



VA DATE STAMP
(Do Not Write In This Space)

**REQUEST FOR NURSING HOME INFORMATION IN CONNECTION
WITH CLAIM FOR AID AND ATTENDANCE**

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. VA uses this form to determine eligibility for pension and aid and attendance benefits based on nursing home status. For more information you can contact us online through **Ask VA:** <https://ask.va.gov>, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI, 53547-4444.**

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable checkbox to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

4. DATE OF BIRTH (MM/DD/YYYY)

SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION (Complete this section ONLY IF the claimant is NOT the veteran)

5. CLAIMANT'S NAME (First, Middle Initial, Last)

6. SOCIAL SECURITY NUMBER

7. VA FILE NUMBER (If applicable)

8. DATE OF BIRTH (MM/DD/YYYY)

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

10. ADDRESS OF NURSING HOME (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

SECTION IV - GENERAL INFORMATION (To be completed by a Nursing Home Official)

NOTE: Your state's Medicaid program may use a different name.

11. DATE ADMITTED TO NURSING HOME (MM/DD/YYYY)

12. IS THE NURSING HOME A MEDICAID APPROVED FACILITY?

☐ YES ☐ NO

13. HAS THE PATIENT APPLIED FOR MEDICAID?

☐ YES ☐ NO

14A. IS THE PATIENT COVERED BY MEDICAID?

☐ YES ☐ NO (If "YES," complete Item 14B)

14B. DATE MEDICAID PLAN BEGAN (MM/DD/YYYY)

15. MONTHLY AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET \$

16. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: (Check one)

☐ SKILLED NURSING CARE ☐ INTERMEDIATE NURSING CARE

17. NURSING HOME OFFICIAL'S NAME (First and Last)

18. NURSING HOME OFFICIAL'S TITLE

19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE
NUMBER (Include Area Code)

Enter International Phone
Number (If applicable)

SECTION V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

20. SIGNATURE OF NURSING HOME OFFICIAL (REQUIRED)

21. DATE SIGNED (MM/DD/YYYY)

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 document you are not entitled to.

PRIVACY ACT NOTICE: The 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 5, Code of Federal Regulations 1.526 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. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

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 2900-0652, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 10 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. 2900-0652 in any correspondence. Do not send your completed VA Form 21-0779 to this email address.