

NOTICE TO VETERAN OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR **VETERANS PENSION BENEFITS**

(This notice is applicable to veterans claims for: Veterans Pension (a needs based benefit) • Special Monthly Pension • Benefits Based on a Veteran's Seriously Disabled Child)

> Use this notice and the attached application to submit a claim for veterans pension. This notice informs you of the evidence necessary to substantiate your claim.

Want your claim processed faster? The Fully Developed Claim (FDC) Program is the fastest way to get your claim processed and there is no risk to participate! To participate in the FDC Program, if you are making a claim for veterans pension, simply submit your claim in accordance with the "FDC Criteria" shown below. 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 making a claim for survivor benefits, use VA Form 21P-534EZ, Application for DIC, Survivors Pension, and/or Accrued Benefits. VA forms are available at www.va.gov/vaforms.

FDC Criteria (Claim(s) for Veterans Pension Benefits

- Submit your claim on a signed and completed VA Form 21P-527EZ, Application for Veterans Pension (attached).
- Submit simultaneously with your claim:
 - All necessary income and asset information; AND
 - All, if any, relevant, private medical treatment records and an identification of any relevant treatment records available at a Federal facility, such as a VA medical center.

Note: Read the Important note below and attach current medical evidence showing that you are permanently and totally disabled, if necessary.

IMPORTANT: If you are a veteran who is claiming pension and you are age 65 or older, or determined to be disabled by the Social Security Administration, you **DO NOT** have to submit medical evidence with your application unless you are claiming special monthly pension. Special monthly pension is an increased amount paid to individuals who, due to mental or physical disability, require the aid of another person to perform activities of daily living, are a patient in a nursing home, have severe visual problems, or are substantially confined to his or her home.

Special Circumstances

Under the special circumstances shown below, you must also submit simultaneously with your claim:

- If claiming veterans 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 a child in school 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, all, if any, relevant, private medical treatment records for the child's pertinent disabilities.
- Report for any VA medical examinations VA determines are necessary to decide your claim.

WHERE TO SEND COMPLETED APPLICATION AND EVIDENCE

When you have completed this application, mail or fax 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 all supporting material you submit to VA before mailing or faxing it.

MAIL TO	FAX TO
Department of Veterans Affairs Pension Intake Center PO Box 5365 Janesville, WI 53547-5365	844-655-1604 (Toll Free)

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 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 below 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.

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.

FDC Program (Optional Expedited Process)	Standard Claim Process		
You must:	You must:		
Submit your claim in accordance with the "FDC Criteria" (see page 1)	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		
	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:	VA will:		
Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain	 Retrieve relevant records from a Federal facility such as a VA medical center, that you adequately identify and authorize VA to obtain 		
 Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim 	 Provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your claim 		
	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:	You are strongly encouraged to:
Send the information and evidence simultaneously with your claim	Send any information or evidence as soon as you can
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 receive the claim, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support the claim.	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 receive 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

If you are claiming	See the evidence table titled
Veterans Pension (a needs-based benefit)	Veterans Pension
Special Monthly Pension	Veterans Pension with Special Monthly Pension
Benefits because your child is severely disabled	Child Incapable of self-support

EVIDENCE TABLES

Veterans Pension

To support a claim for **veterans pension**, the evidence must show:

- You 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 your 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 obligation)

- OR, any length of active service during a period of war with a discharge due to a service-connected disability
- 2. You are age 65 or older *or* are permanently and totally disabled. Your disability or disabilities do not have to be related to your military service. You are considered permanently and totally disabled if medical evidence shows you are:
 - A patient in a nursing home for long-term care or medical foster home; **OR**
 - Receiving Social Security disability benefits; **OR**
 - Unemployable due to a disability reasonably certain to continue throughout your lifetime; **OR**
 - Suffering from a disability that is reasonably certain to continue throughout your lifetime that would make it impossible for an average person to follow a substantially gainful occupation; **OR**
 - Suffering from a disease or disorder that VA determines causes persons who have that disease or disorder to be permanently and totally disabled
- 3. Your income and assets are within established limits. You must report income and assets for:
 - Yourself
 - Your spouse (unless you live apart and you are estranged and you do not contribute to your spouse's support)
 - Your child (unless custody has been legally removed by a court and you do not contribute to your child's support *or* the child's income is not reasonably available to you).

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, not to exceed 2 acres) 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.

Veterans Pension with Special Monthly Pension

To support a claim for increased pension eligibility based on the need for aid and attendance, the evidence must show:

- You have corrected visual acuity of 5/200 or less in both eyes; **OR**
- You have concentric contraction of the visual field to 5 degrees or less; **OR**
- You are a patient in a nursing home due to mental or physical incapacity; **OR**
- You need the aid of another person to perform activities of daily living (ADLs), such as bathing or showering, dressing, eating, toileting, and transferring (e.g. getting in and out of bed); **OR**
- You require regular supervision because you are unsafe if you are left alone due to a mental disorder, **OR**
- You are bedridden, in that your disability requires that you remain in bed apart from any prescribed course
 of convalescence or treatment.

To support your claim for increased pension eligibility based on being housebound, the evidence must show:

- You have a single permanent disability evaluated as 100 percent disabling; AND due to such disability, you are
 permanently and substantially confined to your immediate premises; OR
- You have a single permanent disability evaluated as 100 percent disabled, AND you have an additional disability or disabilities rated 60 percent or higher.

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 his or her 18th birthday, became permanently incapable of self-support due to a 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 recognized marriages is available at http://www.va.gov/opa/marriage/.

How VA Determines the Effective Date

If we grant your claim, the beginning date of your entitlement will generally be based on when we received your claim.

Special monthly pension may be assigned for disabilities that affect your ability to perform certain activities of daily living or the ability to leave your home. Special monthly pension may be effective from the date the medical evidence first shows entitlement.

For more information on the FDC Program, visit our web site at http://benefits.va.gov/transformation/fastclaims/.

For more information on VA benefits, visit our web site at www.va.gov, contact us at https://iris.custhelp.com, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711.

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

IMPORTANT

If you wish to make a claim for veterans **disability compensation and/or related compensation benefits**, use VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*. VA forms are available at www.va.gov/vaforms. If you cannot access this form, write the words "Will claim compensation - send VA Form 21-526EZ" in Item 8 *or* at the top of the attached application and VA will send you the form.

OMB Control No. 2900-0002 Respondent Burden: 25 minutes Expiration Date: 10/31/2021

∞	Department of Veterans A	ffair

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION IMPORTANT: Please read the Privacy Act and Respondent Burden on page 9 before completing the form. **SECTION I: VETERAN'S PERSONAL INFORMATION (MUST COMPLETE)** 1. VETERAN'S NAME (First, Middle Initial, Last) 2. SOCIAL SECURITY NUMBER 4. HAVE YOU EVER FILED A CLAIM WITH VA? 3. DATE OF BIRTH (MM-DD-YYYY) ○ YES
 (If "Yes," provide your file number in Item 5) O NO 5. VA FILE NUMBER (If applicable) 6A. MAILING ADDRESS No. & Street Apt./Unit Number City State/Province Country ZIP Code/Postal Code 6B. TELEPHONE NUMBERS (Include Area Code) DAYTIME **EVENING CELL PHONE** 7. PREFERRED E-MAIL ADDRESS (If applicable) 8. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING? A. DISABILITY(IES) B. DATE DISABILITY(IES) BEGAN 9. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES A. NAME AND LOCATION OF VA MEDICAL CENTER B. DATE(S) OF TREATMENT

SECTION II: VETERAN'S SERVICE INFORMATION (MUST COMPLETE)

ועא. טוט זי	OU SERVE UNDER ANOTHER NAM
O YES	(If "Yes," complete Item 10B)
○ NO	(If "No," skip to Item 11A)

10A. DID YOU SERVE UNDER ANOTHER NAME? 10B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

SECTION II: VETERAN'S SERVICE INFORMATION (MUST COMPLETE) (CONTINUED)				
11A. I ENTERED ACTIVE SERVICE ON (MM-DD-YYYY) 11B. BRANCH OF SERVICE				
		○ ARMY ○ NAVY ○ MARINE CORPS		
		○ AIR FORCE	\sim	
		7 AIRT GROE	0 00/101 0	50, 11, 12
11C. RELEASE DATE FROM ACTIVE SERVICE (MM-DD-YYYY)	11D. SERVICE NU	IMBER	
11E. PLACE OF LAST SEPARATION				
12A. HAVE YOU EVER BEEN A PRISONER OF V	VAR? 12B. D.	ATES OF CONFINEM	MENT ON (MM-	-DD-YYYY)
O YES (If "Yes," complete Item 12B)	From:	_		
\bigcirc NO (If "No," skip to Item 13A)	110111.			
(i) No, sup to new 1511)	To:	_	_	
SECTION III:	VETERAN'S	DISABILITY(IES	S) AND BAC	CKGROUND (MUST COMPLETE)
NOTE: You do not have to submit medical evide	ence or list disab	ilities if you are age	65 or older, un	less you are housebound, or require the regular assistance of
another person.		,		
13A. WHAT DISABILITY(IES) PREVENT YOU FR	OM WORKING?		13B. WHEN DI	ID THE DISABILITY(IES) BEGIN? (MM-DD-YYYY)
			_	-
				SISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL
PROBLEMS, OR ARE GENERALLY CONFIN				
				Exam for Housebound Status or Permanent Need for Regular Aid
			and signed by	a Physician, Physician Assistant (PA), Certified Nurse Practitioner
(CNP), or Clinical N 14B. ARE YOU NOW OR HAVE YOU RECENTLY			NT HOSDITAL	IZATION OR CARE (MM-DD-YYYY)
HOSPITALIZED OR GIVEN OUTPATIENT O		N. DATE(S) OF RECE	INT HOSFITALI	IZATION ON GARE (IMIN-DD-1111)
CARE DUE TO THE DISABILITY(IES) LISTE	D IN	_	_	
ITEM 13A?		_	_	
C YES C NO				
15B. NAME AND MAILING ADDRESS OF FACILI	TY OR DOCTOR			
NOTE: In the table below tell us about all of vo	our employment	including self-emplo	ovment for on	e year before you became disabled to the present.
		T WORK? (MM-DD-	•	C. WERE YOU SELF-EMPLOYED BEFORE BECOMING TOTALLY
O YES O NO	IN DID TOO LAC	T WORK: (MM-DD-	1111)	DISABLED?
O TES O NO	_	_	0	YES O NO (If "Yes," complete Items 16D and 16E)
16D. WHAT KIND OF WORK DID YOU DO?	165 4	RE YOU STILL SELF	-EMDI UAEDS	16F. WHAT KIND OF WORK DO YOU DO NOW?
TOD. WHAT KIND OF WORK DID 100 DO!		S O NO	-LIVIPLOTED!	101. WHAT KIND OF WORK DO TOO DO NOW!
	~	~	E)	
	(ij Te	," complete Item 16F	7)	
17A. ARE YOU NOW IN A NURSING HOME?	17B. WH	AT IS THE NAME AN	D COMPLETE	MAILING ADDRESS OF THE FACILITY?
○ YES ○ NO				
(If "Yes," complete Items 17B and 17C and subm	it a			
statement from an official of the nursing home the				
tells us that you are a patient in the nursing home	?			
because of a physical or mental disability. The				
statement should include the monthly charge you are paying out-of-pocket for your care.)				
17C. DOES MEDICAID COVER ALL OR PART OF	YOUR NURSIN	G HOME COSTS?	17D. HAVE Y	YOU APPLIED FOR MEDICAID?
○ YES ○ NO (If "No," complete Item	17D)		C YES (○ NO
			ĺ	

SECTION III:	VETERAN'S	DISABILITY(IES) A	AND BACKGROUND (MUST COMPLE	TE) (CONTINUED)	
18A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?					
18B. WHAT WAS YOUR JOB TITLE?					
18C. WHEN DID YOUR JOB BEGIN?	_	_	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?		
18D. WHEN DID YOUR JOB END?	_	_	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?	\$,	.00
18A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?					
18B. WHAT WAS YOUR JOB TITLE?					
18C. WHEN DID YOUR JOB BEGIN?	_	_	18E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?		
18D. WHEN DID YOUR JOB END?	_	_	18F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?	\$,	.00
	SEC	CTION IV: MARITA	L STATUS (MUST COMPLETE)		
19A. WHAT IS YOUR MARITAL STATUS MARRIED DIVORCED	S? (Check one) WIDOWED	NEVER MARRIE	ED (Skip to Section VI if never married)		
TELL US ABOUT YOUR MARRIAG	GE/PREVIOUS I	MARRIAGES			
19B. HOW MANY TIMES HAVE YOU BE	EEN MARRIED (In	cluding current marriag	ge)?		
20A. DATE (MM-DD-YYYY) AND PLAC MARRIAGE (City and State or Cou					
20B. TO WHOM MARRIED (First, Middle, Last Name)					
20C. TYPE OF MARRIAGE (Ceremonia Common-Law, Proxy, Tribal, or C					
20D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)					
20E. DATE (MM-DD-YYYY) AND PLACE MARRIAGE ENDED (City and State					
20A. DATE (MM-DD-YYYY) AND PLAC MARRIAGE (City and State or Cou					
20B. TO WHOM MARRIED (First, Middle, Last Name)					
20C. TYPE OF MARRIAGE (Ceremonia Common-Law, Proxy, Tribal, or C	*				
20D. HOW MARRIAGE ENDED (Death, Marriage Has Not Ended)	Divorce,				
20E. DATE (MM-DD-YYYY) AND PLACE MARRIAGE ENDED (City and State	or Country)		•		
20F. IF YOU INDICATED "OTHER" AS T	TYPE OF MARRIA	GE IN ITEM 20C, PLEAS	SE EXPLAIN:		

	T MARITAL INFORMATION (COMPLETE ONLY IF	YOU ARE CURRENTLY MARRIED)
Note - Skip to Section VI if not currently ma		
TELL US ABOUT YOUR SPOUSE'S MARRI		
21. HOW MANY TIMES HAS YOUR SPOUSE BEE	N MARRIED (Including current marriage)?	
22A. DATE (MM-DD-YYYY) AND PLACE OF MARRIAGE (City and State or Country)		
22B. TO WHOM MARRIED (First, Middle, Last Name)		
22C. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, or Other)		
22D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)		
22E. DATE (MM-DD-YYYY) AND PLACE MARRIAGE ENDED (City and State or Country,		
22A. DATE (MM-DD-YYYY) AND PLACE OF MARRIAGE (City and State or Country)		
22B. TO WHOM MARRIED (First, Middle, Last Name)		
22C. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, or Other)		
22D. HOW MARRIAGE ENDED (Death, Divorce, Marriage Has Not Ended)		
22E. DATE (MM-DD-YYYY) AND PLACE MARRIAGE ENDED (City and State or Country,		
22F. IF YOU INDICATED "OTHER" AS TYPE OF N	ARRIAGE IN ITEM 22C, PLEASE EXPLAIN:	
23A. WHAT IS YOUR SPOUSE'S DATE OF	23B. WHAT IS YOUR SPOUSE'S SOCIAL	23C. IS YOUR SPOUSE ALSO A VETERAN?
BIRTH? (MM-DD-YYYY)	SECURITY NUMBER?	YES NO (If "Yes," complete Item 23D)
		(1) Tes, complete test. 222)
23D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (If any)?	23E. DO YOU LIVE WITH YOUR SPOUSE? O YES O NO (If "Yes," skip to Section VI) (If "No," complete Items 23F, 23G and 23H)	
	nber and street or rural route, P.O. Box, City, State, ZIP Coo	de and Country)
No. & Street		
Apt./Unit Number	City	
State/Province Country	ZIP Code/Postal Code	_
23G. TELL US THE REASON YOU ARE NOT LIVIN	IG WITH YOUR SPOUSE (i.e.; illness, work, etc.)	23H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT?
		\$, .00

SECT	ON VI: DEPENDENT CHILDREN (COMPLETE IF YOU HAVE DEPENDENT CHILDREN)
Note - Skip to Section VII if you	have no dependent children.
24A. NAME OF DEPENDENT CHILD (First, Middle initial, Last)	
24B. DATE AND PLACE OF BIRTH (City and State or Country)	
24C. SOCIAL SECURITY NUMBER	
(Check all that apply)	C 24D. BIOLOGICAL C 24E. ADOPTED C 24F. STEPCHILD C 24G. 18-23 YEARS OLD (in school) C 24H. SERIOUSLY DISABLED C 24I. CHILD MARRIED C 24J. CHILD PREVIOUSLY MARRIED
24A. NAME OF DEPENDENT CHILD (First, Middle initial, Last)	
24B. DATE AND PLACE OF BIRTH (City and State or Country)	
24C. SOCIAL SECURITY NUMBER	
(Check all that apply)	C 24D. BIOLOGICAL C 24E. ADOPTED C 24F. STEPCHILD C 24G. 18-23 YEARS OLD (in school) C 24H. SERIOUSLY DISABLED C 24I. CHILD MARRIED C 24J. CHILD PREVIOUSLY MARRIED
24A. NAME OF DEPENDENT CHILD (First, Middle initial, Last)	
24B. DATE AND PLACE OF BIRTH (City and State or Country)	
24C. SOCIAL SECURITY NUMBER	
(Check all that apply)	C 24D. BIOLOGICAL C 24E. ADOPTED C 24F. STEPCHILD C 24G. 18-23 YEARS OLD (in school) C 24H. SERIOUSLY DISABLED C 24I. CHILD MARRIED C 24J. CHILD PREVIOUSLY MARRIED
Note - In Items 25A through 25I	o, tell us about the children listed in Item 24A who <i>do not</i> live with you.
25A. NAME OF DEPENDENT CHILD	First, middle initial, last)
25B. CHILD'S COMPLETE ADDRESS No. & Street Apt./Unit Number	(Number and street or rural route, city or P.O., city, State, ZIP Code and country) City
•	
	ountry ZIP Code/Postal Code —
25C. NAME OF PERSON THE CHILD	LIVES WITH (If applicable) (First, middle initial, last)
25D. MONTHLY AMOUNT YOU CON	TRIBUTE TO THE CHILD'S SUPPORT \$.00
25A. NAME OF DEPENDENT CHILD	(First, middle initial, last)
25B CHILD'S COMPLETE ADDRESS	(Number and street or rural route, city or P.O., city, State, ZIP Code and country)
No. & Street	A. minos. min silver of raral route, ony of 1.10., ony, plane, 211 Code and country)
Apt./Unit Number	City
	ountry ZIP Code/Postal Code -
25C. NAME OF PERSON THE CHILD	LIVES WITH (If applicable) (First, middle initial, last)
25D. MONTHLY AMOUNT YOU CON	TRIBUTE TO THE CHILD'S SUPPORT \$, .00

SECTION VI: DEPENDENT O	HII DREN (COMPLETE IE VOILHAVE DEPENDENT CHILDRE	N) (CONTINI)	(FD)	
SECTION VI: DEPENDENT CHILDREN (COMPLETE IF YOU HAVE DEPENDENT CHILDREN) (CONTINUED) 25A. NAME OF DEPENDENT CHILD (First, middle initial, last)				
20 CIVANE OF BELLEVIET OF HEB (1 1/3), maute initial,				
· · · · · · · · · · · · · · · · · · ·	or rural route, city or P.O., city, State, ZIP Code and country)			
No. & Street				
Apt./Unit Number City				
-				
State/Province Country	ZIP Code/Postal Code -			
25C. NAME OF PERSON THE CHILD LIVES WITH (If appl	icable) (First, middle initial, last)			
25D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CH	IILD'S SUPPORT \$00			
SECTION VIII: OUESTIONS DECA	RDING INCOME AND ASSETS (If you need more space, at	taah a sanaya	ta shaat)	
26. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL		acn a separa	ie sneei.)	
YES NO (If "Yes," complete Items A and B				
(1) Tes, complete tiems A and B) (1) No, skip to Hem 27)			
A. SOCIAL SECURITY	RECIPIENT (First, middle initial, last)	B. GROSS N	MONTHLY AN	JOUNT
		\$.00
		φ	,	.00
		\$.00
		Ψ	,	.00
		\$.00
		Ψ	,	.00
		\$.00
		<u> </u>	,	
		\$,	.00
27. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR	EAMILV'S DDIMADY DESIDENCE?	<u> </u>	,	
YES NO (If "Yes," complete Items 28A and 2	ob) (IJ No, skip to tiem 29A)			
28A. WHAT IS THE SIZE OF THE LOT ON WHICH	28B. COULD ANY PART OF THE LOT BE SOLD WITHOUT SELLING THE	RESIDENCE?	ı	
THE PRIMARY RESIDENCE SITS?	C YES O NO (If "Yes," also complete VA Form 21P-0969, Inc	ome and Asset	Statomont)	
Square feet	(1) Tes, also complete v A Form 217-0909, Inc	ome ana Asser	Siatement)	
IMPORTANT. VA matches in some information reports	d with Federal tax information. Report all income you and your depende		tha ammamuiata	
sections of this form and VA Form 21P-0969, <i>Income and</i>		mis receive on t	me appropriate	
29A. OTHER THAN SOCIAL SECURITY, DO YOU OR YOU	** *			
O YES O NO				
29B. OTHER THAN SOCIAL SECURITY, DID YOU OR YO	UR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?			
○ YES ○ NO				
29C. DO YOU OR YOUR DEPENDENTS HAVE MORE THA	AN \$10,000 IN ASSETS? (Note: Assets are all the money and property yo	u or vour deper	ndents own. Ass	sets do
	personal effects such as appliances and vehicles you or your dependents			
○ YES ○ NO				
29D. IN THE THREE CALENDAR YEARS BEFORE THIS Y giving them away, selling them, purchasing an annui	EAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Ex	camples of asse	t transfers incli	ıde
	ty, or using them to establish a trust.)			
O YES O NO				
29E. DID YOU ANSWER "YES" TO ANY OF THE ITEMS II	N 29A - 29D?			
○ YES ○ NO (If "Yes," you must also comple	te VA Form 21P-0969, Income and Asset Statement)			

SECTION VIII: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL 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, dependents you are under obligation to support, 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 at any time prior to the end of the year following the year of death. 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 or your dependents were/will be reimbursed. Please make sure to complete all 6 criteria below (if applicable). If more space is needed, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

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 10 and 11.

30. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES? YES ONO (If "No," skip to Section IX)						
A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	B. PAID TO (Name of Provider, Insurance company, Nursing home, etc.)	C. PURPOSE (Medicare premiums, Nursing Home,etc.)	D. DATE PAID (MM-DD-YYYY)	E. HOURLY RATE/ HOURS (In-home Provider Only)	F. AMOUNT YOU PAY	
				\$.00	\$.00	
				\$.00	\$.00	
				\$.00	\$.00	
				\$.00	\$.00	
				\$.00	\$.00	
				\$.00	\$.00	
				\$.00	\$.00	
				\$.00	\$.00	
				\$.00	\$.00	
				\$.00	\$.00	
	SECTION IX: DIRECT DEPO	SIT INFORMATION (I	MUST COMPLETE)			
The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. Please attach a voided personal check or deposit slip or provide the information requested below in Items 31, 32, and 33 to enroll in direct deposit. If you <i>do not</i> have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.						
31. ACCOUNT NUMBER (Check the app	propriate box and provide the account nu	mber, or simply write "Establ	ished" if you have a dire	ect deposit with VA.)		
○ YES ○ NO I CERTIFY THAT I DO NOT						
Account No.: HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT						
32. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)		33. ROUTING OR Te	RANSIT NUMBER (The :)	first nine numbers loo	cated at the bottom	

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 and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled *Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected Pension 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 34, 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.

34. 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.

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

35A. VETERAN'S SIGNATURE (REQUIRED)	35B. DATE SIGNED				
SECTION XI: WITNESSES TO SIGNATURE (MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 35A WITH AN "X")					
36A. SIGNATURE OF WITNESS (If veteran signed above using an "X")	37A. SIGNATURE OF WITNESS (If veteran signed above using an "X")				
36B. PRINTED NAME AND ADDRESS OF WITNESS	37B. PRINTED NAME AND ADDRESS OF WITNESS				
Name:	Name:				
Address:	Address:				
Address.	Address.				
	1				

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 Vocational Rehabilitation 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 obligation to respond 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 25 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 DAY CARE, OR SIMILAR FACILITY				
NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.				
IMPORTANT : VA recognizes the following five activities as Activities of Daily Living (A	ADLs) for medical expense purposes:			
(1) Eating				
(2) Bathing/Showering				
(3) Dressing				
(4) Transferring (for example, from bed to chair)				
(5) Using the toilet				
Custodial Care is regular -				
 assistance with two or more ADLs, or supervision because a person with a mental disorder is unsafe if left alone due 	to the mental disorder.			
INSTRUCTIONS : Use this worksheet if you are claiming a disabled person's care in a medical expenses. Follow the steps below to determine whether VA may deduct all or				
STEP 1. Are the expenses you wish to claim due to the disabled person's treatment approved medical foster home?	nent in a hospital, inpatient treatment center, nursing home, or VA			
YES NO (If "NO," continue to Step 2)				
(If "YES," all payments to the facility qualify as medical expense	es in Items 30A - 30F. You are finished completing this worksheet)			
STEP 2. Do all of the following apply to the facility?				
 The facility is licensed (if the State or Country requires it) The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both. 				
If the facility is residential, it is staffed 24 hours per day with caregive	rs			
YES NO (If "NO," payments to the facility do not qualify as medical expe	enses. You are finished completing this worksheet)			
STEP 3. Are you (the veteran) the disabled person?				
YES NO (If "NO," skip to Step 6)				
STEP 4. Did you claim special monthly pension on Page 5, Item 14A of the attac	ched form?			
	ualify as medical expenses. <i>Only</i> claim amounts you pay the facility for <i>health care</i>			
STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the <i>primary reason</i> you live in the facility (or attend day care in the facility)?				
	nenses if VA rates you as eligible for special monthly pension. Please report acility for (1) lodging and meals, (2) health care services or assistance with care. Skip to Step 8)			
STEP 6. Does the disabled person require the health care services or custodial person's mental or physical disability?	care that the facility provides to him or her because of the disabled			
	ician assistant that (1) the disabled person requires the health care services of mental or physical disability, and (2) describes the mental or physical disability)			
(If "NO," claim payments you pay this facility for health care ser - 30F. Skip to Step 8)	rvices or assistance with ADLs provided by a health care provider in Items 30A			
STEP 7. If you answered "YES" in Step 2, you stated that the facility provides th primary reason the disabled person lives in the facility (or attends day				
YES NO (If "YES," claim all payments to this facility (to include meals and	,			
(If "NO," only claim payments you pay the facility for assistance the same of the same o	with <i>health care and/or assistance with custodial care</i> as medical expenses in o not qualify)			
STEP 8. Facility Certification: Please submit a current statement showing the	fees the claimant pays to your facility and a breakdown of the care			
received. I CERTIFY that the information stated within this WORKSHEET FOR AN ASSIS	TED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate			
and reflects the current environment pertaining to				
	(Name of Person Staying at Facility)			
and his or her care at this facility	(Name of Facility)			
at (Address of Facili	ity (Line 1))			
(Address of Facili	ity (Line 2))			
	(Name of Person Certifying for the Facility)			
(Signature of Person Certifying for the Facility)				
(Title of Person Certifying for the Facility)	(Date Certified)			

WORKSHEET FOR IN-HO	OME ATTENDANT EXPENSES
NOTE: Only complete this worksheet if you are claiming expenses for in-he	ome care.
IMPORTANT: VA recognizes the following five activities as Activities of Daily Li	ving (ADLs) for medical expense purposes:
(1) Eating	
(2) Bathing/Showering	
(3) Dressing	
(4) Transferring (for example, from bed to chair)	
(5) Using the toilet	
Custodial Care is regular -	e due to the mental disorder
IMPORTANT : The following activities are examples of Instrumental Activities of with these activities as medical expenses: (1) Shopping; (2) Food Preparation; telephone; (7) Transportation (except for medical purposes such as transportation)	Daily Living (IADLs) for VA purposes. VA generally does not recognize assistance (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the on to a doctor's appointment).
INSTRUCTIONS: Use this worksheet if you are claiming payments to a disable	d person's in-home attendant as an unreimbursed medical expense.
Follow the steps below to determine whether or not:	
 the attendant must be a health care provider for VA purposes and VA may deduct payment for assistance with IADLs as well as assistance 	e with ADLs and custodial care
STEP 1. Are you (the veteran) the disabled person?	
YES NO (If "NO," skip to Step 4)	
STEP 2. Did you claim special monthly pension on Page 5, Item 14A of th	e attached form?
	ce with IADLs do not qualify as medical expenses. Please report separately in Items 30A - r (1) health care services or assistance with ADLs provided by a health care provider, and
STEP 3. Is the <i>primary responsibility</i> of the in-home attendant to provide	e you with health care or custodial care?
	as medical expenses in Items 30A - 30F <i>if</i> VA rates you as eligible for special monthly unts you pay an in-home attendant for (1) health-care services or assistance with ADLs DLs, and (3) custodial care. Skip to Step 6.)
	re with IADLs do not qualify as medical expenses. Please report separately in Items 30A - r: (1) health care services or assistance with ADLs provided by a health care provider and
disabled person's mental or physical disability?	stodial care that the in-home attendant provides to him or her because of the
	or physician assistant that (1) the disabled person requires the health care services or or her because of mental or physical disability, and (2) describes the mental or physical
	Only report payments to the in-home attendant for <i>health care services or assistance</i> al expenses in Items 30A - 30F. Payments for assistance with IADLs do not qualify as
STEP 5. Is the <i>primary responsibility</i> of the in-home attendant to provide	e the disabled person with health care or custodial care?
	nedical expenses (even assistance with IADLs) and can be reported in Items 30A - 30F.) alth care and/or custodial care as medical expenses in Items 30A - 30F. Payment for see)
STEP 6. Check all activities below with which the attendant assists the ve	teran or disabled person with:
ADLs: CEATING BATHING/SHOWERING DRESSING	↑ TRANSFERRING ↑ USING THE TOILET
IADLs: SHOPPING FOOD PREPARATION HOUSEK	EEPING C LAUNDERING MANAGING FINANCES
C HANDLING MEDICATIONS USING THE TELEPHON	E TRANSPORTATION FOR NON-MEDICAL PURPOSES
STEP 7. In-Home Attendant Certification: Please submit a current breal	kdown of the time the attendant spends assisting the veteran or disabled
person with health care services, ADLs and IADLs. I CERTIFY that the information stated within this WORKSHEET FOR IN-H	OME ATTENDANT EXPENSES is accurate and reflects the current
environment pertaining to	(Name of Person Requiring Care)
and his or her care from	(Name of Attendant)
	A. (0.77)
(Signature of Certifying Official)	(Name of Certifying Official)
(Title of Certifying Official)	— — (Date Certified)