FINANCIAL ASSISTANCE FOR AID & ATTENDANCE VA PENSION

Eligibility Requirements:

- The Veteran must have served 90 days or more of active service, with at least **one day** during a period of war, or be the unremarried spouse of a qualifying veteran.
- Discharge must have been **other than dishonorable.** Disability cannot be due to willful misconduct such as alcoholism or drug abuse.
- Assets must total less than $80K within a year period, not including the home or one automobile. This does include IRA's, Mutual Market Accounts, real property, savings, and insurance policies.
- Monthly income must meet allowances set by the Department of Veterans Affairs after all medical costs are deducted. Tables can be found at www.va.gov. Go to Benefits, then Compensation and Pension, then select Rate Tables.
- Veteran/Surviving Spouse must be so disabled that they require medical assistance on a daily basis: assistance with sitting/standing/walking/bathing, medication management, etc.

Documents and information needed for the appointment:

1. **Discharge papers** from active service showing character of discharge. (DD214 or Discharge Certificate)
2. **VA Form 21-2680**—Physician fills out, not the claimant/family member.
3. If the claimant is in Assisted Living or a Nursing Home, give **VA Form 21-0779** to the facility to fill out. Veteran must be under contract if not moved in.
4. **Marriage Certificate** for the filing Spouse only.
5. **Income data:** Social Security statements, bank statements, statements showing annuities and other financial assets.
6. **Medical costs:** Estimated over-the-counter needs per month, co-pay amounts per month, etc.
7. **If claimant is the surviving Spouse,** bring the long-form death certificate of the Veteran.
8. **POA paperwork** if anyone other than the claimant is filing the paperwork.

***When packet is complete and all documents are ready, please call 352-754-4033 to schedule your appointment.**

Appointment date and time: ______________________________

OMB Control No. 2900-0721
Respondent Burden: 30 minutes

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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT *(If other than veteran)*	3. RELATIONSHIP OF CLAIMANT TO VETERAN

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER

6. DATE OF EXAMINATION	7. HOME ADDRESS

8A. IS CLAIMANT HOSPITALIZED?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*		

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.

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

11A. AGE	11B. SEX	12. WEIGHT ACTUAL: LBS. ESTIMATED: LBS.	13. HEIGHT FEET: INCHES:

14. NUTRITION	15. GAIT

16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

20. 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:

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

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "Yes," provide explanation)*
☐ YES ☐ NO

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*
☐ YES ☐ NO

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*
☐ YES ☐ NO

26. DOES CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*
☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*
☐ YES ☐ NO

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

29. 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)*

30. 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.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

32. 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.

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

34. 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)* ________________

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. 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 Records - VA, and 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. 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 of the SSN 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 page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Approved No: 2900-0652
RESPONDENT BURDEN: 10 Minutes

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

VA DATE STAMP
(Do Not Write In This Space)

INSTRUCTIONS: For free help in completing this form, call VA toll-free at 1-800-827-1000. (Hearing Impaired TDD line 1-800-829-4833.)

Section I - IDENTIFICATION INFORMATION

1A. NAME OF NURSING HOME	1B. ADDRESS OF NURSING HOME

2. ADDRESS OF VA REGIONAL OFFICE

3. FIRST NAME - MIDDLE INITIAL- LAST NAME OF CLAIMANT

4. SOCIAL SECURITY NUMBER	5. VA FILE NUMBER

SECTION II - NURSING HOME INFORMATION *(To be completed by a Nursing Home Official)*

6. DATE ADMITTED TO NURSING HOME *(Month, Day, Year)*	7. DATE MEDICAID BEGAN *(Month, Day, Year)*

8. AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET

$

9. 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

10. NURSING HOME OFFICIAL'S NAME *(First & Last) (Please print)*

11. NURSING HOME OFFICIAL'S TITLE *(Please print)*	12. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)*
13A. SIGNATURE OF NURSING HOME OFFICIAL	13B. DATE SIGNED

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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

TO BE COMPLETED BY THE ALF

LEVEL of Care and Cost of Care Statement

Information is requested for the purpose of determining the level of medical care needed by the Veteran/Beneficiary. The cost of that care is used by the VA to determine if expenses are allowed for maximum VA Benefits.

______________________, ______________, ___ ______________

Last Name (Veteran) First M.I. SSAN

______________________, ______________, ___ ______________

Last Name (Claimant) First M.I. SSAN

Relationship to Veteran: ____________

Date of Admission: ______________ VA Claim No: ______________

Level of Care: (Check/X One)

☐ **Level 1:** Room and Board (Independent Living)

☐ **Level 2:** Medical Assistance (Assisted Living: bathing, incontinence, medications, etc)

☐ **Level 3:** Nursing Care (Nursing Home)

Explanation of level of care/medical needs if other than Level 1: ____________

____

____

COST: (circle one)

Basic Charges (Room & Board): $______________ per day/month

Other Charges (Medical) $______________ per day/month

It is important to break down residence and medical costs; the VA will only use medical expenses to adjust the claimant's income base. This is critical to list.

Name of Facility: ____

Address: ____

State: _____ Zip Code: ___________ Phone #: ________________

Administrator's Name (**Print**): ___________________________________

Administrator's Signature: _________________________ Date: __________

ATTENDANT AFFIDAVIT CONCERNING IN-HOME HEALTH CARE SERVICE

____
Veterans Name: Last, First, Middle

____
VA Claim or Social Security Number

____
Claimant Name if other than veteran

____
Claimants Address (street)

____
Claimants

This is a statement of medical services that I, ____________________, provide for the above named claimant.

The services that I provide are:

- ☐ Yes ☐ No Medication Management
- ☐ Yes ☐ No Assistance with bathing
- ☐ Yes ☐ No Standing/ sitting/ walking
- ☐ Other (please describe):
- ☐ Yes ☐ No Dressing and undressing
- ☐ Yes ☐ No Getting in and out of bed
- ☐ Yes ☐ No Eating

____

____

I charge _________________, $________ per (hour/day/week/month) and I provide these services a minimum of_____day(s) per month, normally _____ hours per day. I charge him/her for these services due to his/her inabilityto drive and care for his/herself. I began providing these services on_______________(date).

Are you a licensed Health Care Professional? **Yes** or **No** (please circle one)

If yes, what is your title or certification? ______________________________________

I certify that the above is true and correct to the best of my knowledge and belief.

X________________________________(Signature of Provider)

_________________________________(Print Name)

_________________________________(Address of Provider)

________________________________(Phone Number of Provider)