i.e., dependency, nursing home information, etc.) require additional information to be submitted on another form. Go to **https://www.va.gov/family-and-caregiver-benefits/survivor-compensation** and **https://www.va.gov/disability/how-to-file-claim/evidence-needed/** for the specific forms required to provide the necessary information. Failure to provide such information may delay a decision on your claim.

General Information:

For information on **how to file a claim**, and **where to send** your information or evidence, visit **https://www.va.gov/family-and-caregiver-benefits/survivor-compensation,** call 1-800-698-2411 (TTY:711), or contact us online through Ask VA: **https://www.va.gov/contact-us/ask-va/introduction**. Mail your completed application to **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444 or complete your claim online at https://www.va.gov/family-and-caregiver-benefits/survivor-compensation/apply-for-dic-survivors-pension-accrued-benefits-form-21p-534ez/introduction**.

Direct Deposit: The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called **direct deposit**. Visit **https://www.va.gov/change-direct-deposit/** to enroll or change your direct deposit account information. If you do not have a bank account, visit **https://www.benefits.va.gov/benefits/banking.asp**. If you elect not to enroll, you must contact the Department of Treasury at 1-888-224-2950.

You may contact an accredited representative (attorney, claims agent, or Veterans Service Organization (VSO) representative) to assist you in completing this form. If you have not already appointed a representative or if you want to change your representative, a searchable database of VA accredited VSOs, attorneys, and claims agents is available at **https://www.va.gov/get-help-from-accredited-representative/find-rep/**. You may also contact your State Department(s) of Veterans Affairs at **www.va.gov/statedva**.

Regarding Fees for Claims: 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 and the attorney or agent has complied with the applicable power-of-attorney and fee agreement requirements. Section 5904, Title 38, United States Code (U.S.C.) (codified in 14.636, Title 38, Code of Federal Regulations (C.F.R.)) 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 VA with respect to a claim for benefits under laws administered by the Department. Generally, an accredited attorney or claims agent can **ONLY** charge claimants a fee after VA has issued a decision.

You are entitled to a hearing at any time in the claims process. If you wish to have a hearing, you can contact us in writing, online through **https://www.va.gov**, or call us toll-free at 1-800-698-2411 (TTY:711).

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 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, 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: 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 2900-0004, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 40 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. 2900-0004 in any correspondence. Do not send your completed VA Form 21P-534EZ to this email address

OMB Control No. 2900-0004
Respondent Burden: 25 minutes
Expiration Date: X/XX/20XX

VA | U.S. Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

APPLICATION FOR D.I.C., SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 1. Use this form to submit a claim for D.I.C., Survivors Pension, and/or Accrued Benefits. For more information, you can contact us online through Ask VA: **https://www.va.gov/contact-us/ask-va/introduction**. Ask us a question online or call us toll-free at 1-800-698-2411 (TTY:711).

SECTION I: BENEFITS CLAIMED (Check "Yes" for all that apply)

1A. ARE YOU CLAIMING DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)? ☐ YES ☐ NO *If yes, complete Sections II and IV. Submit a death certificate with your application.*	**NOTE: D.I.C is a tax-free monetary benefit for Survivors of Veterans who died from a service-related injury or illness.**
1B. ARE YOU CLAIMING SURVIVORS PENSION? ☐ YES ☐ NO *If yes, complete Sections II, III and IV. Submit a death certificate with your application.*	**NOTE: Survivors Pension is a tax-free monetary benefit for qualified Survivors of Veterans who are below certain income and net worth limits**.

NOTE: This application always considers accrued benefits for a surviving spouse or dependent child. If you are not a surviving spouse or dependent child, visit **https://www.va.gov/files/2025-05/accrued-benefits.pdf** and **https://www.va.gov/manage-dependents/** for eligibility information.

1C. ARE YOU IN A NURSING HOME? ☐ YES ☐ NO	**If yes, submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance,* and see Section III regarding medical expenses paid for nursing home care.**
1D. DO YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES? ☐ YES ☐ NO	**If yes, submit VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance.***

SECTION II: REQUIRED INFORMATION FOR ALL BENEFITS

PART A: VETERAN'S IDENTIFICATION INFORMATION

2A(1). VETERAN'S NAME *(First, Middle Initial, Last)*

2A(2). VETERAN'S SOCIAL SECURITY NUMBER *(if known)* ___ / ___ / ____

2A(3). VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)* ___ / ___ / ____

2A(4). VETERAN'S DATE OF DEATH? *(MM/DD/YYYY)* ___ / ___ / ____

2A(5). VA FILE NUMBER *(if known)*

2A(6). DID THE VETERAN DIE WHILE ON ACTIVE DUTY? ☐ YES ☐ NO

2A(7). VETERAN'S SERVICE NUMBER *(if known)*

2A(8). DATE ENTERED ACTIVE DUTY *(MM/DD/YYYY)* ___ / ___ / ____

2A(9). DATE RELEASED FROM ACTIVE DUTY *(MM/DD/YYYY)* ___ / ___ / ____

2A(10). BRANCH OF SERVICE:

☐ ARMY ☐ AIR FORCE ☐ NAVY ☐ USPHS ☐ MARINE CORPS ☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA

2A(11). ELECTRONIC DATA INTERCHANGE PERSONAL IDENTIFIER (EDIPI) *(if known)*

2A(12). INTEGRATION CONTROL NUMBER (ICN) *(if known)*

PART B: CLAIMANT'S IDENTIFICATION INFORMATION

2B(1). CLAIMANT'S NAME *(First, Middle Initial, Last)*

2B(2). CLAIMANT'S RELATIONSHIP TO THE VETERAN

☐ SURVIVING SPOUSE *(skip to 2B(5))*
☐ SURVIVING CHILD *(Complete 2B(3) & 2B(4))*
☐ CUSTODIAN FILING FOR CHILD UNDER 18 *(Complete 2B(3) &2B(4))*

2B(3). SURVIVING CHILD'S RELATIONSHIP TO VETERAN *(if applicable)*

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD

2B(4). WHAT IS THE CHILD'S STATUS? *(if applicable)*

☐ UNDER 18
☐ 18-23 YEARS OLD *(in school)*
☐ DISABLED ADULT CHILD
☐ MARRIED OR PREVIOUSLY MARRIED

2B(5). YOUR SOCIAL SECURITY NUMBER ___ – ___ – ____

2B(6). YOUR DATE OF BIRTH *(MM/DD/YYYY)* ___ / ___ / ____

2B(7). ARE YOU A VETERAN? ☐ YES ☐ NO

2B(8). 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 – ____

2B(9). YOUR TELEPHONE NUMBER *(Include Area Code)*

2B(10). E-MAIL ADDRESS *(Optional)*

PART B: CLAIMANT'S IDENTIFICATION INFORMATION (*CONTINUED)*

2B(11). DIRECT DEPOSIT *(To enroll in direct deposit provide the information requested below, see instructions on page 1 for additional Direct Deposit information)*

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

2B(12). ACCOUNT NO: 2B(13). ROUTING OR TRANSIT NUMBER

PART C: MARITAL INFORMATION FOR SURVIVING SPOUSE

Check "Yes" or "No" to 2C(1) - 2C(7)	YES	NO
2C(1). AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?	☐	☐
2C(2). HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?	☐	☐
2C(3). WERE YOU MARRIED TO THE VETERAN AT THE TIME OF THEIR DEATH?	☐	☐
2C(4). IF YOUR MARRIAGE DID NOT END IN DEATH, WAS IT DUE TO DIVORCE?	☐	☐
2C(5). WAS A CHILD BORN TO BOTH YOU AND THE VETERAN?	☐	☐
2C(6). DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF THEIR DEATH?	☐	☐
2C(7). WAS THE REASON YOU DID NOT LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF THEIR DEATH DUE TO MARITAL DISCORD? *(If "YES", explain in 2C(13))*	☐	☐

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

2C(8). START DATE *(MM/DD/YYYY)* ☐☐/☐☐/☐☐☐☐

2C(9). PLACE OF MARRIAGE *(City and State or foreign country)*

2C(10). TYPE OF MARRIAGE
☐ CEREMONIAL
☐ COMMON-LAW
☐ PROXY
☐ TRIBAL

2C(11).END DATE *(MM/DD/YYYY)* ☐☐/☐☐/☐☐☐☐

2C(12). PLACE MARRIAGE ENDED *(City and State or foreign country)*

2C(13). EXPLANATION OF SEPARATION (*Give, the reason, date(s), and duration of the separation, to include the court order if separation is due to court order)*

PART D: MARITAL HISTORY
(NOTE: IF YOU AND THE VETERAN WERE ONLY EVER MARRIED TO EACH OTHER, SKIP TO PART E)

VETERAN'S PRIOR MARRIAGES *(If None, skip to Item 2D(3))*

	a. NAME OF PRIOR SPOUSE	b. DATE OF MARRIAGE *(MM/DD/YYYY)*	c. PLACE OF MARRIAGE *(City & State or foreign country)*	d. HOW MARRIAGE ENDED *(death, divorce, etc)*	e. DATE MARRIAGE ENDED *(MM/DD/YYYY)*	f. PLACE MARRIAGE ENDED *(City & State or foreign country)*
2D(1).						
2D(2).						

YOUR PRIOR MARRIAGES *(If None, skip to Item 2D(5))*

	a. NAME OF PRIOR SPOUSE	b. DATE OF MARRIAGE *(MM/DD/YYYY)*	c. PLACE OF MARRIAGE *(City & State or foreign country)*	d. HOW MARRIAGE ENDED *(death, divorce, etc)*	e. DATE MARRIAGE ENDED *(MM/DD/YYYY)*	f. PLACE MARRIAGE ENDED *(City & State or foreign country)*
2D(3).						
2D(4).						

2D(5). DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?

☐ YES *(If "YES," submit VA Form 21-686c, Application to Request to Add and/or Remove Dependents, to provide the information for additional marital history)*

☐ NO

PART E: CHILDREN OF THE VETERAN INFORMATION
(NOTE: COMPLETE ONLY IF CLAIMING A DEPENDENT)

2E(1). HOW MANY DEPENDENT CHILDREN OF THE VETERAN ARE THERE? (***NOTE:*** *Complete a VA Form 21-686c, if you need to report more than one dependent.)* ☐☐

2E(2). CHILD'S NAME *(First, Middle Initial, Last)*

2E(3). CHILD'S BIRTH DATE *(MM/DD/YYYY)* ☐☐/☐☐/☐☐☐☐

2E(4). CHILD'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

2E(5). CHILD'S PLACE OF BIRTH *(City and State or foreign country)*

2E(6). CHILD'S RELATIONSHIP TO THE VETERAN
☐ BIOLOGICAL
☐ ADOPTED
☐ STEPCHILD

2E(7). REPORT CHILD'S STATUS
☐ UNDER 18
☐ 18-23 YEARS OLD *(in school) (Submit VA Form 21-674, Request for Approval of School Attendance)*
☐ DISABLED ADULT CHILD *(Submit medical documentation for when the disability began)*
☐ MARRIED OR PREVIOUSLY MARRIED

ATTENTION

IF YOU ARE ONLY APPLYING FOR D.I.C. BENEFITS, SKIP TO SECTION IV

SECTION III: REQUIRED INFORMATION FOR SURVIVORS PENSION BENEFITS

(NOTE: ONLY COMPLETE IF YOU ARE APPLYING FOR SURVIVORS PENSION BENEFITS)

PART A: ASSET AND INCOME INFORMATION

IMPORTANT: If you leave an item in 3A(7) through 3A(11) blank, we will assume you have no income to report for that source.

ASSET INFORMATION	REPORT OF INCOME
3A(1). REPORT THE TOTAL VALUE OF YOUR ASSETS *(Not including the value of your primary residence)* $	3A(6). DO YOU HAVE INCOME TO REPORT? ☐ YES ☐ NO *(If "NO", skip to section IV)*

Check "Yes" or "No" to 3A(2) - 3A(5)	YES	NO
3A(2). IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS?	☐	☐
3A(3). DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?	☐	☐
3A(4). IS THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?	☐	☐
3A(5). IS THE LAND OVER 2 ACRES (87, 120 SQ FT) MARKETABLE?	☐	☐

REPORT THE GROSS MONTHLY AMOUNT

INCOME SOURCE	a. SURVIVING SPOUSE	b. DEPENDENT
3A(7). SOCIAL SECURITY	$	$
3A(8). SBP	$	$
3A(9). INTEREST	$	$
3A(10). OTHER	$	$
3A(11). OTHER	$	$

IMPORTANT! If you are a surviving spouse claimant, you must report assets and gross monthly income 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 assets and gross monthly income for yourself, your custodian, and your custodian's spouse (if applicable).

Submit VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.)*, if:

- you reported more than $75,000.00 in assets in 3A(1), **OR**
- you answered "YES" to questions 3A(2) through 3A(5), **OR**
- you have more income to report than space provided

PART B: REPORT OF EXPENSES

(NOTE: Only complete Part B & Part C if you are applying for Survivors Pension benefits. If you leave the entire question blank, we will assume you have no expenses to report)

3B(1). ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES OR OTHER EXPENSES? ☐ YES ☐ NO *(If "NO", skip to section IV)*

VETERAN'S LAST EXPENSES (NOTE: Report any last expenses (burial or expenses of last illness) paid for the Veteran)

PAID TO	3B(2).	DATE PAID *(MM/DD/YYYY)*	3B(3).	TOTAL AMOUNT PAID	3B(4). $

HOUSEHOLD MEDICAL EXPENSES (NOTE: Report any medical expenses for you or your dependents)

	a. FOR WHOM PAID	b. PAID TO *(provider name or insurance company)*	c. PURPOSE *(insurance premium, medical supply, etc.)*	d. DATE PAID *(MM/DD/YYYY)*	e. MONTHLY AMOUNT PAID
3B(5).					$
3B(6).					$
3B(7).					$
3B(8).					$

PART C: IN-HOME CARE OR FACILITY EXPENSES

IN-HOME CARE EXPENSES (NOTE: Claimed in-home care expenses also require a completed ***IN-HOME ATTENDANT Worksheet*** which can be found at the end of this form)

FOR WHOM PAID *(Self, if other than Self, specify name)*	NAME OF PROVIDER	START DATE OF CARE *(MM/DD/YYYY)*	END DATE OF CARE *(MM/DD/YYYY) (Leave blank if no end date)*	AMOUNT YOU PAY	
3C(1).	3C(2).	3C(3).	3C(4).	3C(5). Hourly Rate	
				3C(6). Hours Worked per Month	
				3C(7). Monthly Total Paid	

CARE FACILITY EXPENSES (NOTE: Claimed care facility expenses also require a completed ***RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY Worksheet*** which can be found at the end of this form. If care is continuing, leave END DATE blank)

FOR WHOM PAID *(Self, if other than Self, specify name)*	NAME OF CARE FACILITY	START DATE OF CARE *(MM/DD/YYYY)*	END DATE OF CARE *(MM/DD/YYYY)*	MONTHLY AMOUNT YOU PAY
3C(8).	3C(9).	3C(10).	3C(11).	3C(12). $

IMPORTANT: If you need more space to claim deductible expenses, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

SECTION IV: ACKNOWLEDGMENT AND SIGNATURES (REQUIRED FOR ALL BENEFITS)

PART A: 5103 NOTICE OF ACKNOWLEDGMENT

4A. **IMPORTANT:** FOR SPECIFIC EVIDENCE YOU NEED TO PROVIDE WITH YOUR CLAIM, VISIT https://www.va.gov/resources/evidence-to-support-va-pension-dic-or-accrued-benefits-claims/

☐ **I CERTIFY THAT** I HAVE REVIEWED THE NOTICE OF EVIDENCE THAT RELATES TO MY CLAIM

☐ **I HAVE NOT** REVIEWED THE NOTICE *(**NOTE:** If you check this box. VA will send you the 5103 notice through the mail. This will delay the decision on your claim)*

PART B: CLAIM CERTIFICATION AND SIGNATURE

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. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not disclosable.

I CERTIFY THAT I have enclosed all the information or evidence that will support my claim, including 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.

4B(1). CLAIMANT'S SIGNATURE OR MARK WITH AN "X" IF UNABLE TO SIGN *(REQUIRED)*	4B(2). DATE SIGNED *(MM/DD/YYYY)*
	☐☐ / ☐☐ / ☐☐☐☐

PART C: WITNESSES TO SIGNATURE
(NOTE: Two (2) witness signatures are required only if item 4B(1) is signed with an "X")

4C(1). SIGNATURE OF WITNESS	4C(2). PRINTED NAME
	4C(3). ADDRESS OF WITNESS
4C(4). SIGNATURE OF WITNESS	4C(5). PRINTED NAME
	4C(6). ADDRESS OF WITNESS

PART D: AUTHORIZED REPRESENTATIVE/ALTERNATE SIGNER'S CERTIFICATION AND SIGNATURE
(NOTE: Required only if item 4B(1) is blank. A first claim cannot be signed by anyone other than the claimant)

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.

4D(1). AUTHORIZED REPRESENTATIVE/ALTERNATE SIGNER'S SIGNATURE	4D(2). DATE SIGNED *(MM/DD/YYYY)*
	☐☐ / ☐☐ / ☐☐☐☐

PENALTY: The law provides severe penalties which include fines or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

IF YOU ARE ONLY APPLYING FOR D.I.C. BENEFITS OR YOU DO NOT HAVE EXPENSES LISTED IN SECTION III, PART C FOR SURVIVORS PENSION, YOUR CARE PROVIDER DOES NOT NEED TO COMPLETE THE ATTACHED WORKSHEETS.

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

(NOTE: Only complete this page if you are applying for Survivors Pension and are claiming Care Facility expenses in Secion III)

IMPORTANT: 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?

___ – ___ – ____

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

8. 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 APPROPRIATE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY

YES	NO	
☐	☐	THE STATE OR COUNTRY REQUIRES THIS FACILITY TO BE LICENSED
☐	☐	THE FACILITY IS LICENSED
☐	☐	THE FACILITY IS RESIDENTIAL
☐	☐	THE FACILITY IS STAFFED 24 HOURS BY CARE PROVIDERS

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 third-party provider ☐ NO, care is 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. DATE THE CARE RECIPIENT WAS ADMITTED TO THE FACILITY *(MM/DD/YYYY)*

__ / __ / ____

12. DO YOU EXPECT THIS CARE TO END? (*If "Yes", provide the date care is expected to end in question 13)*

☐ YES ☐ NO

13. DATE YOU EXPECT CARE TO END *(MM/DD/YYYY)*

__ / __ / ____

14. MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY PAYS

$

FACILITY CERTIFICATION AND SIGNATURE

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.

15. SIGNATURE OF PROVIDER *(From question 2)*

16. DATE SIGNED *(MM/DD/YYYY)*

__ / __ / ____

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

(NOTE: Only complete this page if you are applying for Survivors Pension and are claiming In-Home Care expenses in Section III)

IMPORTANT: 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

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/Postal Code –

8. 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. 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 FINANCE

☐ 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?
*(**NOTE:** 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. PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT *(MM/DD/YYYY)*

/ /

12. DO YOU EXPECT THIS CARE TO END?

☐ YES *(If "Yes", provide the date the care is expected to end in question 13)*

☐ NO

13. DATE YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)*

/ /

14. PROVIDE THE CHARGES THE CARE RECIPIENT PAYS PER HOUR.

$ PER HOUR

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

CERTIFICATION AND SIGNATURE

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.

16. SIGNATURE OF PROVIDER *(From question 2)*

17. DATE SIGNED *(MM/DD/YYYY)*

/ /