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

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 $150,538. 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 12-01-2022

SURVIVING SPOUSE	$10,757.	$896.41
SURVIVING SPOUSE WITH 1 CHILD	$14,078.	$1,173.16
EACH ADDITIONAL CHILD	$2,743.	$228.58
SURVIVING SPOUSE HOUSEBOUND	$13,147.	$1,095.58
SURVIVING SPOUSE HOUSEBOUND WITH 1 CHILD	$16,462.	$1,371.83
EACH ADDITIONAL CHILD	$2,743.	$228.58
SURVIVING SPOUSE A&A	$17,192.	$1,432.66
SURVIVING SPOUSE A&A WITH 1 CHILD	$20,509.	$1,709.08
EACH ADDITIONAL CHILD	$2,743.	$228.58

***To be deducted, medical expenses must exceed 5% of MAPR**
Current Medicare Deduction is: $164.90

Cuyahoga County
Veterans Service Commission
Ph: 216.698.2600 • Fax: 216.698.2650
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 years 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)
- VA Form 21-0779 and Invoice
- 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 continuing monthly medical payments such as assisted living, nursing home, medical insurance premiums 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
□ VA Worksheet for an Assisted Living, Adult Day Care, or a Similar Facility
□ VA 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

IMPORTANT: Please read Privacy Act and Respondent Burden information before completing the form.

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'S NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM-DD-YYYY)* — —

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

6. SEX
- ◯ MALE
- ◯ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)* — —

8. 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) (Complete only if you are not the veteran)

11. CLAIMANT'S SOCIAL SECURITY NUMBER — —

12. RELATIONSHIP OF CLAIMANT TO VETERAN
◯ SPOUSE ◯ SELF

13. CLAIMANT'S HOME ADDRESS

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

14. 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

15. DATE OF EXAMINATION *(MM-DD-YYYY)* — —

16A. IS CLAIMANT HOSPITALIZED?
◯ YES ◯ NO *(If "Yes," complete Items 16B, 17A & 17B)*

16B. DATE ADMITTED *(MM-DD-YYYY)* — —

17A. NAME OF HOSPITAL

17B. 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.

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

18A. AGE

18B. WEIGHT

ACTUAL LBS. ESTIMATED LBS.

18C. HEIGHT

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? (Fill in Circle. If "No," provide explanation)

◯ YES ◯ NO

27. IS CLAIMANT ABLE TO PREPARE THEIR OWN MEALS? (Fill in Circle. 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)

◯ YES ◯ NO

29B. CORRECTED VISION

LEFT EYE

RIGHT EYE

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

34. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE 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 REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREEMITY.

36. DESCRIBE RESTRICTION OF 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 38 above)

◯ YES ◯ NO (If "YES," give distance) (Check applicable box or specify distance) ◯ 1 BLOCK ◯ 5 OR 6 BLOCKS ◯ 1 MILE OTHER (Specify distance) ____

SECTION IV: CERTIFICATION AND SIGNATURE

40A. PRINTED NAME OF PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED *(MM-DD-YYYY)*
		__ - __ - ____

41. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	42A. TELEPHONE NUMBER OF MEDICAL FACILITY
	___ - ___ - ____

42B. NAME OF MEDICAL FACILITY	42C. ADDESS OF MEDICAL FACILITY

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 Veteran Readiness 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.

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

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 08/31/2023

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: Before completing this form, read the Privacy Act and Respondent Burden. We use this form to determine eligibility in connection with a claim for aid and attendance. For more information, contact us at https://iris.custhelp.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

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

2. SOCIAL SECURITY NUMBER — – —

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)* — – —

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

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

6. SOCIAL SECURITY NUMBER — – —

7. VA FILE NUMBER *(If applicable)*

8. DATE OF BIRTH *(MM/DD/YYYY)* — – —

SECTION III - NURSING HOME INFORMATION

9. NAME OF NURSING HOME

10. ADDRESS OF NURSING HOME *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code —

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

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

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

12. IS THE NURSING HOME A MEDICAID APPROVED FACILITY? ○ YES ○ NO

13. HAS THE PATIENT APPLIED FOR MEDICAID? ○ YES ○ NO

14A. IS THE PATIENT COVERED BY MEDICAID? ○ YES ○ NO *(If "YES," complete Item 14B)*

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

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

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

○ SKILLED NURSING CARE ○ INTERMEDIATE NURSING CARE

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

18. NURSING HOME OFFICIAL'S TITLE

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

Enter International Phone Number *(If applicable)*

SECTION V - CERTIFICATION AND SIGNATURE

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

20. SIGNATURE OF NURSING HOME OFFICIAL *(REQUIRED)*

21. DATE SIGNED *(MM/DD/YYYY)* — – —

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

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

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

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

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WESITE ADDRESS?

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

- ○ A. EATING
- ○ B. BATHING/SHOWERING
- ○ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
- ○ D. DRESSING
- ○ E. USING THE TOILET
- ○ F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT BELOW PLEASE CHECK THE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:

- ○ THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
- ○ THE FACILITY IS LICENSED
- ○ THE FACILITY IS RESIDENTIAL
- ○ THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

- ○ YES
- ○ NO, Care is being provided by a third-party provider.
- ○ NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY)

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

○ INDEFINITE

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

$ PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)

15. DATE SIGNED (MM/DD/YYYY)

ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITIES
CARE PROVIDER CERTIFICATION OF SERVICES

Section I - Claimant Information

1a. Name of Veteran	1b. Veteran's Claim Number or Social Security Number
2a. Claimant's Name *(if not the Veteran)*	2b. Claimant's Social Security Number *(if not the Veteran)*

SECTIONS II - IV MUST BE COMPLETED BY FACILITY

Section II - Care Service Information

1a. Name of Facility	1b. Complete Address
1c. Telephone Number	

2. Type of Service Offered
- ☐ Assisted Living
- ☐ Adult Day Care
- ☐ Nursing Home
- ☐ Adult Foster Care
- ☐ Residential Care Facility
- ☐ Independent Living

3. The facility licensed by State of Ohio.
- ☐ Yes
- ☐ No
- ☐ Not Applicable

Section III - Care Information

1. Services Provided *(mark all that apply)*

Activities of Daily Living (ADL)		Instrumental Activities of Daily Living (IADL)	
☐ Transferring	☐ Bathing/Showering	☐ Handling Medications	☐ Shopping
☐ Dressing	☐ Toileting	☐ Managing Finances	☐ Food Preparation
☐ Feeding		☐ Using the Telephone	☐ Housekeeping
☐ Ambulating within home/living area		☐ Laundering	☐ Non-Medical Transportation

2. Care Provider anticipates the need for ADLS, IADLS, and care services will continue month-to-month. ☐ Yes ☐ No

3. Care Provider provides a "protected environment" for the care recipient. ☐ Yes ☐ No

4. Date Services Began or Admitted to Facility _____
(Month, Day, Year)

PLEASE COMPLETE THE APPROPRIATE SECTION BELOW FOR THE TYPE OF CARE SERVICES PROVIDED

24 Hour Permanent Resident *(Complete Below)*

Monthly Charges: Lodging $ _____ ADLs/IADLs $ _____ Meals $ _____

Facilty is staffed 24-hours a day with care givers. ☐ Yes ☐ No

NOTE: Attach copy of itmemized billing of monthly charges as documented by at least one month's paid services on an invoice indicated as "paid".

Assistance During the Day at a Facility *(Complete Below)*

Care Services: Number of Hours Per Day _____ Number of Days Per Week _____

Monthly Charges: Custodial Care $ _____ ADLs/IADLs $ _____ Meals $ _____

***Custodial Care** is regular assistance with two or more ADLs or supervision because of a person with a mental disorder is unsafe if left alone due to the mental disorder.

NOTE: Attach copy of itemized billing of monthly charges as documented by at least one month's paid services on an invoice indicated as "paid".

Section IV- Certification

We certify that the above-information is true and correct to the best of our knowledge and the care recipient is receiving the above-indicated services because of physical and/or mental disability.

1a. Certifying Official Name/Title	1b. Certifying Official's Telephone Number
2a. Signature of Certifying Official	2b. Date Signed
3a. Signature of Care Recipient (Claimant)	3b. Date Signed

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency Administrator, Provider)

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)

○ YES ○ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

○ YES ○ NO (If "NO," skip to question 7)

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

6. WHAT IS THE AGENCY TELEPHONE NUMBER?

– –

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.

○ A. EATING ○ B. BATHING/SHOWERING ○ C. TRANSFERRING IN OR OUT OF BED OR CHAIR

○ D. DRESSING ○ E. USING THE TOILET ○ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

○ A. SHOPPING ○ B. FOOD PREPARATION ○ C. NON-MEDICAL TRANSPORTATION

○ D. LAUNDERING ○ E. USING TELEPHONE ○ F. MANAGING FINANCES

○ G. HOUSEKEEPING ○ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

○ YES ○ NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. (MM/DD/YYYY)

/ /

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

/ / ○ INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

$. PER HOUR

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

HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)

/ /

IN-HOME ATTENDANT
CARE PROVIDER CERTIFICATIONS OF SERVICES

Section I - Claimant Information

1a. Name of Veteran	1b. Veteran's Claim Number or Social Security Number
2a. Claimant's Name *(if not the Veteran)*	2b. Claimant's Social Security Number *(if not the Veteran)*

SECTIONS II - IV MUST BE COMPLETED BY CARE PROVIDER

Section II - Care Service Information

1a. Name of Care Services Provider	1b. Complete Address of Care Services Provider
1c. Telephone Number	

2. Type of Service Offered ☐ Private In-Home Attendant ☐ Professional Home Care Company

Section III - Care Information

1. Services Provided *(mark all that apply)*

Activities of Daily Living (ADL)		Instrumental Activities of Daily Living (IADL)	
☐ Transferring	☐ Bathing/Showering	☐ Handling Medications	☐ **Shopping**
☐ Dressing	☐ Toileting	☐ Managing Finances	☐ Food Preparation
☐ Feeding		☐ Using the Telephone	☐ Housekeeping
☐ Ambulating within home/living area		☐ Laundering	☐ Non-Medical Transportation

2. Care Provider anticipates the need for ADLS, IADLS, and care services will continue month-to-month. ☐ Yes ☐ No

3. Care Provider provides a "protected environment" for the care recipient. ☐ Yes ☐ No

4. Date Services Began _____
(Month, Day, Year)

5. Breakdown of Assistance	ADLs	IADLs	Custodial Care
Number of Hours Per Day			
Number of Days Per Week			
Hourly Rate			

****Custodial Care*** is regular assistance with two or more ADLs or supervision because of a person with a mental disorder is unsafe if left alone due to the mental disorder.

Section IV- Certification

We certify that the above-information is true and correct to the best of our knowledge and the care recipient is receiving the above-indicated services because of physical and/or mental disability.

1a. Certifying Official Name/Title or Care Provider	1b. Certifying Official/Care Provider's Telephone Number
2a. Signature of Certifying Official/Care Provder	2b. Date Signed
3a. Signature of Care Recipient (Claimant)	3b. Date Signed