Cuyahoga County
Veterans Service Commission
Ph: 216.698.2600 • Fax: 216.698.2650
1849 Prospect Avenue • Suite 150 • Cleveland, OH 44115

WHAT IS VA PENSION?

Pension is a needs-based benefit paid to wartime Veterans, who meet certain age or non-service connected disability requirements.

WHO IS ELIGIBLE?
You may be eligible if:

You were discharged from service under other than dishonorable conditions, **AND**

You served 90 days or more of active military, naval or air service with at least 1 day during a period of war time*, **AND**

Your countable income is below the maximum annual pension rate, **AND**

You meet the net worth limitations - Total Net Worth + Annual Income – Prospective Annual Medical Expenses = Calculated net Worth, Not to Exceed $130,773. **AND**

You are age 65 or older, **OR** are shown by evidence to have a permanent and total non-service-connected disability, OR are a patient in a nursing home, OR are receiving Social Security disability benefits.

*Veterans who entered active duty after September 7, 1980, must also serve at least 24 months of active duty service. If the total length of service is less than 24 months, the Veteran must have completed his/her entire tour of active duty.

PENSION RATES EFFECTIVE 12-01-2020

If you are a....	Your yearly income must be less than.....	Monthly
VETERAN WITH 0 DEPENDENTS	$13,931.	$ 1,160.91
VETERAN WITH 1 DEPENDENT	$18,243.	$ 1.520.25
EACH ADDITIONAL DEPENDENT	$2,382	$ 198.50
VETERAN WITH 0 DEPENDENTS HOUSEBOUND	$17,024.	$ 1,418.66
VETERAN WITH 1 DEPENDENT HOUSEBOUND	$21,337.	$ 1,778.08
EACH ADDITIONAL DEPENDENT	$2,382.	$ 198.50
VETERAN WITH 0 DEPENDENTS A&A	$23,238.	$ 1,936.50
VETERAN WITH 1 DEPENDENT A&A	$27,549.	$ 2,295.75
EACH ADDITIONAL DEPENDENT	$2,382.	$ 198.50
TWO VETS MARRIED TO EACH OTHER	$18,243.	$1,520.25

***To be deducted, medical expenses must exceed 5% of MAPR**
Current Medicare Deduction is: $148.50

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WHAT IS SURVIVORS PENSION?

Survivors pension is a needs-based benefit paid to surviving spouses and children of wartime Veterans, who meet certain age, disability, and marriage requirements.

WHO IS ELIGIBLE?

You may be eligible if:

the deceased Veteran was discharged from service under other than dishonorable conditions, AND

he or she served 90 days or more of active military, naval or air service with at least 1 day during a period of war*, AND

you are the unmarried surviving spouse (or previously married and the marriage was terminated prior to November 1, 1990); OR

you are the unmarried child of the deceased Veteran who is under 18, who became permanently helpless before 18, or is between 18 and 23 and pursuing a course of instruction at an approved educational institution, AND

your countable income is below the maximum annual pension rate, AND

you meet the net worth limitations - Total Net Worth + Annual Income – Prospective Annual Medical Expenses = Calculated net Worth, Not to Exceed $130,773. AND

*If the deceased Veteran entered active duty after September 7, 1980, he or she must have served at least 24 months of active duty service. If the total length of service is less than 24 months, the Veteran must have completed his/her entire tour of active duty.

WIDOW'S / WIDOWER'S PENSION EFFECTIVE 12-01-2020

SURVIVING SPOUSE	$9,344.	$778.66
SURVIVING SPOUSE WITH 1 CHILD	$12,229.	$1,019.08
EACH ADDITIONAL CHILD	$2,382.	$198.50
SURVIVING SPOUSE HOUSEBOUND	$11,420.	$951.66
SURVIVING SPOUSE HOUSEBOUND WITH 1 CHILD	$14,300.	$1,191.66
EACH ADDITIONAL CHILD	$2,382.	$198.50
SURVIVING SPOUSE A&A	$14,934.	$1,244.50
SURVIVING SPOUSE A&A WITH 1 CHILD	$17,815.	$1,484.58
EACH ADDITIONAL CHILD	$2,382.	$198.50

***To be deducted, medical expenses must exceed 5% of MAPR**
Current Medicare Deduction is: $148.50

Cuyahoga County
Veterans Service Commission

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1849 Prospect Avenue • Suite 150 • Cleveland, OH 44115

CHECKLIST

Thank you for contacting the Cuyahoga County Veterans Service Commission. Please bring with you the items checked below so your claim can be processed completely and efficiently.

- ❑ Military Discharge Document - DD214 or WD AGO (Original if available)
- ❑ Marriage License and information on all prior marriages (divorce decrees, annulments etc.)
- ❑ Death Certificate of Veteran (Widows Pension only)
- ❑ Spouse and dependents social security numbers and dates of birth: Include birth certificates for children under the age of 18 and 18-23 yrs old that are full time students.
- ❑ Provide verification of all monthly household income for veteran, spouse, and dependent's including income from employment, retirement pension, Social Security, financial annuities, rental income, etc.
- ❑ Proof of net worth from all assets to include: financial statements such as checking/saving accounts along with interest earned on all assets. Documentation of any transfer of assets within the last three years.
- ❑ Assisted Living/ Nursing Home Letter (Aid and Attendance)
  - To include date veteran/widow became a resident/patient and cost of care. Indicate whether or not cost is covered by Medicaid and if facility provides assistance with Activities of Daily Living (ADLs).
- ❑ All non-reimbursable monthly medical payments such as assisted living, nursing home, medical insurance premiums, prescriptions, and doctor co-pays for veteran and spouse.
- ❑ Final paid expenses of the Veteran including funeral and medical bills. (Widows pension)
- ❑ VA Form 21-2680 Request for Aid and Attendance
- ❑ Worksheet for an Assisted Living, Adult Day Care, or a Similar Facility
- ❑ Worksheet for In-Home attendant Expenses
- ❑ Direct Deposit Information (ex. voided check)

Please bring these documents with you when you come in for assistance.

REMEMBER APPLYING FOR VA BENEFITS IS ALWAYS FREE

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 09-30-2021

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN/BENEFICARY NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM/DD/YYYY)*
Month Day Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. GENDER
☐ MALE ☐ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*

8. PREFERRED E-MAIL ADDRESS *(Optional)*

9. PREFERRED MAILING ADDRESS (*Number and street or rural route, P. O. Box, City, State, ZIP Code and Country*)

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

SECTION II: CLAIM INFORMATION

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

11. CLAIMANT'S SOCIAL SECURITY NUMBER

12. RELATIONSHIP OF CLAIMANT TO VETERAN

13. BENEFIT YOU ARE APPLYING FOR (*Choose One*)

☐ **Special Monthly Compensation (SMC)** - Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid without eligibility to compensation.

☐ **Special Monthly Pension (SMP)** - Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

SECTION III: INFORMATION OF EXAMINATION

14. DATE OF EXAMINATION

15. HOME ADDRESS

16A. IS CLAIMANT HOSPITALIZED?
☐ YES ☐ NO *(If "Yes," complete Items 16B and 16C)*

16B. DATE ADMITTED

16C. NAME AND ADDRESS OF HOSPITAL

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

17. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 25 through 39)*

18A. AGE	18B. WEIGHT	18C. HEIGHT
	ACTUAL: LBS. ESTIMATED: LBS.	FEET: INCHES:

19. NUTRITION	20. GAIT

21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*

☐ YES ☐ NO

27. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

29A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	29B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*

☐ YES ☐ NO

31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? *(If "No," provide examples and rationale to support your conclusion.)*

☐ YES ☐ NO

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

33. POSTURE AND GENERAL APPEARANCE *(Attach a separate sheet of paper if additional space is needed)*

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE *(Attach a separate sheet of paper if additional space is needed)*

35. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

36. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

37. SET FORTH ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE, SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

38. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

39. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? *(If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)*

☐ YES
☐ NO

(If "YES," give distance) (Check applicable box or specify distance)

☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

40A. PRINTED NAME OF EXAMINING PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED

41A. NAME AND ADDRESS OF MEDICAL FACILITY	41B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

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 38, code of Federal Regulations 1.576 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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). 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.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 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 pate at **http://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 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, ***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 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?

☐ YES ☐ NO (If "NO," continue to Step 2)

(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.

☐ YES ☐ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

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 ***do not*** qualify as medical expenses. ***Only*** 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 ***primary reason*** you live in the facility (or attend day care in the facility)?

☐ YES ☐ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** 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 ***health care services or assistance with ADLs provided by a health care provider*** as medical expenses in Items 45A thru 45F. Skip to Step 8)
(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay the facility for: (1) ***health care services or assistance with ADLs provided by a health care provider***; and (2) ***custodial care***. Skip to Step 8)

STEP 6. 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?

☐ YES ☐ NO (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 disabilty)
(If "NO," claim payments you pay this 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 7. 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 ***primary reason*** the disabled person lives in the facility (or attends day care in the facility)?

☐ YES ☐ NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)
(If "NO," ***only*** claim payments you pay the facility for assistance with ***health care and/or assistance with custodial care*** as medical expenses in Items 45A thru 45F. Payment to this facility for meals and lodging ***do 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 ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to _____
(Name of person staying at your facility)
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)

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 02/29/2020

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

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

INSTRUCTIONS: If you have any questions about completing this form, call VA toll-free at 1-800-827-1000 (Hearing Impaired TDD federal relay number is 711).

Section I - VETERAN/CLAIMANT'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing the form.

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

2. VETERAN/CLAIMANT'S SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
Month — Day — Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II - NURSING HOME INFORMATION

6. NAME OF NURSING HOME

7. 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 III - GENERAL INFORMATION *(To be completed by a Nursing Home Official)*

8. DATE ADMITTED TO NURSING HOME *(MM/DD/YYYY)*
Month — Day — Year

9. IS THE NURSING HOME FACILITY MEDICAID OR EQUIVALENT APPROVED?
☐ YES ☐ NO

10. HAS THE PATIENT APPLIED FOR MEDICAID?
☐ YES ☐ NO

11A. IS THE PATIENT COVERED BY MEDICAID OR EQUIVALENT PLAN?
☐ YES ☐ NO *(If "YES," complete Item 11B)*

11B. DATE MEDICAID OR EQUIVALENT PLAN BEGAN
Month — Day — Year

12. MONTHLY AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET
$

13. 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

14. NURSING HOME OFFICIAL'S NAME *(First and Last) (Please print)*

15. NURSING HOME OFFICIAL'S TITLE *(Please print)*

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

SECTION IV - DECLARATION OF INTENT

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

17. SIGNATURE OF NURSING HOME OFFICIAL *(Sign in ink)*

18. DATE SIGNED *(MM,DD,YYYY)*

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 Vocational Rehabilitation 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: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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 you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** 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).

INSTRUCTIONS: 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:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care

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 ***do not*** 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 ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

☐ YES ☐ NO (If "YES," payments to this in-home attendant ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** 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 ***do not*** 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?

☐ YES ☐ NO (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 ***must be a health care provider***. Only report payments to the in-home attendant for ***health care services or 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 ***primary responsibility*** 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 ***health care and/or custodial care*** as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs ***do not*** 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 _____ (Name of Person Requiring Care)

and his or her care from _____ (Name of Attendant)

_____ (Name, Signature and Title of Certifying Official) _____ (Date Certified)

ATTENDANT AFFIDAVIT

Re: _____
Veteran's Name – Last, First, Middle

_____
VA Claim or Social Security Number

_____
Claimant's Name

_____
Claimant's Address (Street)

_____
City, State and Zip Code

My name is _____, and I provide health care for the above named claimant.

The services which I provide are:

☐	Yes	☐	No	Assistance with bathing
☐	Yes	☐	No	Standing and sitting
☐	Yes	☐	No	Getting in and out of bed
☐	Yes	☐	No	Eating
☐	Yes	☐	No	Walking
☐	Yes	☐	No	Dressing and undressing
☐	Yes	☐	No	Taking medication

☐ Other: (Please describe)

_____

_____

_____

For these services, I am paid by the claimant _____ per week / month / year (please circle only one).

I began employment on _____.

_____
Signature of provider

_____
Street Address

_____
City, State, and Zip Code

_____
Phone number (including area code)

I CERTIFY, under the penalty of law, that the above information is true and correct, that I do pay the above referenced sitter the amount listed for the services listed. (If claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____