

Veteran Pension, Housebound and Aid & Attendance

****This sheet is meant to be used as a checklist, ensuring you have all necessary documentation needed to complete the process successfully****

- Discharge indicating wartime service (DD Form 214 or equivalent).
- Death Certificate if applicable
- Marriage and divorce history, to include dates and places of marriage and divorce.
- Social Security numbers
- Gross monthly household income information with supporting documents. Include dividends, interest, retirement income, social security award letters
- Net worth documentation for all liquid assets -- include most recent checking and savings account statements, retirement account statements, and documentation for stocks, bonds, CDs
- NOTE: 2019 calculated net worth annual limit is \$127,061. Calculated net worth = Net worth plus income minus annual medical expenses.
- NOTE: Primary residences on lots greater than 2 acres will require an assessment of worth of property in excess of 2 acres. Bring the tax assessment document from York County Tax Assessor's office from the previous tax year.
- Information and supporting documents for recurring medical expenses, to include medical insurance.
- Banking information for direct deposit (voided check)
- Medical Examination: If the veteran is in need of daily aid and attendance or is housebound, **VA FORM 21-2680** is completed by a medical authority (attached).
- If the veteran is in a nursing home or personal care facility, a **Worksheet for an Assisted Living, Adult Day Care or Similar Facility** (attached). Please bring documentation of recurring cost for care.
- If the veteran or spouse is receiving in-home care, a **Worksheet for In-Home Care Expenses** is needed (attached). Please bring documentation of recurring cost for care. If the in home attendant is not a licensed health care provider, provide a **Verification of Need of In-Home Attendant Letter** signed by a medical authority (sample attached).

All VA Forms can be found at http://www.va.gov/vaforms/search_action.asp

Any questions or need an appointment? Call 771-9218 or email yorkvet@yorkcountypa.gov

County of York Veterans Affairs
28 East Market Street
York PA 17401
(The Old Courthouse)

Information current as of 12/6/2018

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (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 30A -30F. You are finished completing this worksheet)

STEP 2. Do all of the following apply to the facility?

- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with 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 veteran) the disabled person ?

- YES NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension on Page 5, Item 14A of the attached form?

- YES NO (If "NO," payments to this facility for meals and lodging do not qualify as medical expenses. Only claim amounts you pay the facility for health care services or assistance with ADLs provided by a health care provider in Items 30A -30F. 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 if VA rates you as eligible for special monthly pension. Please report separately in Items 30A - 30F applicable amounts you pay the facility for (1) lodging and meals, (2) health care services or assistance with ADLs provided by a health care provider, and (3) 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 disability)
(If "NO," claim payments you pay this facility for **health care services or assistance with ADLs provided by a health care provider** in Items 30A - 30F. 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 30A -30F) (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 30A -30F. 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 facility)

and his or her care at this facility

(Name and address of facility)

(Name, Signature and Title of Person Certifying for the Facility)

12-10-2018
(Date Certified)

 <b style="font-size: 1.2em; margin-left: 10px;">Department of Veterans Affairs	VA DATE STAMP DO NOT WRITE IN THIS SPACE
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**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 <i>(First, Middle Initial, Last)</i>			
2. SOCIAL SECURITY NUMBER - -	3. VA FILE NUMBER <i>(If applicable)</i>	4. DATE OF BIRTH <i>(MM/DD/YYYY)</i> Month Day Year - -	
5. VETERAN'S SERVICE NUMBER <i>(If applicable)</i>		6. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
7. TELEPHONE NUMBER <i>(Include Area Code)</i>		8. PREFERRED E-MAIL ADDRESS <i>(Optional)</i>	
9. PREFERRED MAILING ADDRESS <i>(Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)</i> No. & Street Apt./Unit Number City State/Province Country ZIP Code/Postal Code -			

SECTION II: CLAIM INFORMATION

10. CLAIMANT'S NAME <i>(First, Middle Initial, Last)</i>	11. CLAIMANT'S SOCIAL SECURITY NUMBER - -	12. RELATIONSHIP OF CLAIMANT TO VETERAN
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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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Items 16B and 16C)</i>	16B. DATE ADMITTED	16C. NAME AND ADDRESS OF HOSPITAL	

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 ACTUAL: LBS. ESTIMATED: LBS.	18C. HEIGHT FEET: INCHES:
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19. NUTRITION	20. GAIT
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21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?
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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? <i>(If "Yes," provide explanation)</i>	29B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
<input type="checkbox"/> YES <input type="checkbox"/> 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

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 CONTRACTURES OR 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 *(If "YES," give distance) (Check applicable box or specify distance)*
 1 BLOCK
 5 or 6 BLOCKS
 1 MILE
 OTHER *(Specify distance)* _____

NO

40A. PRINTED NAME OF EXAMINING PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED
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41A. NAME AND ADDRESS OF MEDICAL FACILITY	41B. TELEPHONE NUMBER OF MEDICAL FACILITY <i>(Include Area Code)</i>
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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(e) 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 <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.