

# NOTICE TO SURVIVOR OF EVIDENCE NECESSARY TO SUBSTANTIATE A CLAIM FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

(This notice is applicable to survivors claims for: Survivors Pension • Dependency Indemnity Compensation (DIC) • DIC under 38 U.S.C. 1151 • Increased Survivor Benefits Based on Need for Special Monthly Pension • Accrued Benefits • Benefits Based on a Veteran's Seriously Disabled Child)

Use this notice and the attached application to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits.

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 <u>fastest</u> 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 DIC, Survivors Pension, and/or Accrued Benefits, 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 claiming veterans Pension benefits, use VA Form 21P-527EZ, *Application for Veterans Pension*. VA forms are available at <u>www.va.gov/vaforms</u>.

## FDC Criteria (Claim(s) for DIC, Survivors Pension, and/or Accrued Benefits)

- Submit your claim on a <u>signed and completed</u> VA Form 21P-534EZ, Application for DIC, Survivors Pension, and/or Accrued Benefits (Attached).
- 2. Submit simultaneously with your claim:

A copy of the veteran's Death Certificate (unless he or she died on active duty); AND

## If claiming Survivors Pension:

- All necessary income and asset information; AND
- If claiming Survivors Pension with <u>special monthly pension</u>, 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 DIC:

- All, if any, of the veteran's relevant, private medical treatment records and an identification of any
  of the veteran's treatment records available at a Federal facility, such as a VA medical center, that supports
  your claim that a service-connected disability caused the veteran's death or the veteran's death was caused by the VA.
- Any and all Service Treatment and Personnel Records in the custody of the veteran's Guard or Reserve Unit(s).
- If claiming DIC as the parent of the veteran, all necessary income information and, if claiming benefits as the foster parent of the veteran, a completed VA Form 21P-524, Statement of Person Claiming to Have Stood in Relation of Parent.
- If claiming DIC with <u>special monthly DIC</u>, 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

## **Requirements for Certain Claimants:**

- If claiming benefits as the surviving spouse of the veteran, a copy of your marriage certificate showing your marriage to the veteran, or if claiming benefits for a child or biological/adoptive parent of the veteran, a copy of the birth certificate or court record of adoption showing relation to the veteran.
- If claiming benefits for a child of the veteran 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 of the veteran, all, if any, relevant, private medical treatment records for the child's pertinent disabilities showing the child was incapable of self-support before age 18.
- 3. Report for any VA medical examinations VA determines are necessary to decide your claim.

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. If your claim involves a disability the veteran had before entering service and that was made worse by service, please provide any information or evidence in your possession regarding the health condition that existed before the veteran's entry into service.

FDC Program (Optional Expedited Process)	Standard Claim Process
You must:  • Submit your claim in accordance with the "FDC Criteria" (see page 1)	You must:  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

DC Program (Optional Expedited Process)	Standard Claim Process
'A will:  • Retrieve relevant records from a Federal facility, such as a VA medical center, that you adequately identify and authorize VA to obtain	PA will:  Retrieve relevant records from a Federal facility that you adequately identify and authorize VA to obtain  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:	We strongly encourage you 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.

# WHERE TO SEND INFORMATION AND EVIDENCE

Mail or take your application and any evidence in support of your claim to the closest VA regional office. VA regional office addresses are available on the Internet at <a href="https://www.va.gov/directory">www.va.gov/directory</a>.

#### WHAT THE EVIDENCE MUST SHOW TO SUPPORT YOUR CLAIM

If you are claiming	See the evidence table titled
Needs-based benefits based on the veteran's wartime service.	Survivors Pension
<ul> <li>The veteran's death was related to his or her service (DIC), OR</li> <li>DIC because the veteran was receiving or entitled to receive benefits for a service-connected disability rated totally disabling.</li> </ul>	Dependency and Indemnity Compensation (DIC)
The veteran's death was a result of VA medical treatment, vocational rehabilitation, or compensated work therapy.	DIC under 38 U.S.C. 1151
DIC and it was previously denied by VA.	Reopened DIC
Special Monthly Pension.	Increased Survivor Benefits Based on Special Monthly Pension
You are entitled to the benefits that were due to the veteran at the time of the veteran's death.	Accrued Benefits
You are eligible to benefits because a child of the veteran is severely disabled.	Child Incapable of self-support

#### **EVIDENCE TABLES**

## **Survivors Pension**

To support your claim for **Survivors Pension**, the evidence must show:

- 1. The veteran met certain minimum <u>active service</u> requirements during a period of war. Generally, those requirements are:
  - 90 days of consecutive service, at least one day of which was during a period of war; OR
  - 90 days of combined service during at least one period of war;

(**Note**: If the veteran's 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 obligations.)

**OR** any length of active service during a period of war when:

- At the time of death, the veteran was receiving (or entitled to receive) VA disability compensation or retirement pay for a service-connected disability; **OR**
- The veteran was discharged from active service due to a service-connected disability.
- 2. Your income and assets do not exceed certain requirements.

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.

## Dependency and Indemnity Compensation (DIC)

To support a claim for Dependency and Indemnity Compensation (DIC) based on a service-connected disability:

- The veteran died while on active service; OR
- The veteran had a service-connected disability(ies) that was either the principal or contributory cause of the veteran's death;
- The veteran died from non service-connected injury or disease **AND** was receiving, or entitled to receive VA compensation for a service-connected disability rated totally disabling:
  - · For at least 10 years immediately before death; OR
  - For at least 5 years after the veteran's release from active duty preceding death; OR
  - For at least 1 year before death, if the veteran was a former prisoner of war who died after September 30, 1999.

To support a claim for **DIC** based on a disability that was not service-connected or for which the veteran did not file a claim during his or her lifetime, the evidence must show:

- An injury or disease that was incurred or aggravated during active service, or an event in service that caused an injury or disease: AND
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by
  medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; AND
- A relationship between the disability associated with the cause of death and an injury, disease, or event in service. This may be shown by medical records or medical opinion or, in certain cases, by lay evidence.

## **EVIDENCE TABLES (Continued)**

## Dependency and Indemnity Compensation (DIC) (Continued)

To support your claim for DIC based upon the service person's active duty for training, the evidence must show:

• The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty, and the disease or injury caused or contributed to the service person's death.

If VA granted service connection for a disease or injury during the service person's lifetime, evidence that the service-connected disease or injury caused or contributed to the service person's death may satisfy this requirement.

To support a claim for DIC based on a disability that was not service-connected or for which the service person did not file a claim during his or her lifetime. the evidence must show:

- The service person was disabled during active duty for training due to a disease or injury incurred in the line of duty; AND
- A physical or mental disability that was either the principle or contributory cause of death. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that were visible or observable; **AND**
- A relationship between the principal or contributory cause of death and the disability due to injury or disease, incurred in the line of duty. This may be shown by medical records or medical opinions or, in certain cases, by lay evidence.

To support your claim for **DIC** based upon the service person's inactive duty training, the evidence must show:

- The service person died during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident during such training; **OR**
- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; and that injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

If VA granted service connection for an injury, acute myocardial infarction, or cerebrovascular accident during the service person's lifetime, evidence that the service-connected condition caused or contributed to the service person's death may satisfy this requirement.

To support a claim for DIC based on a disability that was not service-connected or for which the service person did not file a claim during his or her lifetime, the evidence must show:

- The service person was disabled during inactive duty training due to an injury incurred or aggravated in the line of duty, or acute myocardial infarction, cardiac arrest, or cerebrovascular accident that occurred during such training; **AND**
- The injury, acute myocardial infarction, cardiac arrest, or cerebrovascular accident caused or contributed to the service person's death

#### DIC under 38 U.S.C. 1151:

In order to support your claim for DIC under 38 U.S.C. 1151, the evidence must show:

- The deceased veteran died as a result of undergoing VA hospitalization, medical or surgical treatment, examination, or training; AND
- · The death was:
  - the direct result of VA fault such as carelessness, negligence, lack of proper skill, or error in judgment; OR
  - the direct result of an event that was not a reasonably expected result or complication of the VA care or treatment; OR
  - the direct result of participation in a VA Vocational Rehabilitation and Employment or compensated work therapy program

## Reopened DIC:

In order to reopen a claim previously denied by VA, we need new and material evidence. New and material evidence must raise a reasonable possibility of substantiating your claim. The evidence cannot simply be repetitive or cumulative of the evidence we had when we previously decided your claim. VA will make reasonable efforts to help you obtain currently existing evidence. However, we cannot provide a medical examination or obtain a medical opinion until your claim is successfully reopened.

- · To qualify as new, the evidence must currently exist and be submitted to VA for the first time
- In order to be considered material, the additional existing evidence must pertain to the reason your claim was previously denied

## **EVIDENCE TABLES (Continued)**

#### **Increased Survivor Benefits Based on Special Monthly Pension**

In order to support your claim for **increased survivor benefits based on the need for aid and attendance**, the evidence must show:

- you have corrected vision of 5/200 or less in both eyes; OR
- · you have concentric contraction of the visual field to 5 degrees; OR
- · you are a patient in a nursing home due to mental or physical incapacity; OR
- you require the aid of another person to perform personal functions required in everyday living, such as bathing, feeding, dressing yourself, attending to the wants of nature, adjusting prosthetic devices, or protecting yourself from the hazards of your daily environment (38 Code of Federal Regulations 3.352(a)); OR
- you are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment (38 Code of Federal Regulations 3.352(a)); OR

In order to support your claim for increased benefits based on being housebound, the evidence must show:

· you are substantially confined to your immediate premises because of permanent disability

## **Accrued Benefits:**

To support a claim for **accrued benefits**, the evidence must show:

- Benefits were due the veteran based on existing ratings, decisions, or evidence in VA's possession at the time of death, but the benefits were not paid before the veteran's death; **AND**
- · You are the surviving spouse, child, or dependent parent of the deceased veteran

VA pays accrued benefits in the following order of priority:

- 1. Spouse
- 2. Children of the veteran (in equal shares)
- 3. Dependent parents (in equal shares)

#### 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 recognizes marriages is available at <a href="http://www.va.gov/opa/marriage/">http://www.va.gov/opa/marriage/</a>.

## **HOW VA DETERMINES THE EFFECTIVE DATE**

If we grant a claim for Survivors benefits, the beginning date of your entitlement will generally be the date we received your claim. However, if VA receives your claim within one year after the date of the veteran's death, entitlement will be from the first day of the month in which the veteran died.

The veteran's death certificate is evidence relevant to determining the effective date of any benefits we award.

Special monthly pension may be available for a veteran's surviving spouse and/or parents who are unable to perform certain activities of daily living, are a patient in a nursing home, or are substantially confined to their immediate premises. Special monthly pension may be effective from the date medical evidence first shows entitlement.

For more information on the FDC Program, visit our web site at <a href="http://benefits.va.gov/transformation/fastclaims/">http://benefits.va.gov/transformation/fastclaims/</a>. For more information on VA benefits, visit our web site at <a href="https://iris.custhelp.va.gov">https://iris.custhelp.va.gov</a>, 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.

OMB Control No. 2900-0004 Respondent Burden: 25 minutes Expiration Date: 10/31/2021

M Department of Votorone Affairs			VA DATE STAMP			
Department of Veterans Affairs			(DO NOT WRITE IN THIS SPACE)			
APPLICATION FOR DIC, SU AND/OR ACCRUE		·N,	_			
IMPORTANT: Please read the Privacy Act and Respondent	IMPORTANT: Please read the Privacy Act and Respondent Burden on page 11 before completing the form.					
SECTION I: P	PERSONAL INFORMAT	ION (MUST COMPLET	<u> </u>   <u> </u>			
1. VETERAN'S NAME (First, Middle Initial, Last)						
2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S DATE OF BIR (MM,DD,YYYY)	ТН	4. VETERAN'S GENDER			
	Month Day	Year				
		-	MALE FEMALE			
5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PAREN EVER FILED A CLAIM WITH VA?	NT 6. VA FILE NUMBER		7. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?			
YES NO (If "Yes," provide the file number in Item 6	3)		YES NO			
8. VETERAN'S SERVICE NUMBER	9. WHAT IS THE VET	TERAN'S DATE OF DEATH	I? (MM,DD,YYYY)			
	Month E	Day Year				
	_	_				
10. WHAT IS YOUR NAME? (First, middle, last name)						
11. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check of	one)	12. WHAT IS YOUR S	SOCIAL SECURITY			
	,	NUMBER?	300M			
SURVIVING SPOUSE PARENT CHILD CL	USTODIAN FILING FOR CHILE		_			
13. WHAT IS YOUR DATE OF BIRTH? 14. ARE YOUND, YYYYY)	OU A VETERAN?					
Month Day Year						
<b>–</b> – ()	YES NO					
15A. WHAT IS YOUR ADDRESS?						
Street address, rural route, or P.O. Box						
And the it Normalises						
Apt./Unit Number City						
State/Province Country	ZIP Code/Postal Code		_			
15B. YOL	UR TELEPHONE NUMBER(S)	(include Area Code)				
DAYTIME	G	CELL F	PHONE			
16A. YOUR PREFERRED E-MAIL ADDRESS (If applicable)	16B. YO	OUR ALTERNATE E-MAIL	ADDRESS (If applicable)			
17. WHAT ARE YOU CLAIMING? (Check all that apply)						
O DEPENDENCY AND INDEMNITY COMPENSATION (DIC)	SURVIVORS PENSIC	ON ACCRUED BEN	IEFITS			
SECTION II: VETERAN'S SERVICE INFORMATION	ON (COMPLETE ONLY IF	THE VETERAN WAS N				
	ON BENEFITS AT THE TIN	ME OF DEATH)				
18A. DID THE VETERAN SERVE UNDER ANOTHER NAME?	belving v/v compensation of	porision bononto at and	sume of the or their deadily			
	"No," skip to Item 18C)					
18B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UP	NDER:					

18C. VETERAN ENTERED ACTIVE SERVI	CE ON (MM,DD,YYYY) 1	8D. BRANCH	OF SERVICE		ELEASE DA <sup>-</sup> //M,DD,YYY	TE FROM ACTIVE SERVICE	
Month Day Yea	r			Mont		Day Year	
					_	_	
18F. PLACE OF LAST SEPARATION							
TOT . PLACE OF EAST SEPARATION							
19A. WAS THE VETERAN ACTIVATED TO TITLE 10, U.S.C. (National Guard)?	FEDERAL ACTIVE DUTY UN	IDER AUTHOR	RITY OF	19B. DATE OF AC	TIVATION (N	MM,DD,YYYY)	
TITLE 10, 0.3.C. (National Guard):				Month	Day	Year	
YES NO (If "Yes," answer Iten	ns 19B 19C and 19D)			_	· _	_	
O 120 O 110 (iii 100, dilettol itell				400 WHAT IS TH	E TELEBUIO	NE NUMBER OF THE	
19C. WHAT IS THE NAME AND ADDRESS	OF THE VETERAN'S RESER'	VE/NATIONAL	. GUARD UNIT?	RESERVE/N	ATIONAL GI	NE NUMBER OF THE UARD UNIT?	
				(Include Area	Code)		
				_		_	
20A. WAS THE VETERAN EVER A PRISON	NER OF WAR?		20B. DATES OF (	CONFINEMENT			
			Month	Day	Year		
			FROM:				
O 1/2-							
YES NO (If "Yes," complete It	tem 20B) (If "No," skip to Sect	tion III)	TO:				
SECTION	III- MARITAL INFORMA	ATION (CO	MPLETE ONLY	IF CLAIMING E	ENEFITS	AS	
	THE SURVIV	ING SPOU	ISE OF THE VE	TERAN)			
(Skip to	Section IV if you are NOT	r claiming be	nefits as the surviv	ing spouse of the	veteran)		
TELL US ABOUT THE VETERAN'S M							
21A. HOW MANY TIMES WAS THE VETER	AN MARRIED (including marri	iage to you)?					
21B. DATE (month, day, year) and PLACE	21C. TO WHOM MARRIE		PE OF MARRIAGE	  21E. HOW MARRIA		. DATE (month, day, year) and	
OF MARRIAGE (city, state or country)	(first, middle, last name)	(cerem	onial, common-law, y, tribal, or other)	ENDED	PI PI	LACE MARRIAGE ENDED (city/state or country)	
		p. 5	,,	(death, divorce)		(engretate en ecunary)	
21G. IF YOU INDICATED "OTHER" AS TYP	F OF MARRIAGE IN ITEM 21	D DI FASE EX	/DI ΔINI·				
210. II TOO INDICATED OTHER ACTITI	2 OF MARKINAGE INTERNIZIO	D, I LLAGE LA	VI LAIIV.				
TELL US ABOUT YOUR MARRIAGE	<u> </u>						
22A. HAVE YOU REMARRIED SINCE THE I		22B. HC	OW MANY TIMES HA	AVE YOU BEEN MAR	RIED? (inclu	uding your marriage to the	
YES NO	SEATT OF THE VETEROUS.	veterar	1)		,		
0 120 0 No				005 1101// 1/4		LOOC DATE (th, d	
22C. DATE (month, day, year) and PLACE OF	22D. TO WHOM MARRIE		PE OF MARRIAGE onial, common-law,	22F. HOW MA ENDEI		22G. DATE (month, day, year) and PLACE	
MARRIAGE (city/state or country)	(first, middle, last name)		r, tribal, or other)	(death, divorce, has not en		MARRIAGE ENDED (city/state or country)	
				nas not en	ieu)	(City/state of Country)	
22H. IF YOU INDICATED "OTHER" AS TYP	E OF MARRIAGE IN ITEM 22	E, PLEASE EX	(PLAIN:			.1	
23. WAS A CHILD BORN TO YOU AND THE	VETERAN DURING YOUR N	MARRIAGE	24. ARE YOU EXP	ECTING THE BIRTH	OF THE VE	TERAN'S CHILD?	
OR PRIOR TO YOUR MARRIAGE?			O VEC	NO.			
YES NO				NO 			
25. DID YOU LIVE CONTINUOUSLY WITH T						REASON, DATE(S) AND	
DATE OF MARRIAGE TO THE DATE OF	HIO/FIER DEATH!		DURATION OF THE SEPARATION (IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)				
YES NO (If "No," complete I	tem 26)						

27. AT THE TIME OF YOUR MAR	RRIAGE TO THE VETER provide explanation):	RAN, WERE YOU AW	ARE OF ANY	REASON T	HE MARRIAGI	E MIGHT NOT BE	LEGALLY VA	LID?	
	ILD OF THE VETE ion V if you are NOT								N)
	28B. DATE (month, da	7/1 786. 5016.101			(C	heck all that app	oly)		
28A. NAME OF CHILD (First, middle initial, last name)	year) and PLACE OF BIRTH (city/state or country)	SECURITY	28D. BIOLOGICAL	28E. ADOPTED	28F. STEPCHILD	28G. 18-23 YEARS OLD (in school)	28H. SERIOUSLY DISABLED	28I. CHILD MARRIED	28J. CHILD PREVIOUSLY MARRIED
				0	0	0	0	0	0
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If claiming benefits as the survive with you.	viving spouse or cust				h 29D tell us	about the childre			
29A. NAME OF CHIL (First, middle initial, last i		29B. CHILD'S COMPI per and street or rural State, ZIP Code a	route, city or P			PERSON THE CH TH (If applicable)			MOUNT YOU THE CHILD'S RT
							\$		
							\$		
\$ SECTION V: VETERAN'S PARENT (COMPLETE ONLY IF CLAIMING BENEFITS AS THE PARENT OF VETERAN) (Skip to Section VI if you are NOT claiming benefits as the parent of a veteran)									
30A. WHAT IS YOUR MARITAL STATUS? (Check one)  MARRIED AND LIVE WITH MARRIED AND LIVE WITH SPOUSE WHO OTHER PARENT OF VETERAN IS NOT THE OTHER PARENT OF THE VETERAN  SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE DIVORCED WIDOWED									
NEVER MARRIED  30B. IF YOUR MARRIAGE HAS ENDED, PLEASE SPECIFY THE DATE (month, day, year) AND HOW MARRIAGE ENDED (death, divorce, etc.)									
30C. IF YOU ARE SEPARATED, WHAT WAS THE CAUSE OF THE SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION (IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)									
31A. WHAT IS YOUR SPOUSE'S NAME? (First, middle initial, last name) (Skip to Item 32A if never married or no longer married)  31B. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (MM,DD,YYYY)  31C. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?									
31D. IS YOUR SPOUSE ALSO A			31E. WHAT IS	YOUR SPO	USE'S VA FIL	E NUMBER? (If a	pplicable)	•	
	complete Item 31E)								
32A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL (If veteran did not live in your household continuously before age 18 provide the time period (dates) when he/she was under your parental control)									
YES NO (If "Yes," skip to Item 34) (MM DD YYYY) to (MM DD YYYY) to (MM DD YYYY) to (MM DD YYYY)							<u> </u>		
32C. WHY WASN'T THE VETERA AGE OF MAJORITY? (Expla		JR HOUSEHOLD OR	UNDER YOUR	( PAKEN I A	AL CONTROL /	AT ALL TIMES BE	FORE HE/SH	E REACHE	DIHE

AS ALME AND ADDRESS OF EACH DEDOCATION ASSUMED DADENTAL	CONTROL OVER THE VE	EDAN OUTSIDE THE DATE (O) SHOWN IN ITEM COD
33. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL	. CONTROL OVER THE VET	. ,
A. NAME (FIRST, MIDDLE, LAST)		B. ADDRESS
		DO D
	Street address, rural route	, or P.O. Box Apt. number
	City State ZIP	Code Country
		·
	Street address, rural route	, or P.O. Box Apt. number
	Oli eet address, fulai fodte	, or i.o. box Apt. humber
	O:t-	Onder Country
34. IF YOU ARE NOT THE BIOLOGICAL PARENT OF THE VETERAN. PROVIDE TI	<del>' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' </del>	Code Country  CICAL PARENTS IF DECEASED PROVIDE THE DATE(S)
OF DEATH.	TE TO THE BIOLOG	NOVE TAKENTO, IL BEGENGEB, TROVIDE THE BATE(O)
A. NAME (FIRST, MIDDLE, LAST)		B. DATE OF DEATH (MM,DD,YYYY)
SECTION VI: DIC (COMPLETE ONLY IF CLAIMING	DEPENDENCY AND IN	DEMNITY COMPENSATION (DIC))
(Skip to Section VII if	ou are <b>NOT</b> claiming DIC	
35. WHAT BENEFIT ARE YOU CLAIMING?		
DIC DIC under 38 U.S.C. 1151 (RARE)		
36. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED T	REATMENT PERTAINING T	O YOUR CLAIM AND PROVIDE TREATMENT DATES:
A. NAME AND LOCATION OF VA MEDICAL CENTER		B. DATE(S) OF TREATMENT
SECTION VII: NURSING HOME OR	NCREASED SURVIV	ORS ENTITLEMENT
37. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY D	DIC BECAUSE YOU NEED T	HE REGULAR ASSISTANCE OF ANOTHER PERSON,
HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YO		
(If "Yes," please complete and attach with this application, Attendance. Please make sure every box is complete and	VA Form 21-2680, Exam for I signed by a Physician, Physi	Housebound Status or Permanent Need for Regular Aid and cian Assistant (PA), Certified Nurse Practitioner (CNRP), or
YES NO Clinical Nurse Specialist (CNS).)		
38A. ARE YOU NOW IN A NURSING HOME?  (If "Ves." answer Items 38B and 38C. Also, submit a state.	ment from an official of the nu	rsing home that tells us that you are a patient in the nursing
YES NO NO No home because of a physical or mental disability. The state		
38B. WHAT IS THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILIT	Y?	
38C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS	?	
YES NO (If "No," complete Item 38D)		
38D. HAVE YOU APPLIED FOR MEDICAID?		
YES NO		
SECTION VIII: INCOME AND ASSETS (COMPLETE)	ONLY IF CLAIMING SUR	EVIVORS PENSION OR PARENTS DIC)
(Skip to Section XI if you are <b>NOT</b> claimin		
IMPORTANT:		
<ul> <li>If you are a surviving spouse claimant, you must report income and assets for y</li> </ul>	ourself and for any child of th	e 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), your	nust report income and assets for vourself, your custodies
and your custodian's spouse.	or a surviving spouse,, your	nust report income and assets for yoursell, your custodiall,
<ul> <li>If you are a surviving parent claimant, you must report income for yourself and y</li> </ul>	our spouse.	
39. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?		

YES NO (If "YES," complete Item 40) (If "NO," skip to Item 41)

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	40. GROSS M	ONTHLY INCO	<b>ME</b> (Attach a separa	ate sheet if r	necessary)		
	SOCIAL SE	CURITY REC	IPIENT			GROSS MO AMOUN	NTHLY NT
						\$	
						\$	
						\$	
						\$	
						\$	
41. DO YOU OWN YOUR PRIMARY F	RESIDENCE? (Parents	DIC claimants skip	to Item 43A)				
YES NO							
42A. WHAT IS THE SIZE OF THE LO		12B. COULD PART	OF YOUR LOT BE SOLD	WITHOUT SE	LLING YOUR RE	SIDENCE?	
PRIMARY RESIDENCE SITS? ( Square Feet:	(Square Feet)	YES N	O (If "YES," complete a	and attach VA F	Form, 21P-0969,	Income and Asset Sta	tement)
IMPORTANT: VA matches in receive on the	ncome information e appropriate secti	reported with F ons of this form	ederal tax information and VA Form 21P-0	on. Report A 1969, Incom	ALL income yo e and Asset S	ou and your depe Statement, if appr	ndents opriate.
43A. OTHER THAN SOCIAL SECUR RECEIVE ANY INCOME?	RITY, DO YOU OR YOU	IR DEPENDENTS	43B. OTHER THAN SO ANY INCOME LAS		TY, DID YOU OR	YOUR DEPENDENT	S RECEIVE
YES NO			YES NO				
43C. DO YOU OR YOUR DEPENDE do not include your primary resi							n. Assets
YES NO							
43D. IN THE THREE CALENDAR YE them away, selling them, purcha				ANSFER ANY	ASSETS? (Exan	nples of asset transfer	s include giving
YES NO	asing an annuity, or usin	g them to establish	a trust)				
43E. DID YOU ANSWER "YES," TO	ANY OF THE QUESTION	ONS IN ITEMS 43A	THRU 43D?				
YES NO (If "Yes," you	u <i>must</i> also complete V	'A Form 21P-0969,	Income and Asset Statem	ent)			
S	ECTION IX: INFO	RMATION ABO	OUT YOUR MEDICA	L OR OTH	ER EXPENSI	ES	
Family medical expenses and ce expenses, including the Medical members of your household. Als Last illness and burial expense rehabilitation expenses are amou were/will be reimbursed. Please Form 21P-8416, Medical Expens	re deduction, you pa so, show unreimburs is are unreimbursed unts you paid for cou make sure to comp	aid over the last ed last illness an amounts you pa urses of education	year (or expect to pay d burial expenses and iid for the last illness n including tuition, fees	and continu educational and burial of and materia	e indefinitely) for vocational referenced in or vocational referenced in for a spouse or als. Do not incli	for yourself or relat ehabilitation expens child. Educational ude any expenses	tives who are ses you paid. or vocational for which you
<b>IMPORTANT:</b> If you are claimir worksheet on pages 13 and 14.	ng expenses for in-h	nome care or ass	sisted living, adult day	care, or sim	nilar facility, yo	u must complete tl	ne applicable
44. ARE YOU CLAIMING UNREIMBU	JRSED MEDICAL EXPE	ENSES?					
YES NO (If "No," sk	kip to Section X)						
45A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	45B. PAIE (Name of provide company, nursing	r, insurance	45C.PURPOSE (Medicare premiur nursing home, etc	ns, $\frac{46}{6}$	5D. DATE PAID MM,DD,YYYY)	45E. HOURLY RATE/HOURS (In-home Provider only)	45F. AMOUNT YOU PAY
	1						1

CONTINUED						
45A. WHOSE MEDICAL, LEGAL, OR OTHER EXPENSES WERE PAID?	45B. PAID TO (Name of provider, insurance company, nursing home, etc.)	(M	45C.PURPOSE edicare premiums, ursing home, etc.)	45D. DATE PAID (MM,DD,YYYY)	45E. HOURLY RATE/HOURS (In-home Provider only)	45F. AMOUNT YOU PAY
	SECTION X: DIRECT DEF	OSIT INI	FORMATION (MUST	COMPLETE)		
attach a voided personal check have a bank account, you must apply at <a href="https://www.usdirectexpress.crequests">www.usdirectexpress.crequests</a> for the Department of you may have.	y requires all Federal benefit paymor deposit slip or provide the informate receive your payment through Direct on by telephone at 1-800-333-the Treasury at 1-888-224-2950. The	ents be ma ation reques Express D 1795. If yo aey will end	ade by electronic funds sted below in Items 46, Debit MasterCard. To re- ou elect not to enroll, y courage your participation	transfer (EFT), a 47, and 48 to enr quest a Direct Exp ou must contact on in EFT and ad	oll in direct deposit.  press Debit Master( representatives had dress any question	If you <b>do not</b> Card you must andling waiver
46. ACCOUNT NUMBER (Check the CHECKING	appropriate box and provide the account  SAVINGS	number, or	simply write "Established" i  I CERTIFY THAT I DO INSTITUTION OR CER	NOT HAVE AN ACC	OUNT WITH A FINAN	NCIAL
Account No.:	Account No.:		- INOTHIOTION ON CEN	THE LATIVICIAL A	CLIVI	
47. NAME OF FINANCIAL INSTITU where you want your direct depo	TION (Please provide the name of the ba sit)	nk	48. ROUTING OR TRANS at the bottom left of yo		irst nine numbers loca	ted

#### SECTION XI: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

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 except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.

I certify I have enclosed all 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 49, 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.

- 49. 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 box below **ONLY if you <u>DO NOT</u> want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.
- O I <u>DO NOT</u> want my claim considered for rapid processing under the FDC Program because I plan to submit further evidence in support of my claim.

50A. CLAIMANT'S SIGNATURE (REQUIRED)		50B. DATE SIGNED
SECTION XII: WITNESSES TO SIGNATURE (COMPL	ETE ONLY IF CLA	AIMANT SIGNED ITEM 50A WITH AN "X")
51A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	51B. PRINTED NAME AND ADDRESS OF WITNESS	
52A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	52B. PRINTED NAI	ME AND ADDRESS OF WITNESS
	1	

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or 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 <a href="https://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. 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 A 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 (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, <b>or</b> • supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.
<b>INSTRUCTIONS</b> : Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.
STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?  (If "NO," continue to Step 2)
YES NO (If "YES," all payments to the facility qualify as medical expenses in Items 45A thru 45F. 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 caregivers.
STEP 3. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?
YES NO (If "NO," skip to Step 6)
STEP 4. Did you claim special monthly pension or special monthly DIC in Item 37?
YES NO (If "NO," payments to this facility for meals and lodging <i>do not</i> qualify as medical expenses. <i>Only</i> claim amount you pay the facility for health care services or assistance with ADLs provided by a health care provider in Items 45A thru 45F. Skip to Step 8)
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)?
(If "YES," all payments to this facility <i>may</i> qualify as medical expenses in Items 45A thru 45F <i>if</i> VA rates you as eligible for special monthly pension or special monthly DIC. Please report the amount you pay the facility for lodging and meals separate from the amount you pay the facility for <i>health care services or assistance with ADLs provided by a health care provider</i> as medical expenses in Items 45A thru 45F. If NO," payments to this facility for meals and lodging <i>do not</i> qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay the facility for: (1) <i>health care services or assistance with ADLs provided by a health care provider</i> ; and (2) <i>custodial care</i> . Skip to Step 8)
<b>STEP 6.</b> Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?
(If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)
(If "NO," claim payments you pay this facility for <i>health care services or assistance with ADLs provided by a health care provider</i> in Items 45A thru 45F. Skip to Step 8)
<b>STEP 7.</b> If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the <i>primary reason</i> the disabled person lives in the facility (or attends day care in the facility)?
(If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)
YES NO (If "NO," <i>only</i> claim payments you pay the facility for assistance with <i>health care and/or assistance with custodial care</i> as medical expenses in Items 45A thru 45F. Payment to this facility for meals and lodging <i>do not</i> 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 ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and
reflects the current environment pertaining to
and his or her care at this facility
(Name and address of facility)
(Name, Signature and Title of Person Certifying for the Facility) (Date Certified)

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES
NOTE: Only complete this worksheet if you are claiming expenses for in-home care.
IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (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, <b>or</b> • supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder
<b>IMPORTANT</b> : The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally <i>does not</i> recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).
<b>INSTRUCTIONS</b> : Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.
Follow the steps below to determine whether or not:
<ul> <li>the attendant must be a health care provider for VA purposes and</li> <li>VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care</li> </ul>
STEP 1. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?
YES NO (If "NO," skip to Step 4)
STEP 2. Did you claim special monthly pension on Item 37?
YES NO (If "NO," payments to this in-home attendant for assistance with IADLs <b>do not</b> qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)
STEP 3. Is the <i>primary responsibility</i> of the in-home attendant to provide you with health care or custodial care?
(If "YES," payments to this in-home attendant <i>may</i> qualify as medical expenses in Items 45A thru 45F <i>if</i> VA rates you as eligible for special monthly pension. Please report separately in Items 45A thru 45F amounts you pay an in-home attendant for: (1) health-care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs, and (3) custodial care. Skip to Step 6) (If "NO," payments to this in-home attendant for assistance with IADLs <i>do not</i> qualify as medical expenses. Please report separately in
Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)
STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?
(If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)
(If "NO," the attendant <i>must be a health care provider</i> . Only report payments to the in-home attendant for <i>health care services or</i> assistance with ADLs provided by the health care provider as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs do not qualify as medical expenses. Skip to Step 6)
STEP 5. Is the <i>primary responsibility</i> of the in-home attendant to provide the disabled person with health care or custodial care?
YES NO (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 45A thru 45F)
(If "NO," report payments to this in-home attendant for <b>health care and/or custodial care</b> as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs <b>do not</b> qualify as medical expenses)
STEP 6. Check all activities below that the attendant assists the veteran or disabled person with:
ADLS: © EATING © BATHING/SHOWERING © DRESSING © TRANSFERRING © USING THE TOILET
IADLs: SHOPPING FOOD PREPARATION HOUSEKEEPING LAUNDERING MANAGING FINANCES HANDLING MEDICATIONS
USING THE TELEPHONE TRANSPORTANTION FOR NON-MEDICAL PURPOSES
STEP 7. In-Home Attendant Certification: Please submit a current breakdown 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-HOME ATTENDANT EXPENSES is accurate and
reflects the current environment pertaining to
and his or her care from
(Name of Attendant)
(Name, Signature and Title of Certifying Official) (Date Certified)