SOUTH DAKOTA
VETERAN'S SERVICE OFFICER
MANUAL

Prepared by:

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Revised: October 2024

SDDVA Vision, Mission and Core Functions

Vision

Insuring excellence, integrity, advocacy, accountability, collaboration, and treating every person with dignity and respect is carried through in everything we all strive to do and accomplish for veterans and their families.

Mission

Provide comprehensive care and quality service to veterans and their families, regarding health care, education, disability benefits, long-term care, and burial honors by providing professional customer service and care.

Core Functions

(1) Provide ongoing training and supervision to our state's network of County & Tribal Veterans Service Officers in all areas of federal and state laws and programs pertaining to veteran's benefits.

(2) Counsel and assist veterans and their family members with preparing and submitting claims for benefits they are eligible for through the US Department of Veterans Affairs (VA) and any other state or federal agencies.

(3) Advocate for the claimant(s) by ensuring that all award actions and decisions by the VA or other agencies are accurate and in compliance with existing laws and regulations.

(4) Evaluation, approval and supervision of all programs/schools that offer educational opportunities to those eligible for VA educational benefits; also provide overview for those programs offered at training establishments.

(5) Provide public relations and outreach efforts to properly promote and educate the public on all programs and services available to our veteran's, military service personnel and their families.

(6) The Department serves as primary liaison between state agencies, the SD Veterans Commission, South Dakota Veterans Council and other service partners (federal, national, state).

(7) Ensure the protection, privacy and integrity of all veterans and claimant personal identity data, medical information, and VA claim/military data entrusted to the Department staff and the state's network of County and Tribal Veterans Service Officers, as an ethical and legal obligation.

South Dakota County/Tribal Veterans Service Officer

This is professional work which involves counseling and assisting military veterans and their dependents or survivors. Work involves assisting and advising claimants in their pursuit of benefits from the US Department of Veterans Affairs (VA) and other agencies. Duties include studying and explaining State and Federal veterans' legislation, regulations and procedures, consulting with medical care providers, preparing veteran's benefit claims, and consulting with other government agencies to ensure that their clientele are receiving the maximum level of assistance and benefits to which they are entitled.

Examples of Work Performed

(Any one position may not include all of the duties listed nor do the listed examples include all tasks which may be found in this position).

- Interviews veterans and their dependents, reviews the veterans' military and medical history to gather accurate information pertinent to the claim.
- Assists claimants in the preparation of necessary forms for benefits such as compensation, pension, insurance, education and hospitalization.
- Corresponds and consults with other Veterans Service Officers and appropriate entities relative to background information which may materially affect the applicants' benefit entitlements.
- Consults with medical care providers concerning specific benefits to which veterans or their dependents may be entitled and assists the individuals in obtaining these benefits.
- Advises claimants regarding other benefits to which they may be entitled, including social security, vocational rehabilitation and other forms of public assistance.
- Maintains liaison with, and delivers speeches to, veterans' organizations and other interested groups to ensure public awareness of available benefits and assistance.
- Performs other related work as necessary to ensure expedient delivery of benefits.

Required Knowledge, Skills and Abilities

- Working knowledge of the benefits and services available to veterans and their dependents, and of State and Federal laws and regulations.
- Knowledge of the principles and methods of interviewing.

- Knowledge of available community resources and agencies, both public and private.
- Ability to establish and maintain effective working relationships with veterans and their dependents, community organizations, and the general public.
- Ability to explain Federal and State veterans' legislation.
- Ability to operate standard office equipment such as a calculator, computer, typewriter etc. for use in the preparation of forms, reports and necessary correspondence.
- Ability to express ideas clearly, in written or oral form.

Minimum Qualifications

Must be a veteran as defined in South Dakota Codified Law 33-A-2-1 or 33A-2-2.

Veterans Service Officers Code of Ethics

1. Confidential information, whether supplied by the veterans, the Department of Veterans Affairs, or other parties shall remain confidential and will not be released or discussed except to those personally connected to the case with a need to know in order to assist the veteran's or his/her family members.

2. The Service Officer will prepare and perfect all claims to the best of his/her ability with the intent of affording the claimant the benefits to which they are entitled. The Service Officer must insure that all information is true and factual to the best of his/her knowledge.

3. The Service Officer shall maintain high professional standards in dealing with other service officers, (federal, state, and local) and other persons and agencies as necessary in service to his/her client.

4. The Service Officer will provide services without prejudice to all persons making a claim to the Department of Veterans Affairs.

5. The Service Officer will to the best of his/her ability, maintain a working knowledge of all rules and regulations concerning veteran's benefits and will strive to keep such knowledge updated in light of constantly changing laws and regulations.

6. Veterans Service Officers should not, under any circumstances, accept remuneration in cash or other form for services rendered.

7. Veterans Service Officers should not, under any circumstances, serve as guardians or fiduciaries for any other individuals receiving benefits from the Department of Veterans Affairs or any other agency.

SDDVA Privacy and Confidentiality Policy

Privacy and confidentiality are basic rights in our society. Safeguarding those rights, with respect to a claimant's personal identity data, medical information, and VA claim data is our ethical and legal obligation and expectation for all SD Department of Veterans Affairs personnel and our states' county or tribal Veterans Service Officers.

This is perhaps the single most important virtue a Veterans Service Officer must possess. A breach of confidentiality will result in a loss of trust from the effected individual(s) and will render you useless in your job with respect to that individual(s). It is vitally important to take every possible precaution to protect sensitive information from unauthorized access. To protect the rights of our clientele, it is imperative the following measures are strictly followed and adhered to:

1. Never discuss a case in public. If, for some reason you must discuss the case with the veterans in a public setting, ensure that it is okay or ask or if he/she would rather relocate to continue the discussion.

2. Never discuss a veteran's case with anyone else without the subject veteran's permission. If you need to discuss the case with another VSO or official for advice, clarification, or other reason, omit the veteran's name and other identifying information unless absolutely necessary.

3. Do not discuss your work in social settings. Innocent conversations could haphazardly lead to a breach of confidentiality.

4. Treat requests for information from an unauthorized individual as a criminal act. Report it to your local authorities so they can assess and act on the situation.

5. All files and sensitive information should be kept in a locked filing cabinet and, when possible a locked office.

6. Visit your county Register of Deeds to ensure that ***all*** DD Form 214's are protected from unauthorized access. Most recent forms are scanned into a computer and stored electronically with password protection.

7. Ensure your computer has every available shield against unauthorized access (at least equal to highest security level in other county offices). If your county employs or contracts an information technology (IT) or security person, have him/her access the security on your computer. If it is deficient, address the matter with your commissioners or their delegate.

8. In most cases, confidential information pertaining to clients does not belong on electronic devices. If there is some reason for storing confidential information on these devices, the device must have adequate security measures installed.

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South Dakota Veterans Benefits

Definition of a Veteran (SDCL 33A-2-1 and 33A-2-2)

South Dakota Codified Law 33A-2-1 For the purposes of all statutes relating to rights, privileges, ceremonial recognition, exemptions, and benefits (except a state bonus) of veterans and their dependents, the term, veterans, means any person who:

(1) Has served the full obligation for active duty, Reserve, or National Guard service in the military, or received an early discharge for a medical condition, hardship, reduction in force, or at the convenience of the military; and

(2) Has been separated or discharged from such service honorably or under honorable conditions. For purposes of this section, the term, benefits, includes veteran's designation on a driver license or identification card, veteran's license plates, veteran's job preference, and burial benefits pursuant.

SDCL 33A-2-2 defines a wartime veteran as any person who has performed qualifying military service as follows:

World War I – Active duty for one day, or more, between the dates of:

- April 6, 1917 to November 11, 1918 OR;
- July 28, 1914 to November 11, 1918 for any US citizen serving on active duty with an allied nation

World War II – Active duty for one day, or more, between the dates of:

- December 7, 1941 to December 31, 1946 OR;
- September 1, 1939 to December 31, 1946 for any US citizen serving on active duty with an allied nation.

Korea – Active duty for one day, or more, between the dates of:

- June 27, 1950, to January 31, 1955.

Vietnam - Active duty for one day, or more between the dates of:

- November 1, 1955, to May 7, 1975, for veterans who served in the Republic of Vietnam during that period.
- August 5, 1964, to May 7, 1975, for veterans who served outside the Republic of Vietnam.

Southwest Asia – Active duty for one day, or more, between the dates of:

- August 2, 1990 to a date to be determined.

(Do note use these dates for pension calculating)

Other Qualifying Periods of Service

Any military service during which the individual received an Armed Forces Expeditionary Medal or other United States campaign, expeditionary, or service medal awarded for participation in combat operations against hostile forces outside the boundaries of the United States.

Service Connected Disability

Veterans rated as service connected by the US Department of Veterans Affairs (VA) are eligible for state veterans benefits regardless of when they served on active duty.

Active duty for training by National Guard or Reserve personnel is not considered as active duty for state veterans benefit purposes.

Headstone Setting Reimbursement (SDCL 33A-5-4)

The state will pay $200 towards the cost of setting a government headstone or marker at the grave of a veteran who was a citizen of the US and a resident of the State of South Dakota for one year immediately prior to entering into military service or one year immediately prior to death. NOTE**:** This fee is not available if the headstone is set in a VA National Cemetery.

The state will pay $100 for the professional etching of the veterans military information on the back of a privately purchased headstone.

The application forms (SDDVA Form 2 and SDDVA Form 5) must be received in the Pierre office no later than one year from the date the headstone was set.

The veteran's medallion that can be provided by the VA, in lieu of the traditional government headstone or marker, **DOES NOT** qualify for the South Dakota Headstone Setting Fee.

Burial Allowance (SDCL 33A-5-2 and 33A-5-3)

A payment of up to $100 may be paid by the state to help defray the burial and funeral expenses of any honorably discharged veteran or the wife, widow or widower of a veteran when the estate, or immediate family, of the deceased is lacking in funds to pay the expenses.

The veteran must have been a citizen of the US and a resident of the State of South Dakota for one year immediately prior to entering into military service or one year immediately prior to death.

NOTE**:** This payment CANNOT be made to another unit of government such as a county**.**

Application for the burial allowance must be received in the Pierre office no later than one year from the date of burial and the following forms are required:

Application for Veteran's $100 Burial Allowance – SDDVA Form 4
'Affidavit' of insufficient funds to pay expenses – SDDVA Form 4 – Page 3
Copy of the Funeral Bill

South Dakota Veterans Bonus (SDCL 33A-2-10 to 33A-2-33)

Veterans who served on active duty during Operations Desert Shield/Storm and/or Operations Iraqi Freedom/Enduring Freedom may be eligible to receive a bonus from the State of South Dakota.

To qualify the veteran must:

- Have been discharged honorably or under honorable conditions, and
- Have been a legal resident of South Dakota at least six months immediately prior to entering into service, or
- If not a resident of this state, must have been a member and served with a South Dakota National Guard or Reserve Unit that was called to active duty.

Eligibility Service Dates

Desert Storm/Desert Shield Program

- August 2, 1990 – March 3, 1991 all service counts for payment
- March 4, 1991 – December 31, 1992 only hostile service counts for payment

Operation Iraqi / Enduring Freedom Program

- January 1, 1993 – September 10, 2001 only hostile service counts for payment.
- September 11, 2001 – "a date to be determined" all service counts for payment

Payment Schedule

- Non-hostile pay starts at $100 the first month & then $20 a month after that to a maximum of $240
- Hostile pay starts at $150 the first month & then $50 a month after that with a possible max of $500
- There is one bonus for Desert Storm/Desert Shield service. The maximum for that program is $500
- There is another bonus for Operation Iraqi / Enduring Freedom service. The maximum for that program is $500
- Any part of a month is considered a full month for payment purposes
- Qualifying Veterans with a VA disability rated at 10% or more will receive the full bonus of $500

Other Requirements

- Only Federal Active Duty is applicable for bonus purposes
- Active Duty for training is not allowed for bonus purposes
- Active Duty applicants and applicants living outside South Dakota may request an application by email to jeri.smith@state.sd.us
- Applicants living in South Dakota can apply through their local County or Tribal Veteran's Service Officer

Applicants without email may request an application by calling or writing:
South Dakota Department of Veterans Affairs
Attn: Bonus Program
425 East Capitol Avenue
Pierre, SD 57501-5070
Phone: 605.773.7251

Veterans and Military License Plates

Special distinctive license plates are available for veterans and Active Duty personnel who are residents of South Dakota. For additional information on eligibility and application procedures, visit the SD Department of Revenue website at **http://dor.sd.gov/Motor_Vehicles/.**

The distinctive plates available include:

Air Force Cross
Bronze Star
Bronze Star with Valor
Disabled Veteran
Distinguished Flying Cross
Distinguished Service Cross
Gold Star
Tribal Veteran
Legion of Merit
Medal of Honor Navy
Cross Organizational
Pearl Harbor Survivor
Prisoner of War
Purple Heart
Silver Star
Woman Veteran

Military Plates:

Air Force
Army
Coast Guard
Marine
National Guard
Navy

Veteran ID Card Designation SDCL 32-12

Provides that veterans as defined by SDCL 33A-2-1 may add a veteran designator to driver's license or state identification card. Veterans who have been honorably discharged from the military have the option of adding the word "Veteran" to the front of their South Dakota Driver's License or Identification Card. In addition to the required documents, veterans need to present one of the following:

- DD-214 form to show honorable discharge status from active duty
- DD Form 2 (Retired) or 2A (Retired)
- Certificate signed by a county or tribal veteran's service officer verifying their status
- National Guard Form NGB22
- Uniformed Services ID Card (Retired)

Honorary High School Diploma SDCL 33A-2-34

Provides for honorary high school diplomas for veterans who served during certain wartime periods. Eligible veterans include anyone who served on active duty at any time during the periods: December 7,1941 to September 2, 1945; June 25, 1950 to July 31, 1953; or February 28, 1961 to May 7, 1975. As stated in the law, the school district selected by the veterans shall award the diploma to the veterans. (SDDVA Form 14)

Education Benefits for South Dakota Veterans and Dependents

Veterans: (SDCL 13-55-2 TO 13-55-5)

Certain veterans are eligible to take undergraduate courses at a state supported university,or technical college without payment of tuition provided they have no remaining eligibility under any federal programs.

To be eligible, the veterans must have been discharged under Honorable conditions, must be a current resident of South Dakota, must qualify for in- state tuition, and meet one of the following:

- Served on active duty between August 2,1990 and date to be determined, or
- Received an Armed Forces Expeditionary medal, or other United States campaign, expeditionary, or service medal awarded for participation in combat operations against hostile forces outside the boundaries of the United States, or
- Has a service connected disability

Veterans may receive one month of free tuition for each month of 'qualifying service' with a minimum of one, up to a maximum of four academic years.

Qualifying service is defined as: The amount of time served on active duty between the beginning and ending dates of the particular period of conflict or hostilities during which the veteran's earned eligibility for this program.

To apply, the veteran needs to complete form SDDVA Form 16 'Veteran's Application for Free Tuition at State Supported Schools'. The applications are available at the schools' financial aid office, Veteran representative or registrars' office, or they can also be obtained from the SD Department of Veterans Affairs.

The completed application and a copy of the veteran's discharge must be sent to:

South Dakota Dept of Veterans Affairs
Attn: Shane Olivier
425 E. Capitol Avenue
Pierre, SD 57501

Once the VA verifies that the veteran is not eligible for VA Educational Benefits, and the form is returned to the veteran, he or she will need to present it to the Registrar of the University.

Children of Veterans Who Die During Service: (SDCL 13-55-6 to 13-55-9)

A child may be eligible for free tuition at a state supported school or technical college, if their parent passed away, for any cause, while on active duty. The parent must have been a bona-fide resident of South Dakota for at least six months immediately preceding entry into active service. The receipt of federal educational benefits **does not affect eligibility** for this program.

To be eligible the child must be under the age of 25 and must be a resident of South Dakota. To apply, the student will need to complete SDDVA Form 17 'Veteran's Dependents or Survivors Application for Free Tuition'. This form is available at the schools' financial aid office, veterans' representative or registrars' offices or, they can be obtained from the SD Department of Veterans Affairs. The application and a copy of the deceased parents Casualty Report must be presented to the school's registrar office.

Dependents of POW'S and MIA'S (SDCL 13-55-9.1 to 13-55-9.6)

The spouse or child of a veteran who is a prisoner of war or who is listed as missing in action, may be entitled to attend a state supported school or technical college without the payment of tuition or mandatory fees provided they are not eligible for equal or greater benefits under any federal educational program. The veteran must have been a bona-fide resident of the State of South Dakota at time of entry into active duty service.

To be eligible, the spouse or child must be a current resident of South Dakota. To apply, the student needs to complete SDDVA Form 17 'Veteran's Dependents or Survivors Application for Free Tuition'. This form is available at the schools' financial aid office, veterans' representative or registrars' office or, they can be obtained from the Department of Veteran's Affairs. The application and verification of the parents POW/MIA status must be presented to the school's registrar office.

Dependents of National Guardmembers Disabled or Deceased in Line of Duty (SDCL 13-55-10)

Dependents of a SD National Guard member who dies or becomes permanently disabled while on state or federal active duty may be entitled to free tuition for any course or courses of study in any state supported educational institution or technical college in South Dakota. Receipt of federal educational benefits does not affect eligibility for this program.

The dependent must be a current resident of South Dakota. The dependent will need to complete SDDVA Form 17 'Veteran's Dependents or Survivors Application for Free Tuition'. This form is available at the schools' financial aid office, veterans' representative or registrars' office or, they can be obtained from the SD Department of Veteran's Affairs. The application and a copy of the deceased parents' Casualty Report or verification of permanent disability must be presented to the school's registrar office.

Property Tax Exemptions

Paraplegic Veteran and Their Widow(er) (SDCL 10-4-24.10)

Dwellings or parts of multiple family dwellings which are specifically designed for use by paraplegics as wheelchair homes and which are owned and occupied by veteran with the loss, or loss of use, of both lower extremities, or by the un-remarried widow or widower of such veteran, is exempt from taxation. The dwelling must be owned and occupied by the veteran for one full calendar year before the exemption becomes effective. Application for the exemption is made through the county assessor.

Totally Disabled Veteran and Surviving Spouse (SDCL 10-4-40 and 10-4-41)

$200,000 of the full and true value of a dwelling that is owned and occupied by a veteran who is rated permanently and totally disabled from a service connected disability(ies),or the un-remarried surviving spouse of such veteran, or the surviving spouse of a veteran who receives dependency and indemnity compensation from the United States Department of Veterans Affairs as a result of the veteran's service-connected death, is exempt from taxation. The dwelling must be owned and occupied by the veteran or eligible surviving spouse. Application for the exemption is made through the county assessor. If the director of equalization determines that the surviving spouse receives an exemption for the dwelling pursuant to this section, the surviving spouse retains that exemption until such time as the property ownership is transferred, the surviving spouse does not occupy the dwelling, the surviving spouse remarries, or the property has a change in use. If the legal description of property is changed or amended and the surviving spouse continues to reside in the dwelling, the surviving spouse retains the exemption provided by this section.

Other Taxation Benefits

- Property Tax Refund for Aged and Disabled Persons: (SDCL 10-18A-2)
- Sales Tax Refund for Certain Elderly and Disabled Persons: (SDCL 10-45A-2)

For more information contact your local county treasurers' office.

Hunting and Fishing Licenses

Hunting and Fishing Cards for Disabled Veteran (SDCL 41-6-10.2)

Eligible veterans may receive a hunting and fishing card which is valid for four years for a $10 fee. This card is the equivalent of the resident fishing and small game license. Applicants must be a resident of South Dakota and meet at least one of the following conditions:

- A copy of a letter from the VA indicating they have received the K Award or they receive a veteran's allotment for a 40% or greater disability which is deemed a service-connected injury and will meet eligibility as established in state law SDCL 41-6-10.2 or,

- A copy of a benefit verification letter from the Social Security Administration indicating that they are receiving Social Security disability and verification that they have served on active duty in the armed forces or as a member of the armed forces reserve or national guard. This letter is available on line by creating an account at: http://www.ssa.gov/myaccount/ or,
- A copy of the discharge papers verifying the Prisoner of War status.

If the veteran does not have the verification papers in his or her possession, contact the South Dakota Department of Veterans Affairs for assistance (http://www.veteranaffairs.sd.gov) or the Veterans Benefits Administration in Sioux Falls and have them mailed. If the veteran has received a prior reduced fee license and papers as described above have been submitted, there is no need to submit them again unless there has been a status change. Application and verification papers, along with the $10 fee, must be submitted to: South Dakota Game, Fish and Parks, ATTN: Disability License, 20641 SD Hwy 1806, Ft. Pierre, SD 57532. To complete the application visit http://gfp.sd.gov/hunting/accessibility/reduced-fees.aspx. Upon completion of this form and verification of eligibility, South Dakota residents will receive a Reduced Fee Hunting & Fishing License. This license (card) will be a replacement for the resident small game license and resident fishing license.

Special Provisions for Handicapped Hunters (SDCL41-8-31)

Veterans who are missing an upper limb or are physically incapable of using an upper limb or who are confined to a wheelchair may use a crossbow to take game birds and animals once they have obtained a disabled hunter permit. A legally blind or quadriplegic, legally licensed individual who possesses a disabled hunter permit and who is physically present and participating in the hunt may claim birds and animals taken by a designated hunter in accordance with the licenseor licenses possessed by the handicapped hunter. Applications are obtained from the Game Fish and Parks office in Pierre or from a game warden.

Military General Hunting and Fishing License (SDCL 41-6-16.2)

Residents who are serving on Active Duty and stationed at a location outside of the state may fish and hunt small game without payment of a fee or the applicable hunting and fishing license. If the resident is hunting migratory birds, the federal migratory bird stamp and the migratory bird certification permit must be purchased. Must have valid military ID and copy of orders.

State Parks

Free Admission and Reduced Camping Fees for Veterans (SDCL 41-17- 13.4)

Certain resident veterans may obtain free admission to any South Dakota state park and a fifty percent discount on any camping fee or associated electrical fee. To be eligible the veteran's must:

- Be totally disabled from service connected disabilities or,
- Be in receipt of the VA 'K' award or,
- Have been held as a Prisoner of War.

Application forms may be obtained from the local park manager or through the Game, Fish and Parks office in Pierre.

For additional information on hunting, fishing, and outdoor activities, visit the SD Department of Game, Fish and Parks website at **www.sdgfp.info/**

Veterans Preference (SDCL 33A-2)

South Dakota defines an eligible veteran as:

- Honorably discharged
- A citizen of the United States
- Having served under qualifying conditions

Eligible veterans receive preference for appointment, employment and promotion at all levels of government, including state, counties, municipalities and school districts. If the applicant possesses at least the minimum qualifications necessary to fill the position, the veteran shall be granted an interview. IIf the veteran is deceased, his veteran's preference moves to his surviving spouse.

They may not be disqualified by their age, by loss of a limb or by any other physical impairment which is not incapacitating. However, they must possess the qualifications necessary to do the job in question. A veteran disabled due to a service-connected cause is given preference over a non-disabled veteran.

State Veterans Cemetery

Burial Eligibility – Veterans

Veterans and Members of the Armed Forces

(1) Members of Armed Forces who died on active duty
(2) Any veteran who was discharged under conditions other than dishonorable (certain veterans must meet 24-month continuous active duty requirement)
(3) Certain United States citizens who serve in the Armed Forces of an allied nation

Reserves Components

(1) Certain Reservists and National Guard members entitled to retired pay
(2) Certain Reservists and National Guard members hospitalized or undergoing treatment at government expense
(3) Certain members of the Reserve Officers' training Corps who die while traveling to, or conducting, authorized training or while hospitalized or undergoing treatment at government expense
(4) Certain Reserve Components who were disabled or died from a disease or injury incurred or aggravated in the line of duty during period of active and/or inactive duty for training

Commissioned Officers, National Oceanic Atmospheric Administration

(1) Certain Commissioned Officers of the National Oceanic and Atmospheric Administration

Public Health Service

(1) Certain Commissioned Officers of the Public Health Service

World War II Merchant Mariners

(1) Certain World War II Merchant Marines with oceangoing service during armed conflict in World War II

Philippine Armed Forces

(1) Certain Philippine veterans with United States citizenship or lawful alien status who served during World War II

Spouses and Dependents

(1) Spouses and surviving spouses of eligible veterans
(2) Minor children of an eligible veteran
(3) Certain unmarried disabled adult children of an eligible veteran

Parents

1. Certain biological or adoptive parents of veterans

****The Secretary of Veterans Affairs or the Secretary of Defense may designate other persons or classes of persons as eligible for burial****

INELIGIBILITY

(1) Former spouses (if not otherwise eligible)
(2) Other family members not already listed
(3) Disqualifying characters of discharge
(4) Discharge from Draft
(5) Persons found guilty of a Capital Crime
(6) Certain persons convicted of subversive activities
(7) Active or Inactive duty for training unless they meet eligibility criteria listed above

Cemetery Burial Eligibility - Dependents

Spouses and Dependents

(1) Spouses and surviving spouses of eligible veterans
(2) Minor children of an eligible veteran
(3) Certain unmarried disabled adult children of an eligible veteran

Parents

1. Certain biological or adoptive parents of veterans

****The Secretary of Veterans Affairs or the Secretary of Defense may designate other persons or classes of persons as eligible for burial****

Burial Costs

What is Provided

Gravesite or Columbarium Niche
Pre-placed Grave liner (Standard Size and some Oversized)
Headstone/Niche Cover
Perpetual Care

Costs - Veteran

There is no fee for burial of an eligible veteran.

Costs - Spouse/Eligible Dependent

Additional charges may be added if the casket is oversized and a larger grave-liner is needed.

If a grave-liner is supplied as part of a prepaid burial plan, the plan will be reviewed and every effort made to meet the terms of the prepaid plan within existing cemetery guidelines.

** Fees for spouse/eligible dependents cannot be prepaid and are subject to change.

Pre-Registration

The South Dakota Department of Veterans Affairs operates the State Veterans Cemetery spanning 74 acres in Sioux Falls.

Burial sites at the South Dakota Veterans Cemetery include casket gravesites, cremation gravesites, and columbaria for cremated remains.

The South Dakota Veterans Cemetery compliments services provided by the National Cemetery Administration. The National Cemetery Administration provides support to state cemeteries in the form of grants that are used for development, expansion, and/or improvement of state veterans cemeteries.

Anyone interested in burial at the South Dakota Veterans Cemetery is encouraged to complete the pre-registration application. Pre-registration establishes the Veteran's eligibility for burial. It does not, however, reserve a specific gravesite.

The cemetery administrative staff assigns gravesites at the time of death. Pre-registration applications are available at the cemetery office, through your local County and Tribal Veterans Service Officer

There is no cost for pre-registration and it does not obligate the veteran/dependent to be interred at the South Dakota Veterans Cemetery.

Cemetery Burial Arrangements

The person(s) coordinating burial should contact the South Dakota Veterans Cemetery to make arrangements for burial.

A DD214, or equivalent military discharge document, must be provided to establish the veteran's eligibility. If these documents are not available, the cemetery must be provided with sufficient military information to allow the cemetery to access VA and/or military records to establish eligibility.

Cemetery staff will set a tentative date for the committal service pending verification of service and character of discharge; and will notify the applicant when the committal service is scheduled. The proposed date and time will be approved only when the cemetery verifies eligibility and confirms the arrangements.

Committal Services

The cemetery can conduct seven committal services per day, Monday - Friday, every hour from 9 a.m. to 3 p.m. (3 p.m. is cremation only).

Committal services are limited to 20 minutes. All committal services should be brief and need to start on the hour at the scheduled time. Families who extend their services can greatly affect others who have scheduled services following theirs.

All committal services are held at the committal service building rather than at the gravesite. This ensures the family's safety and provides a fitting location for military honors and the ability of our staff to conduct cemetery operations.

The remains are removed from the committal service building for burial following the family's departure and are never left unattended by cemetery staff.

Clergy services and other arrangements are the responsibility of the family or family representative. These arrangements are normally coordinated through a funeral director.

Casket

A pre-placed graveliner is provided by the cemetery for all casket burials. Casket gravesites are permanently marked with an upright headstone.

Cremation (In-Ground)

In-ground cremation gravesites provide a traditional burial option for cremated remains. In-ground cremation gravesites are permanently marked with an upright headstone.

Cremation (Columbarium)

The columbarium provides an above-ground option for cremated remains. Columbarium niches are permanently marked with a niche cover.

** Placement of cremated remains, either in-ground or above-ground, is determined by family.

Flower Policies

Fresh cut flowers may be placed on graves at any time. Temporary containers and water are provided in locations around the main cemetery drive. Floral items will be removed from graves by cemetery personnel as soon as they become faded or unsightly.

Artificial flowers may be placed on graves during periods specified on the Floral Regulation signs located around the main cemetery drive. Plantings, statues, vigil lights, breakable objects of any nature, or any other commemorative items are not permitted on the graves.

State Veterans Home (SDCL 33A-4)

The Michael J. Fitzmaurice State Veterans Home (MJFSVH) in Hot Springs includes 24 residential living and 65 skilled nursing care beds for eligible South Dakota veterans and their spouses, widows, and widowers. To be eligible for residency, the applicant must be an honorably discharged veteran or the spouse, widow, or widower of such a veteran. In addition, he or she must:

- Have had a complete physical exam not more than six months prior to moving into the South Dakota Veterans Home
- The spouse of the veteran must be admitted with the veteran, unless the Veteran is institutionalized
- Non-Veteran (spouses of Veteran) are limited to 25% of the total residents of the Veterans Home by VA rules.

Criteria for Residential Living

- Resident's general health status is stable and does not require frequent medical interventions of a physician, physician assistance, or certified nurse practitioner
- Resident is free of communicable disease
- Potential residents have total independence with personal care needs; such as, bathing, dressing, eating, ambulating (walking), toileting, transferring, etc.
- Applicants who have a diagnosis of alcohol or substance abuse must have at least one year of documented sobriety before being accepted to the MJFSVH. If the potential resident has a mental health condition it must be stabilized at the time of admission.

Criteria for Nursing Care

- The skilled nursing care unit requires that a potential resident meet the South Dakota criteria for nursing home placement.

Cost of Care for the Michael J. Fitzmaurice South Dakota Veterans Home

Residential Living

- Single veteran pays 50% of their income towards rent
- A couple pays 55% of their income towards rent
- Individuals with cash assets of $10,000 - $49,999 will have monthly asset fee added to the rent calculation. For couples, the monthly asset fee begins at $15,000.
- Liquid assets of more than $50,000 will pay approximately $4,050 per month.

Nursing Care (NCU)

- A veteran pays $360/day until resources are below $2000 at which time they can apply for Medicaid.
- A veteran that is 70% service-connected-disabled or needs nursing care for their SCD's are eligible to live at the MJFSVH at no cost to the veteran.

Application for admission to MJFSVH may be made through the local County or Tribal Veterans Service Officer and any Department of Veterans Affairs employees. Once the application forms are completed, they are then submitted to:

Michael J Fitzmaurice South Dakota Veterans Home
2500 Minnekahta Avenue
Hot Springs, SD 57747-1199

SOUTH DAKOTA DEPARTMENT OF VETERANS AFFAIRS

APPLICATION FOR VETERANS $200 VA HEADSTONE SETTING REIMBURSEMENT

SDCL 33A-5-4

Note: See reverse side for instructions.

DECEASED VETERAN'S INFORMATION

Name: (Last, First, Middle)		Social Security Number:
Date of Birth:	Date of Death:	Dates of Service: From: To:

Was the veteran honorably discharged, received a U.S. Government headstone/marker, a citizen of the U.S. and a resident of South Dakota for one year immediately preceding entry into military service or preceding death? (Please check one):

◯ YES ◯ NO

INDIVIDUAL OR BUSINESS REQUESTING SETTING REIMBURSEMENT

Name of Individual or Business That Permanently Set the VA Provided Headstone/Marker at the Grave Site:			Date of Placement: (Month, Day, Year)
Name of Cemetery:	Location of Cemetery: (City and State)		
Name of Individual or Business Requesting $200 Payment: (If Funeral Home, **MUST** Provide Itemized Bill)			
Mailing Address of Individual or Business: (Where the Check Will Be Mailed)	City:	State:	Zip Code:
Telephone Number of Individual or Business:	Individual Social Security # or Business Federal Tax ID #:		

I agree that the above information is true and correct to the best of my knowledge.

Signature of Individual or Business Receiving $200 Payment:	Date: (CAN NOT be dated before the date of placement)

I agree that the above information is true and correct to the best of my knowledge.

Signature of C/TVSO:	Date: (CAN NOT be dated before the date of placement)

Please return form to:

South Dakota Department of Veterans Affairs
ATTN: Headstone Setting Reimbursement
425 E. Capitol Avenue
Pierre, SD 57501-3100
PH: 605-773-3269

Please note - previous versions of this form will not be accepted

Instructions - Please Read Carefully

Note: All claims must be presented to the South Dakota Department of Veterans Affairs **within one-year** from the date the headstone was permanently set.

It is the responsibility of the county/tribal veterans service officer to ensure that the information contained on this application is true and correct.

1. To qualify, the deceased veteran must have been a citizen of the United States, a resident of the State of South Dakota for one year immediately preceding entry into the Armed Forces or for the year immediately preceding death, and be eligible to receive a U.S. Government headstone/marker.

2. The middle portion of the form must be signed, dated by, and contain the Social Security or Tax ID number of the person or business to whom payment is being made.

3. Funeral Homes applying for the setting reimbursement must also submit an itemized statement for the deceased veteran's services.

4. Any application form which is not complete or legible will be returned to the C/TVSO for correction.

5. Photo of permanently set headstone/marker must be included with application.

SOUTH DAKOTA DEPARTMENT OF VETERANS AFFAIRS

APPLICATION FOR VETERANS $100 HEADSTONE ETCHING REIMBURSEMENT

SDCL 33A-5-4

Note: See reverse side for instructions.

DECEASED VETERAN'S INFORMATION

Name: (Last, First, Middle)	Social Security Number:	
Date of Birth:	Date of Death:	Dates of Service: From: To:

Was the veteran honorably discharged, a citizen of the U.S. and a resident of South Dakota for one year immediately preceding entry into military service or preceding death? (Please check one):

◯ YES ◯ NO

INDIVIDUAL OR BUSINESS REQUESTING ETCHING REIMBURSEMENT

Name of Individual or Business That Permanently Etched the Headstone at the Grave Site:			Date of Etching: (Month, Day, Year)
Name of Cemetery:	Location of Cemetery: (City and State)		
Name of Individual or Business Requesting $100 Payment: (If Funeral Home, **MUST** Provide Itemized Bill)			
Mailing Address of Individual or Business: (Where the Check Will Be Mailed)	City:	State:	Zip Code:
Telephone Number of Individual or Business:	Individual Social Security # or Business Federal Tax ID #:		

I agree that the above information is true and correct to the best of my knowledge.

Signature of Individual or Business Receiving $100 Payment:	Date: (CAN NOT be dated before the date of etching)

I agree that the above information is true and correct to the best of my knowledge.

Signature C/TVSO:	Date: (CAN NOT be dated before the date of etching)

Please return form to: **South Dakota Department of Veterans Affairs**
ATTN: Headstone Etching Reimbursement
425 E. Capitol Avenue
Pierre, SD 57501-3100
PH: 605-773-3269

Instructions - Please Read Carefully

Note: All claims must be presented to the Pierre office of the South Dakota Department of Veterans Affairs **within one-year** from the date the headstone was professionally etched.

It is the responsibility of the county/tribal veterans service officer to ensure that the information contained on this application is true and correct.

1. To qualify, the deceased veteran must have been a citizen of the United States, a resident of the State of South Dakota for one year immediately preceding entry into the Armed Forces or for the year immediately preceding death, and be eligible to receive a U.S. Government headstone/marker.

2. The middle portion of the form must be signed, dated by, and contain the Social Security or Tax ID number of the person or business to whom payment is being made.

3. Funeral Homes applying for the etching reimbursement must also submit an itemized statement for the deceased veteran's services.

4. Any application form which is not complete or legible will be returned to the C/TVSO for correction.

5. Photo of etching must be included with application.

SOUTH DAKOTA DEPARTMENT OF VETERANS AFFAIRS

APPLICATION FOR $100 VETERANS BURIAL ALLOWANCE SDCL 33A-5-2

Note: See reverse side for instructions.

VETERAN'S INFORMATION

Name: (Last, First, Middle)		Social Security Number:
Date of Birth: (MM/DD/YYYY)	Date of Death: (MM/DD/YYYY)	Dates of Service: From: To:
Was the above-named veteran honorably discharged veteran as defined in SDCL 33A-1, a citizen of the United States, and a resident of South Dakota for one year immediately preceding entry into military service or preceding death? (Please check one) YES NO		

Funeral Home or Other Payee Information

Name of Decedent: (if different than above):	Social Security Number of Decedent:	Date of Burial: (MM/DD/YYYY)
Name of Cemetery:		Location of Cemetery: (City and State)
Name of Funeral Home or Other Payee Requesting $100 Payment:		Total Cost of Funeral: $
Mailing Address of Funeral Home or Other Payee: (where the check will be mailed)	City:	State: Zip Code:
Telephone Number of Funeral Home or Other Payee:	Individual Social Security # or Business Federal Tax ID #:	

I agree that the above information is true and correct to the best of my knowledge.

Signature of Funeral Home or Other Payee: (Signature MUST be original)	Date: (CAN NOT be dated before the date of burial)

I certify that the surviving spouse or relatives of the Decedent have furnished an affidavit acceptable to me that the estate of the Decedent, or of his or her surviving spouse, is not sufficient to defray the above funeral expenses and I hereby authorize payment in the amount of $100 to above Funeral Home or Other Payee.

Signature C/TVSO or SDDVA Employee: (Signature MUST be original)	Date: (CAN NOT be dated before the date of burial)

Please return form to: South Dakota Department of Veterans Affairs
ATTN: Burial Allowance
425 E. Capitol Avenue
Pierre, SD 57501-3100
PH: 605-773-7251

Instructions - Please Read Carefully

Note: All claims must be presented to the Pierre office of the South Dakota Department of Veterans Affairs **within one year** from the date of burial.

It is the responsibility of the county/tribal veterans service officer or SDDVA employee to ensure that the information contained on this application is true and correct.

SDCL § 33A-5-2 provides that a burial allowance of $100 may be paid toward the funeral expenses of any veteran, or the spouse, widow or widower, of a veteran when the estate of the deceased, or of the surviving spouse or other family members is not sufficient to defray the costs of the funeral. The law also requires that the surviving family members furnish an affidavit verifying that sufficient funds are not available for payment of the funeral expenses.

1. To qualify, the veteran must have been a citizen of the United States, a resident of the State of South Dakota for one year immediately preceding entry into the Armed Forces or for the year immediately preceding death, and must meet the definition of a veteran as defined in SDCL § 33A-2-1.

2. Payment of the burial allowance for the funeral expenses of a veteran's spouse or widow(er) is authorized only when the veteran's residency and period of active Duty service meets the above requirements.

The name of the veteran's spouse or widow(er), as requested on the front side of this application, is required only when the spouse or widow(er) is the decedent.

3. A copy of the **Funeral Bill and the Original Affidavit** must be submitted along with this application.

4. The middle portion of the form must be signed, dated by, and contain the Social Security or Tax ID number of the person to whom payment is being made.

5. Any application form which is not complete or legible will be returned to the C/TVSO or SDDVA employee for correction.

Affidavit

State of South Dakota

County of _____

I,_____, being first duly sworn, say I am the

_____of _____
(Relationship) *(Name of Decedent)*

and that at the time of the decedent's death, the estate of the said decedent was not sufficient to defray the funeral expenses of said decedent; that neither affiant nor other surviving relatives have sufficient funds or estate to defray decedent's funeral expenses and cost of burial.

_____
(Signature)

_____
(Address)

_____

Subscribed and sworn before me
This_____day of_____,_____.

_____
Notary Public

(Seal)

VETERANS APPLICATION FOR FREE TUITION AT STATE SUPPORTED **UNIVERSITIES AND TECHNICAL COLLEGES**

(SDCL **§13-55-2** THROUGH **§13-55-5)**

IMPORTANT: SEE INFORMATION ON REVERSE SIDE BEFORE COMPLETING THIS FORM

1. Last Name *First Name* *MI*	*2. Social Security Number*
3. Mailing Address (Street, City, State and Zip)	*4. Phone Number*
5. Name of School Where Attending Courses	*Date Courses Start (Month/Day/Year)*

6. Service Information - Enter the following data for each period of service

Branch of Service	*Date Entered Active Duty (Month/Day/Year)*	*Date Separated (Month/Day/Year)*	*Type of Discharge*

7. My eligibility for this program is based upon: (check appropriate box)

☐ Served on Active Duty at any time from August 2, 1990 through date to be determined
☐ Awarded one of the qualifying medals listed on the reverse side of this form in paragraph 3b
☐ Service connected disability rated as 10% or more (Must include Award Letter from VA)
(NOTE – Must include a **MEMBER-4** copy of your DD214)

_____ _____
(Signature of Veteran) *(Date)*

THIS SECTION FOR VA USE ONLY

1. Has the Veteran **EXHAUSTED ALL** Federal VA educational benefits? Yes ◯ No ◯
2. If entitlement for free tuition is based upon a service connected disability, the date of rating establishing a compensable service connected disability is _____.
(Month/Day/Year)

_____ _____
(Signature of VA Official) *(Date)*

CRITERIA GOVERNING THE VETERANS FREE TUITION
AT STATE SUPPORTED UNIVERSITIES AND TECHNICAL COLLEGES

SDCL §13-55-2 through §13-55-5 provides that certain veterans are eligible for free tuition at South Dakota universities and technical colleges. The tuition waiver is good for UNDERGRADUATE courses only. To qualify, the student must meet the following criteria:

1. Must have been discharged under "Honorable conditions", must be a CURRENT RESIDENT of South Dakota, and must qualify for resident tuition payments.

2. Must have used up all entitlement to, or not be eligible for, any educational benefits from the Federal government.

3. Must meet the definition of a "veteran" as found in SDCL §33A-2-1 and §33A-2-2 which is as follows:

   a. Served on Active Duty at any time from August 2, 1990 through a date to be determined,
   OR;

   b. Was awarded the Armed Forces Expeditionary Medal, Navy/Marine Corps Expeditionary Medal, or other United States Campaign or Service Medal for participation in combat operations against hostile forces, during dates other than those specified in 3.a, **OR**;

   c. Has a service connected disability rated by the U.S. Department of Veterans Affairs (VA) as 10%, or more, disabling. Must include award letter from VA.

   33A-2-2. Wartime veteran and qualifying military service defined. For purposes of all statutes relating to rights, privileges, exemptions, and benefits of wartime veterans and their dependents, the term, wartime veteran, means any veteran who has performed qualifying military service or any person who has performed qualifying military service and then been released to any National Guard or Reserve component of the armed forces of the United States. Qualifying military service is:

   (1) Active duty in the armed forces of the United States for one day or more during the period from April 6, 1917, to November 11, 1918, inclusive;

   (2) Active duty for one day or more during the period from July 28, 1914, to November 11, 1918, inclusive, performed by a citizen of the United States in the armed forces of any nation that was allied with the United States during any part of the period from April 6, 1917, to November 11, 1918, inclusive;

   (3) Active duty in the armed forces of the United States for one day or more during the period from December 7, 1941, to December 31, 1946, inclusive;

   (4) Active duty for one day or more during the period from September 1, 1939, to December 31, 1946, inclusive, performed by a citizen of the United States in the armed forces of any nation that was allied with the United States during any part of the period from December 7, 1941, to December 31, 1946, inclusive;

   (5) Active duty in the armed forces of the United States for one day or more during the period from June 25, 1950, to May 7, 1975, inclusive;

(6) Active duty in the armed forces of the United States for one day or more during the period from August 2, 1990, until the end of hostilities as determined by the Legislature;

(7) Active duty in the armed forces of the United States for one day or more in a military action for which the veteran earned an armed forces expeditionary medal or other United States campaign, expeditionary, or service medal awarded for participation outside the boundaries of the United States in combat operations against hostile forces; or

(8) Active duty in the armed forces of the United States for one day or more if the veteran has established the existence of a service-connected disability.

Service on active duty by any Reserve or National Guard personnel for training may not be construed as service on active duty, unless the Veterans Commission determines, by rules promulgated pursuant to chapter 1-26, that such training involved the person in direct participation in or direct support of combat operations against a hostile force.

4. The veterans are entitled to one month of free tuition for each month of qualifying service with a minimum of one, up to a maximum of four academic years. Qualifying service is defined as the amount of time served on Active Duty between the beginning and ending dates of the particular conflict or period of hostilities during which the veteran earned eligibility for this program.

Individuals applying for free tuition must complete this application and email it, along with a **MEMBER-4** copy of your DD-214 and VA Award Letter if applicable, to:

Email: shane.olivier@state.sd.us

5. Once completed by SDDVA, the form will be returned to the veteran, where it should then be presented to the school where the veteran will be attending classes.

VETERAN'S DEPENDENTS OR SURVIVORS APPLICATION FOR FREE TUITION AT STATE SUPPORTED UNIVERSITIES AND TECHNICAL COLLEGES

(SDCL 13-55-6 THROUGH 13-55-10)

IMPORTANT: SEE INFORMATION ON REVERSE SIDE BEFORE COMPLETING THIS FORM

1. Veteran or National Guard Members Information *Last Name* *First Name* *MI*	2. *Social Security Number*

3. Service Information - Enter the following data for each period of service			
Branch of Service	*Date Entered Active Duty (Month/Day/Year)*	*Date Separated (Month/Day/Year)*	*Type of Discharge*

4. Date and place of Veteran's death or National Guard member's death or permanent disability

5. Students Information *Last Name* *First Name* *MI*	*Date of Birth (Month/Day/Year)*	*Social Security Number*

Mailing Address (Street, City, State and Zip)	*Phone Number*
6. Name of School Where Attending Courses	*Date Classes Start (Month/Day/Year)*

7. My eligibility for this program is based upon: (check appropriate box and attach verification of your relationship to the veteran or National Guard Member and Death Certificate or VA Award Letter)

- ☐ I am the child of a veteran who died during service in the Armed Forces
- ☐ I am the spouse or child of a veteran who was a Prisoner of War or was declared Missing in Action
- ☐ I am the spouse or child of a National Guard Member who died or was permanently and totally disabled in the line of duty

Signature of Dependent or Survivor**:** _____ Date:_____

THIS SECTION FOR VA USE ONLY

I hereby verify that the records of the US Department of Veterans Affairs or the Department of Defense confirm that the above named veteran or National Guard Member: (please check appropriate box)

- ☐ Died during service in the Armed Forces
- ☐ Is listed as a Prisoner of War or Missing in Action
- ☐ Died or was permanently and totally disabled in the line of duty while a member of the National Guard.

Is above named student entitled to VA Educational Benefits? ◯ Yes ◯ No

_____
(*Signature of VA Official*)

CRITERIA GOVERNING THE VETERAN'S DEPENDENTS OR SURVIVORS

FREE TUITION PROGRAMS AT STATE SUPPORTED UNIVERSITIES AND TECHNICAL COLLEGES

Free Tuition for Children of Veterans Who Die During Service

(SDCL §13-55-6 to §13-55-9)

Children who are under the age of 25, are residents of South Dakota, and whose mother or father was killed in action or died of other causes while on active duty in the armed forces, are eligible for free tuition at a state supported university or technical college. The deceased parent must have been a bona fide resident of this state for at least six (6) months immediately preceding entry into active service.

Free Tuition for Dependents of POW's and MIA's

(SDCL §13-55-9.2 to §13-55-9.6)

Children and spouses of prisoners of war, or of persons listed as missing in action, and who were residents of this state at the time of entry into the armed forces, are entitled to attend a state supported school without the payment of tuition or mandatory fees provided they are not eligible for equal or greater federal benefits.

Free Tuition for Dependents of South Dakota National Guard Members Disabled or Deceased In Line of Duty

(SDCL §13-55-10)

Resident children who are under the age of twenty-five years, and/or the spouse of a South Dakota National Guard Member who died or sustained a total disability, permanent in nature, resulting from duty as a member of the National Guard, while on state or federal active duty or any authorized training duty, are entitled to free tuition at any state supported university or technical college in South Dakota.

Individuals applying for free tuition must complete this application and email it along with veterans DD214, NGB22, dependent verification, death certificate or VA Award Letter whichever is applicable to:

Email: shane.olivier@state.sd.us

Once completed by SDDVA, the form will be returned to the veteran, where it should then be presented to the registrar of the school where the veteran will be attending classes.

HIGH SCHOOL DIPLOMA APPLICATION

QUALIFYING DATES OF SERVICE
December 7 1941 – September 2, 1945
June 25, 1950 – July 31, 1953
February 28, 1961 – May 7, 1975

Note: Attach a Copy of Veteran's Discharge Papers

VETERAN'S NAME AND PERSONAL INFORMATION

First Name:_____ Middle Initial: _____ Last Name: _____

Address (number, street, apartment, city, state and zip):_____

Home Phone (include area code):_____

Date of Birth (month/day/year):_____

VETERAN'S MILITARY SERVICE INFORMATION

Branch of Service:_____ Service Number: _____ Highest Rank/Grade Attained:_____

Periods of Active Duty Military Service:

Dates Entered Month/Day/Year	Dates Separated Month/Day/Year
_____	_____
_____	_____

HIGH SCHOOL INFORMATION

High School Attended (if applicable): _____

Highest Grade Completed or Formal Schooling:_____

I certify that all information I have provided on this application and the supporting documentation is true and correct to the best of my knowledge.

_____

Signature of Veteran (or legal representative): Date: _____

SDCL 33A-2-34. Honorary high school diploma to be awarded to veterans serving during certain periods. Any honorably discharged veteran as defined in § 33A-2-1 may request and shall receive an honorary high school diploma as provided in this section if the veteran served in the armed forces of the United States during the period December 7, 1941, to September 2, 1945, inclusive; during the period June 25, 1950, to July 31, 1953, inclusive; or during the period February 28, 1961 to May 7, 1975, inclusive. The school district selected by the eligible veteran shall award an honorary high school diploma to the veteran.

SOUTH DAKOTA DEPARTMENT OF VETERANS AFFAIRS
Veteran/Active Duty Bonus Application

Bonus Claim #

APPLICANT'S IDENTIFYING INFORMATION

Member-4 copy of DD214 or current orders must be included with this application. Carefully read the instructions found on the reverse side of this form before filling in the requested information. Incomplete or illegible applications may be returned to sender.

Name: (Last, First, Middle)		Social Security Number:
Date of Birth: (Month/Day/Year)	Phone Number:	Email Address:

Current Mailing Address: (Street or PO Box)		
City:	State:	Zip Code:

Address for 6 Months Prior to Entry into Service: (Street)		
City:	State:	Zip Code:

Date Entered Active Duty: From: To:	Second Tour: From: To:
Actual Dates Served in Area of Hostilities or War Zones: From: To:	Second Tour: From: To:
Have you received, or are you eligible to receive from any other state, a bonus or compensation based on the above period of service? Yes No	Do you have a service connected disability rating by the US Dept. of Veterans Affairs of 10% or more? Yes No

Information provided on this form is true and accurate to the best of my knowledge.

Signature of Applicant: (MUST be original)	Date

TO BE COMPLETED BY TRIBAL/COUNTY VETERANS SERVICE OFFICER (IF DISCHARGED) OR COMMANDING OFFICER (IF ACTIVE DUTY) I certify that I have reviewed the above application and find it to be true and correct to the best of my knowledge.

Signature and printed name: (MUST be original)	County/Tribe or Commanding Officer Title:
Remarks:	Date:

Please return to: South Dakota Department of Veterans Affairs

ATTN: Bonus Program
425 E. Capitol Avenue
Pierre, SD 57501-3100
PH: 605-773-7251

FOR DEPARTMENT USE ONLY

Claims Examiner Review: ☐ Approved ☐ Disapproved	Amount:	Administrative Review: ☐ Approved ☐ Disapproved	Date:
Initials:	Date:	Signature:	

Instructions - Please Read Carefully

In South Dakota, all applications must be certified by your local County or Tribal Veterans Service Officer, SDDVA Personnel, or Active Duty Commanding Officer.

1. MUST include Member 4 copy of DD214 or Active Duty Orders with this application.

2. Include name as shown on DD-214. (If different, attach copy of document explaining the difference in name, i.e., marriage certificate, etc.)

3. Include address to which bonus check should be mailed.

4. If more than one address, list on a separate sheet of paper. To be eligible for the bonus, you must have been a legal resident of South Dakota for at least six months immediately preceding entry into the armed forces.

5. To be eligible for payment, you must have honorable service during the qualifying period(s).

   For Active Duty service between the dates of January 1, 1993, through September 10, 2001, bonus payments will be made only to those veterans who served in a location qualifying as an area of hostilities based on DOD Regulations, and for the time actually spent in that area.

   All Active Duty service from September 11, 2001, through a date to be determined, qualifies for a bonus payment of $100 for the first month and $20 for each subsequent month to a maximum of $240. Veterans who served in an area of hostilities, will be paid $150/month for the first month and $50/month for each subsequent month served in that area, together with the above rates of $100/month and $20/month for other services during the qualifying dates, to a maximum of $500.

   Any period of active duty service during a calendar month shall be considered as one full month in determining monthly totals.

   No veteran may receive a bonus payment in excess of $500. However a veteran who was eligible for a bonus for service prior to December 31, 1992, and is also eligible for a bonus for service after January 1, 1993, may receive two separate bonuses.

6. Show the ACTUAL DATES SERVED. Example: for service in Iraq - From: Apr. 20, 2003 To: Apr. 19, 2004.

7. Veterans who are eligible for a bonus payment and who have a service connected disability rated by the U.S. Department of Veterans Affairs (VA) as 10% or more disabling, will receive the maximum payment of $500. If you marked YES, you MUST send a current copy of your VA award letter or other verification from the VA along with this application.

8. Please list any extended remarks regarding this bonus application on a separate sheet of paper.

If you have questions on completing this form contact Jeri Smith at (605) 773-7251.

SEND COMPLETED APPLICATION AND ALL OTHER REQUIRED DOCUMENTS TO:

South Dakota Department of Veterans Affairs
ATTN: Bonus Program
425 East Capitol Avenue
Pierre SD 57501-3100
PH: 605-773-7251

SOUTH DAKOTA VETERANS CEMETERY

DETERMINATION OF ELIGIBILITY FORM

PLEASE READ ALL INSTRUCTIONS AND REQUIREMENTS. This application will only be used for certification of eligibility for burial at the South Dakota Veterans Cemetery.

A COPY OF THE VETERAN'S DD214 OR DISCHARGE PAPERS IS REQUIRED AND MUST ACCOMPANY THIS APPLICATION. IF APPLICABLE, A COPY OF MARRIAGE CERTIFICATE AND DEATH CERTIFICATE, (VETERAN AND/OR SPOUSE) IS ALSO REQUIRED.

VETERAN APPLICANT'S NAME, PERSONAL AND SERVICE INFORMATION: (Type or Print Legibly)

1. LAST NAME (legal last name, **not** maiden name)		1b. FIRST NAME			1c. MIDDLE NAME	
1d. PHONE NUMBER	2. ADDRESS				2a. EMAIL ADDRESS	
3. CITY	3a. STATE	3b. ZIP	4. DATE OF BIRTH (MM/DD/YYYY)		4a. DATE OF DEATH (MM/DD/YYYY)	
5. SOCIAL SECURITY NUMBER	6. MARITAL STATUS ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ NEVER MARRIED ☐ DIVORCED		7. GENDER ☐ MALE ☐ FEMALE	8. MILITARY STATUS ☐ VETERAN ☐ RETIRED	9. DATE OF MILITARY RETIREMENT	
10. BRANCH OF SERVICE ☐ ARMY ☐ MARINE CORPS ☐ NAVY ☐ AIR FORCE ☐ COAST GUARD OTHER (specify) _____			11. WAR SERVICE (must be consistent with discharge & federal guidelines) ☐ WWII ☐ KOREA ☐ VIETNAM ☐ PERSIAN GULF OTHER (specify) _____			
12. SERVICE NUMBER (if applicable)			13. LAST NAME ON DISCHARGE IF DIFFERENT THAN ABOVE			
14. PERIODS OF **ACTIVE DUTY** MILITARY SERVICE (MM/DD/YYYY) Entry Date(s):			Discharge/Separation Date(s):			

SPOUSE'S NAME AND PERSONAL INFORMATION:

15. LAST NAME (legal last name, **not** maiden name)	15b. FIRST NAME		15c. MIDDLE NAME
16a. DATE OF BIRTH (MM/DD/YYYY)	16b. DATE OF DEATH (MM/DD/YYYY)	17. SOCIAL SECURITY NUMBER	
18. WILL VETERAN'S SPOUSE ALSO BE INTERRED AT THIS CEMETERY? ☐ YES ☐ NO		***NOTE* IF THE SPOUSE IS A VETERAN, A SEPARATE APPLICATION**	
19. IS THE SPOUSE ALSO A VETERAN? ☐ YES ☐ NO		**AND SUPPORTING DOCUMENTATION MUST BE SUBMITTED**	
20. **IF SPOUSE IS ALSO A VETERAN**, PLEASE CHOOSE ONE OF THE FOLLOWING: (Only if eligible and all documentation is received prior to veteran spouse burial, otherwise will be in same gravesite)		☐ I DESIRE TO BE INTERRED WITH VETERAN **OR** ☐ I DESIRE ADJACENT GRAVE/NICHE OF MY OWN	

ADDITIONAL CONTACT INFORMATION:

21. LAST NAME	22. FIRST NAME	23. RELATIONSHIP
24. CURRENT ADDRESS (number, street, city, state, zip)		25. PHONE NUMBER (home or cell)

****Please forward this form to the South Dakota Veterans Cemetery, 25965 477th Ave, Sioux Falls, SD 57104****

Instructions and Requirements for South Dakota Veterans Cemetery

Eligibility:

- Criteria for burial at the South Dakota Veterans Cemetery is the same as for a national cemetery. For a complete list of eligibility criteria for veterans, spouses and dependents, please visit the National Cemetery Administration website at **www.cem.va.gov/burial_benefits/eligible.asp**
- Marriage - Veteran and spouse MUST be legally married. Former spouse of an eligible veteran whose marriage to that veteran has been terminated by annulment or divorce is **not** eligible.

Military Service:

- Veterans may request military service records at the National Archives website at **https://www.archives.gov/veterans/military-service-records**

Residency:

- There are no residency requirements for burial in the South Dakota Veterans Cemetery

Fees:

- There is no fee for a qualifying veteran
- There is a fee for a non-veteran spouse & eligible dependent

PERSONS FOUND GUILTY OF A FEDERAL OR STATE CAPITAL CRIME, ARE INELIGIBLE.

***38 U.S.C. §2411 Summary Persons Found Guilty of a Capital Crime and Persons Convicted of Certain Sex Offenses** Under 38 U.S.C. § 2411, interment or memorialization in a VA national cemetery or in Arlington National Cemetery is prohibited if a person is convicted of a federal or state capital crime, for which a sentence of imprisonment for life or the death penalty may be imposed and the conviction is final. Federal officials may not inter in veterans cemeteries persons who are shown by clear and convincing evidence to have committed a federal or state capital crime but were unavailable for trial due to death or flight to avoid prosecution. Federally funded state veterans cemeteries must also adhere to this law. This prohibition is also extended to furnishing a Presidential Memorial Certificate, a burial flag, and a headstone or marker. Under 38 U.S.C. § 2411, interment or memorialization in a VA national cemetery or in Arlington National Cemetery is prohibited if a person is convicted of a Tier III sex offense, who was sentenced to a minimum of life imprisonment and whose conviction is final. Federally funded state and tribal organization veterans cemeteries must also adhere to this law. This prohibition also applies to Presidential Memorial Certificate, burial flag, and headstone and marker benefits.

By signing below, I certify that I am the veteran identified on this document or an authorized individual signing for the veteran. All information is true and correct to the best of my knowledge. A faudulent statement that leads to burial in a state cemetery could result in disinterment from the state cemetery. I acknowledge that otherwise eligible individuals may be barred from burial by committing certain serious crimes, as provided under 38 U.S.C. § 2411. I acknowledge that I am obligated to inform cemetery personnel if such crimes have been committed.

Printed Name: _____ **Relationship to veteran: _____**

Signature: _____ **Date: _____**

****Please forward this form to the South Dakota Veterans Cemetery, 25965 477th Avenue, Sioux Falls, SD 57104****

Department of Veterans Affairs
Michael J. Fitzmaurice
South Dakota Veterans Home
2500 Minnekahta Avenue
Hot Springs, SD 57747
Phone 605.745.5127

REQUIRED DOCUMENTATION CHECKLIST

Please review and return the below checklist to ensure all additional items are included with the application or indicate why they are not included. Please send copies of the items below with the application. Thank you.

Applicant Name:

Not Applicable	Included	Required Documentation
☐	☐	Previous three (3) months bank statements
☐	☐	Any "other" income documentation
☐	☐	Authorization for Release of Health Information (For Providers, Clinics, Hospitals outside of the VA)
☐	☐	VA Request for and Authorization to Release Health Information (Form 10-5345)
☐	☐	Most recent VA pension / disability award letter
☐	☐	DD-214
☐	☐	Most recent Social Security Award letter
☐	☐	Medicare Card: Part A ☐ Part ☐ Part D (Prescripti☐
☐	☐	Supplemental insurance card
☐	☐	Medicaid Card
☐	☐	Social Security Card
☐	☐	Driver's license or ID Card
☐	☐	Current vehicle insurance card (if you have a current driver's license)
☐	☐	Burial Trusts / Arrangement Note: If you do not have a burial plan, please list the name and phone number of your preferred funeral home: _____
☐	☐	Healthcare Power of Attorney
☐	☐	Financial Power of Attorney

MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME

As of January 4, 2022

APPLICANT INFORMATION

Applicant's Name:

Date of birth: SSN: Phone:

Physical address:

City: State: Zip:

Mailing address:

City: Hot Springs State: SD Zip: 57747

Married ☐ Single ☐ Divorced ☐ Widow/Widower ☐ Never Married ☐ Separated ☐

Spouse Name:

Date of Birth: SSN:

IN CASE OF EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Address:

Home Phone: Cell Phone:

LEVEL OF CARE/MEDICAL INFORMATION

Level of Care Sought (select one): ☐ Residential Living (Independent) ☐ Nursing Care

Criteria for Residential Living:

- General health status is stable and does not require frequent medical Interventions for a Physician, Physician Assistant, or Certified Nurse Practitioner
- Free of communicable disease
- Residential living requires that potential residents have total independence with personal care needs; such as, bathing, dressing, eating, ambulating (walking), toileting, transferring, etc.
- Applicants who have a diagnosis of alcohol or substance abuse must have twelve months of documented sobriety before being accepted to the SDVH

Criteria for Nursing Care:

- The applicant requires nursing care 24 hours per day.
- The applicant requires nursing staff to manage, observe, and evaluate care.
- The applicant requires supervision or monitoring to ensure his or her safety.
- The applicant may require nursing restorative services and / or therapy rehabilitation services.
- Applicants who have a diagnosis of alcohol or substance abuse must have twelve months of documented sobriety before being accepted to the SDVH.
- PASRR (Pre-Admission Screening and Resident Review) Required

List all major medical conditions:

Cost of Care for the Michael J. Fitzmaurice South Dakota Veterans Home

Residential Living (Independent)	**Nursing Care**
Assets above $50,000 rate is $203.75 per day (**Approximate Cost: $6,197.40 per month based on Calendar Year 2022 rates)**	$360.00 per day (**Approximate Cost: $10,950.00 per month based on Calendar Year 2022 rates)**
Assets below $50,000 is 50% of total income (single) 55% of total income (couple)	

MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME

APPLICANT INFORMATION

Applicant's Name:	Preferred Name:
Mother's Maiden Name:	
Birth Sex: ☐ Male ☐ Female	
Are you Hispanic or Latino: ☐ Yes ☐ No	
What is your race? (You may check more than one): ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander	
Birth City:	Religion:

MILITARY SERVICE INFORMATION

Last branch of service	Last Entry Date	Last Discharge Date
Discharge Type	Military Service # if known	

Military History (select those that apply):

- ☐ Are you a Purple Heart Recipient?
- ☐ Are you a former prisoner of war?
- ☐ Did you serve in a combat theater of operations after 11/11/98?
- ☐ Were you discharged or retired from military for a disability incurred in the line of duty?
- ☐ Are you receiving disability retirement pay instead of VA compensation?
- ☐ Did you serve in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998?
- ☐ Do you have a VA Service-Connected Rating? If yes, what percentage? _____%
- ☐ Did you serve in Vietnam between January 9, 1962 and May 7, 1975?
- ☐ Were you exposed to radiation while in the military?
- ☐ Did you receive nose and throat radium treatments while in the military?
- ☐ Did you serve on active duty at least 30 days at Camp Lejeune from August 1, 1953 through December 31, 1987?

Signatures

I certify that the information contained above is true and correct to the best of my knowledge. My signature, or the signature of my representative, signifies my interest in admission to the Michael J. Fitzmaurice South Dakota Veterans Home. I agree to cooperate fully with providing additional admissions documentation that is necessary prior to admission to the Michael J. Fitzmaurice South Dakota State Veterans Home.

Signature of Applicant or Representative (required):	Date:
Signature of Spouse (if applicable):	Date:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

Name _____ Date of Birth _____

I hereby authorize the *Michael J. Fitzmaurice South Dakota Veterans Home* at *2500 Minnekahta Ave., Hot Springs, SD 57747* to release my Protected Health Information as described below:

Name (please print)	Relationship to Resident	Phone Number	Mailing Address	Email address (if applicable)

Information to be released (check each requested item):

☐ History and Physical ☐ Progress Notes ☐ Social Worker Notes
☐ Laboratory Reports ☐ Radiology Reports ☐ Other (see below)
Other is specified as: _____

The following information will not be released unless you specifically authorize it by checking the relevant box(es) below:
☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.

The purpose of this release is (check one or more):
☐ Continuity of care or discharge planning
☐ At the request of the resident / resident's representative
☐ Other (state reason) _____

Expiration of Authorization: Unless otherwise revoked, in writing, this authorization expires at the time I am on longer a resident at the Michael J. Fitzmaurice South Dakota Veterans Home.

_____ _____
Signature of Resident or Resident Representative Date

_____ _____
Printed Name Resident Representative Relationship

NOTICE: The Michael J. Fitzmaurice South Dakota Veterans Home (MJFSDVH) and many other organizations and individuals, such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect it.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the MJFSDVH at 2500 Minnekahta Avenue, Hot Springs, SD 57747. The revocation will take effect when the MJFSDVH receives it, except to the extent that the MJFSDVH or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

AUTHORIZATION FOR FINANCIAL VERIFICATION

I HEREBY AUTHORIZE THE VETERANS ADMINISTRATION AND ANY BANK, SAVINGS AND LOAN OR OTHER FINANCIAL INSTITUTION TO RELEASE TO ANY AGENT OR REPRESENTATIVE OF THE MICHAEL J. FITZMAURICE SOUTH DAKOTA VETERANS HOME A FINANCIAL STATEMENT OR OTHER FINANCIAL INFORMATION REGARDING ALL ASSETS, INCLUDING PROPERTY, ACCOUNTS, LOANS, AND INVESTMENTS, IN WHICH I OR MY SPOUSE HAVE AN INTEREST.

- **SUCH AUTHORIZATION IS CONTINUING AND WITHOUT LIMITATION FROM THIS DATE.**

DATED THIS _____ DAY OF _____ 20 ___

_____
(APPLICANT SIGNATURE)

_____
(NOTARY PUBLIC SIGNATURE)

SEAL COMMISSION EXPIRES_____

The following summary is provided to help you understand the laws that refer to disposition of assets while residing at the South Dakota Veterans Home.

- There often is a difference between what you will pay as your monthly maintenance rent and the actual full cost of care. South Dakota Codified Laws provide for a claim against your estate up to the amount of that difference.
- The specific laws are reprinted below. We recommend that you share a copy of this information with your next of kin.
- If you have any questions, please feel free to contact the Veterans Home Business Office at (605) 745-5127.

SDCL 33A-4-16. Distribution of assets of deceased member. If any member of the State Veterans' Home dies without legal dependents, the member's property shall be distributed to the South Dakota State Veterans' Home as sole heir for the sole use and benefit of the home. The member may, by will, dispose of the member's estate subject to the preferred claim provided in §§ 33A-4-17 to 33A-4-20, inclusive. A spouse residing at the home is considered as a legal dependent for the purpose of this section.

SDCL 33A-4-17. Authority to turn deceased member's property over to department--Subsequent claim for property. If a member of the State Veterans' Home dies, leaving at the home cash or other personal property of value, the superintendent of the home may turn over the cash, property, or its proceeds to the Department of Veterans Affairs for the sole use and benefit of the home, without administration. The cash, property, and proceeds are subject to refund within three years to any creditor, legal dependent, or heir, if the deceased member left a will, and if the creditor, legal dependent, or heir establishes a right to the cash, property, or proceeds or any portion of the cash, property, or proceeds. The attorney general, upon being satisfied that a claim out of the cash, property, or proceeds is legal and valid, may certify the claim to the secretary of veterans affairs, and the secretary of veterans affairs shall satisfy the claim.

SDCL 33A-4-18. Claim for maintenance of deceased member--Disposition of funds. If an estate is left by a deceased member of the State Veterans' Home leaving no surviving spouse or dependent, the state home shall file a claim against the estate of the deceased member in the amount of the full maintenance charge for each month the member was in the home, retroactive from the date of admission with proper credits allowed to the estate of the deceased member for any payments made by the member. However, the credits may not include any allowances of the state government. Any such money received from the deceased member shall go to a capital fund of the state home for repairs, equipment, improvements, or construction.

SDCL 33A-4-19. Claim against estate of deceased spouse or dependent. If a deceased member of the State Veterans' Home leaves a spouse, or other dependent, the member's estate is payable to the spouse, or other dependent. Upon the death of the spouse or other dependent, the state home shall file a claim against the estate of the deceased spouse or other dependent for any claim against the estate of both the deceased husband and wife as provided in § 33A-4-18. The claim is a preferred claim against the estates.

SDCL 33A-4-20. Transfers to avoid state's claim. Any transfer of property to avoid the payment of a claim of the State Veterans' Home shall be voidable.

SDCL 29A-6-107 Payment to surviving party from multiple-party account -- Liability for debts and expenses of administration -- Procedure -- Liability of financial institution. No multiple-party account is effective against an estate of a deceased party to transfer to a survivor sums needed to pay debts, taxes, and expenses of administration, including statutory allowances to the surviving spouse, minor children and dependent children, if other assets of the estate are insufficient. A surviving party, P.O.D. payee or beneficiary who receives payment from a multiple-party account after the death of a deceased party shall be liable to account to his personal representative for amounts the decedent owned beneficially immediately before his death to the extent necessary to discharge the claims and charges mentioned above remaining unpaid after application of the decedent's estate. No proceeding to assert this liability may be commenced unless the personal representative has received a written demand by a surviving spouse, a creditor or one acting for a minor or dependent child of the decedent, and no proceeding shall be commenced later than two years following the death of the decedent. Sums recovered by the personal representative shall be administered as part of the decedent's estate. This section does not affect the right of a financial institution to make payment on multiple-party accounts according to the terms thereof or make it liable to the estate of a deceased party unless before payment the institution has been served with process in a proceeding by the personal representative.

I hereby acknowledge that I have received a copy and understand the provisions of SDCL 33A-4-16, 33A-4-17, 33A-4-18, 33A-4-19, 33A-4-20 and SDCL 29A-6-107 regarding the state's preferred claim for maintenance payments of deceased members.

_____ _____

Applicant's Signature Date

_____ _____

Signature of Next of Kin/Witness Date

1. SPOUSE INFORMATION (whether or not spouse is moving in)**:**

Spouse's Name	Birth date	Sex	SSN

2. INFORMATION ON DEPENDENTS:

Dependents Name(s)	Birthdate(s)

3. LIVING ARRANGEMENTS: Check the box that describes current living conditions

Self: ☐ Own Home	☐ Renting	☐ In someone else's Home	Other (describe)	
Spouse: ☐ Own Home	☐ Renting	☐ In someone else's Home	Other (describe)	

4. INFORMATION ON MEDICARE:

Attach copies of Medicare card(s), front and back, if you or your spouse have Medicare.

Do you have Medicare? ☐ Yes ☐ No	☐ Part A	☐ Part B	☐ Part D	Effective date(s)	Medicare ID Number
Does your spouse have Medicare? ☐ Yes ☐ No	☐ Part A	☐ Part B	☐ Part D	Effective date(s)	Medicare ID Number

5. INFORMATION ON MEDICAID:

Attach copies of Medicaid card(s), front and back, if you or your spouse have Medicaid.

Do you have Medicaid? ☐ Yes ☐ No	Medical ☐	Long Term Care ☐	Effective date(s)	Medicaid ID Number
Does your spouse have Medicaid? ☐ Yes ☐ No	Medical ☐	Long Term Care ☐	Effective date(s)	Medicaid ID Number

6. INFORMATION ON ALL OTHER INSURANCE: If you have other insurance, please complete the following information and provide copies. This includes health, long term care, and prescription medication coverage. Attach another sheet if more room is needed.

Insurance Provider Name and Address	Annual Premium	Type: Hospital, Medigap, Rx, etc.	Effective Date(s)	Policy Number
Self				
Spouse				

7. INCOME AND EARNINGS:

List all types of earnings and income that you, your spouse, or dependents receive.
List the income amount before deductions (such as taxes and insurance) are taken out.
Include proof of all income (check stubs, bank statements, benefits letters, etc.)
Make copies, do not send the Original Documents.

Examples of income include:

*Social Security	*Social Security Income	*Wages/Self Employment	*Annuities
*Railroad/Retirement Benefits	*Veterans Benefits	*Trust or Annuity Payments	*Long Term Care Benefits
*Pension/Retirement Benefits	*Rental Income	*Oil Royalties/Mineral Rights	*Disability Income

Who Receives Income Self/Spouse	Type of Income	Amount	Source of Income	How often Received?	ID Number (if Req)

8. ALL ASSETS:

Do you or your spouse own all or part of any Real Estate? ☐ Yes ☐ No
If yes, please complete the following for each piece of real estate.

Address	Value	Amount Owed

Do you or your spouse, own a Car, Truck, Motorcycle, Boat trailer, or other vehicles? ☐ Yes ☐ No
If Yes, please complete the following information about each vehicle

Owner(s)	Year	Make	Model	Value	Amount Owed

9. ALL ASSETS:

List all types of assets owned by you or your spouse. Include any accounts or properties on which your name or your spouse's name appears. Include verification (such as copies of your most recent bank statement, trust fund statements, etc.) of all resources. Examples of resources:

* Checking accounts
* Savings accounts
* Government bonds
* Trust funds
* Funeral plans/burial arrang
* Burial Plots
* Stocks and Bonds
* Certificates of Deposit
* Cash on hand
* Safety Deposit boxes
* Retirement Funds
* Other Income, Resources
* Annuities
* Life Insurance

Attach additional pages if needed.

Type of Resource	Account/Policy #	Value	Name & Address of Bank, Insurance Company or other Financial Institution

10. STATEMENT OF PROPERTY TRANSFERS:

I have ☐ (or) have not ☐ sold, transferred or conveyed any property or other assets within the last five (5) years

If so, to whom:

Name: _____

Address: _____

Phone #: _____

Description of the property or assets:

Value of the property or assets: _____

Amount received: _____

Disposition of the proceeds:

11. APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT: I understand that, by signing this application, I am agreeing to a review of my eligibility by state officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my financial information. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary verification. I authorize the use of my (our) Social Security Number's) for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify my financial status.

12. OPTION TO PAY FULL COST OF CARE: I hereby choose and agree to pay the full cost of care in lieu of providing my financial information and documentation. I further understand that the current maintenance rent for the proposed level of care is currently _____per month, and that this is recalculated on an annual basis according to the Administrative Rules of South Dakota. (Further details provided upon request) Full signature is also required below.

13. APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN: State law provides for fine, imprisonment, or both for any person who withholds or gives false information. I understand the questions on this application, and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I also agree that during my stay at the Home neither I nor any agent of mine will transfer any of my assets to avoid payment for my care, or if any amount is still owed based on the full cost of my care at the time of my death. I agree to notify the SDVH of changes in my income, resources, or assets which might affect my maintenance rent at the MJ Fitzmaurice SD Veterans Home.

14. MEDICARE PART B & D: If I do not have Medicare part B and D upon admission, I agree to apply for both during the next open enrollment period.

15. MEDICAL RECORDS: Medical records will be obtained via the attached medical records Release of Information (ROI) forms on pages 11-13. If your received records do not contain a History & Physical or annual exam within the last 60 days proceeding the date of the application you may be required to schedule an appointment with your primary care provider for a History & Physical or annual exam.

_____ _____

Signature of Applicant or Representative (REQUIRED) Date

_____ _____

Signature of Applicant's Spouse Date

The MJF S.D. Veterans Home Nursing Care Units and Special Care Units operate under Medicaid Guidelines. The Independent Living Households operate under South Dakota Veterans Affairs Administrative Rules defined by South Dakota Codified Laws which determine your monthly fee. It is important to remember that this fee is reviewed annually and can change based on changes in your gross income and asset status, operating cost of the MJF S.D. Veterans Home and changes in administrative rules. Initial maintenance rent will be based on current income (and assets), or an adjusted gross income from your prior year's federal income tax return (and assets), whichever is greater. Annual updates to your financial statement may be required.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION ***Please do not use this form for VA Medical Records. It is only for providers, clinics, hospitals outside of the VA***

Name _____ Date of Birth _____

Medical Record Number _____ SSN _____

I hereby authorize (name of person or facility sending information) _____

_____

to release my health information to the *Michael J. Fitzmaurice South Dakota Veterans Home* at *2500 Minnekahta Ave., Hot Springs, SD 57747*.

Information to be released (check each requested item):

☐ History and Physical ☐ Progress Notes ☐ Social Worker Notes
☐ Laboratory Reports ☐ Radiology Reports ☐ Entire Record
Other (please specify): _____

The following information will not be released unless you specifically authorize it by checking the relevant box(es) below:
☐ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.

The purpose of this release is (check one or more):
☐ Continuity of care; Assessment for admission; Treatment; Discharge planning
☐ At the request of the resident / resident's legal representative
☐ Other (state reason) _____

Expiration of Authorization: Unless otherwise revoked, in writing, this authorization expires at the time I am on longer a resident at the Michael J. Fitzmaurice South Dakota Veterans Home.

_____ _____
Signature of Resident or Legal Representative Date

_____ _____
Printed Name Legal Representative Relationship

_____ _____
Witness Date

NOTICE: The Michael J. Fitzmaurice South Dakota Veterans Home (MJFSDVH) and many other organizations and individuals, such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect it.

MY RIGHTS:

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the MJFSDVH at 2500 Minnekahta Avenue, Hot Springs, SD 57747. Any information disclosed prior to receipt of written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information be disclosed under authorization in any form or medium including oral, written, or electronic transmission.
- I am entitled to receive a copy of this Authorization.

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

VA Black Hills HCS
500 N. 5th Str.
Hot Springs,SD 57747
Fax: 612-725-1329

Sioux Falls VA HCS OR
2501 W. 22nd Str.
Sioux Falls SD 57105
Fax: 612-725-1355

Please indicate VA facility you received care at:

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Michael J. Fitzmaurice South Dakota Veterans Home
2500 Minnekahta Ave.
Hot Springs, SD 57747
Medical Records contact: 605-745-5127 Ext. 1500115- Medical Records Fax: 605-745-5507

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☒ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* Admission Assessment

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☒ HEALTH SUMMARY *(Prior 2 Years)*

☒ INPATIENT DISCHARGE SUMMARY *(Dates)*: Last 2 and last 2 H&P and last 2 annual exams

☒ PROGRESS NOTES:

- ☒ SPECIFIC CLINICS *(Name & Date Range)*: All Clinics to include mental health providers (MPH)
- ☒ SPECIFIC PROVIDERS *(Name & Date Range)*: All providers to include mental health providers
- ☒ DATE RANGE: Six months all providers & clinics;One year all mental health providers

☒ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: Last 2

☒ LAB RESULTS:

- ☒ SPECIFIC TESTS *(Name & Date)*: All
- ☒ DATE RANGE: Last six

☒ RADIOLOGY REPORTS *(Name & Date)*: Last 3

☒ LIST OF ACTIVE MEDICATIONS: Please include any allergies to medications

☒ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: Please include all immunizations in my record
If Covid vaccinated please include type of vaccine, Moderna, Pfizer, etc.

☒ OTHER *(Describe)*: My signature authorizes MJFS.D.Vet.Home to request additional records

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Upon written revocation or discharge from the Michael J. Fitzmaurice South Dakota Veterans Home

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

This form allows our staff to contact Medicaid in the event you are applying for Medicaid or need to apply for Medicaid in the future.

Section K

Authorization to Release Information is optional. This is used when you want us to communicate with others about your application or case.

Signing up to vote - Optional

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote?

☐ **Yes** ☐ **No**

If you checked yes, the Department of Social Services will send you a voter registration form. Return the completed registration card to the County Auditor in your county of residence or to your local Department of Social Services office, Department of Human Services office, WIC office or military recruitment office. **The deadline for registration is 15 days before any election.**

If you did not check either box, you will be considered to have decided not to register to vote at this time.

Please note that the information and office to which application was made will remain confidential and be used for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private.

If you believe that someone has interfered with your right to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the:

South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537

EA Authorization to Release Information

I, _____, authorize the Department of Social Services (DSS), Division of Economic Assistance (EA) to disclose my protected health information to the following individual/facility. My date of birth is _____

Individual/Facility and Name of Facility Person to Receive Information: South Dakota Veterans Home/Business Office Personnel
Address: 2500 Minnekahta Ave. Hot Springs, SD 57747
Phone Number: (605)745-5127 Fax Number: (605)745-5547

This authorization is for the time period from: _____ to _____. If left blank, this authorization shall expire 1 year from the date of execution.

I allow DSS-EA to release only the following checked information to the above strategy: (check all that apply)

- [x] Copy of Application/Renewal Form Dated: Month(s) ____ Year(s) ____ ☐ Address on File
- [ ] Copy of Notices from DSS-EA Relating to Application/Renewal Form Dated: Month(s) _____ Year(s) _____
- [x] Copy of Verification Checklist Form (EA-300) Dated: Month(s) _____ Year(s) _____

Purpose of this disclosure: _____.

I understand if this information is released to a third part, the information may be released by the person or entity that receives that information may no longer be protected by federal or other applicable privacy regulations.

I understand that I may revoke this authorization, except to the extent that staff has already taken action upon it, by sending written notice to the Department of Social Services, Division of Economic Assistance, 700 Governors Drive, Pierre, SD 57501.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
Address of Individual Signing	City/State/Zip	Phone

If signed by someone other than Applicant/Recipient indicate relationship (check appropriate box)

☐ Spouse ☐ Parent (if for child under 18) ☐ Power of Attorney ☐ Legal Guardian

Service-Connected Disability Compensation Quick Reference Sheet

Service-Connected Disability Compensation is a monetary award paid for injuries or diseases that were incurred on, or aggravated by, active military service.

Eligibility

Veterans with Active Duty, Active Duty for Training, and Inactive Duty for Training (Guard/reserves while actively training) who incur injuries or disease in the line of duty. Service must have been terminated by discharge or separation under conditions other than dishonorable. No time limit to file.

Types of Service-Connection:

Direct - Injury/disease was incurred in or began during a qualifying period of service and was not due to misconduct. Must show there is current condition and an incident/treatment for that condition while in-service or symptoms are related to that condition.

Aggravated - Injury/disease existed prior to military service but is now worse because of veteran's participation in service.

Presumptive - Diseases known to be caused by specific exposures while on active service, or injuries/diseases that manifest to the 10% level within a specific timeframe.

Secondary - Disease/injury directly attributed to a condition for which the veteran is already service-connected.

38 USC 1151 - Veteran's is injured by a VA medical facility. Injury can result from services provided for a service connected disability or from some other treatment procedure. (essentially a tort claim against government)

Records

Guard/Reserve STRs must be obtained by veteran. For a FDC, the veteran must obtain their private medical records or VA will kick claim to traditional track and require medical information release form.

Forms to File

21-22	SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
21-526EZ	Fill in all blanks. Claims office can sign if not original claim and POA on file
DD 214	Certified copy of discharge paperwork
21-686c	Dependents info if applicable
21-0781	PTSD – Stressor Statement
21-0781a	MST – Stressor Statement
21-8940	Application for IU
21-4192	Request for employment information
26-4555	Application for specially adapted housing
21-4502	Application for auto/conveyance adaptive equipment

Disability Compensation

Basic Eligibility Requirements

Compensation is payable to a veteran who incurs or aggravates a disability while serving on 'active military service'. This term should not be confused with 'active duty' which is required for most other VA benefits.

Active Military Service, as defined in 38 CFR 3.6(a) includes "active duty, any period of **active duty for training** during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in the line of duty, **and** any period of **inactive duty for training** during which the individual concerned was disabled or died from an injury incurred or aggravated in the line of duty or from an acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident which occurred during such training".

Active Duty, as defined in 38 CFR 3.6(b), means "full-time duty in the Armed Forces, other than active duty for training…."

Active Duty for Training, as defined in 38 CFR 3.6(c) means "full-time duty in the Armed Forces performed by reserves for training purposes" or "full-time duty performed by members of the National Guard…."

Inactive Duty for Training, as defined in 38 CFR 3.6(d) means "duty (other than full-time duty) prescribed for Reserves…" or "duty (other than full-time duty) performed by a member of the National Guard…."

The following explanations are in layman's terms; they are not the official definitions.

1. **Active Duty**. Those serving on active duty (Army, Marines, Navy, Air Force, and Coast Guard) can receive compensation for service connected **disease or injury.** Active duty personnel are those who work at their military units as a regular Monday – Friday job.
2. **Full-Time Reservist/Guardsman**. Those who are full-time members of the Reserves or National Guard can receive compensation for **diseases as well as injury**. Full-time reservists and guardsmen are those who are considered AGR on Title 32 and work at their military units as a regular Monday – Friday job.
3. **Traditional Reservist/Guardsman**. Part-time Reservists/Guardsmen are eligible for compensation as follows:
   - For **injuries** incurred while serving on drill status, i.e., weekend duty. They **are not eligible** for compensation for disease except for an acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident which occurred during such training.
   - For **injuries or disease** incurred while serving on annual training status**,** i.e., two week summer camp (AT).

When filing a claim for compensation for a traditional reservist or guardsman, submit a copy of their orders with the claim so the VA can make a determination as to duty status at time of injury.

Some other important factors about disability compensation are:

- Veteran must have been discharged or released from service under conditions 'other than dishonorable'
- Veteran must NOT have incurred the injury or disease as a result of willful misconduct
- There is no length of service requirement. A veteran could have served one day, and still be eligible for compensation – if other service requirements are met
- There is no wartime service requirement. A veteran's entire period of service could have been during peacetime and he or she could be eligible for compensation.

A service connected disability is normally one that was incurred or aggravated during a veteran's military service. However, there are several ways a disability can be established as service connected. It is important to note that, in most cases, the injury or disease must leave some type of **residual disability**. If the injury or disease happened only once and resolved without leaving any affect, it will be hard to establish service- connection. This is because the disability may no longer be present.

Example: A veteran had his appendix surgically removed while on active duty. The disability (appendicitis) was temporary and is no longer present. Service connection can, however, be established for the scars left by the surgery.

Establishing Service Connection

The ways that service connection can be established are:

1. **Direct** (38 CFR 3.304 & 3.305) The injury or disease first occurred during the veteran's military service.

2. **Aggravation** (38 CFR 3.306) This applies to a veteran who has a disability prior to entering service. If the veteran can prove that the disability was aggravated by, or made worse during military service, compensation may be awarded. Besides proving that the condition was indeed aggravated, evidence must establish that this worsening was not attributed to natural progression. In other words, if the disability would have gotten worse even if the veteran was not in the military, service connection may be difficult to prove.

3. **Presumption** (38 CFR 3.307 & 3.308) Presumption considers certain disabilities that surface after military service. Because of the nature of certain diseases, a veteran may leave the service not knowing that he or she has the disease. This is because many diseases show no symptoms until long after they are incurred.

4. **Secondary Condition** (38 CFR 3.310) This is a condition that is directly related to another service connected condition. In other words, this provision recognizes that a service connected disability may cause a second disability, for example: a veteran has a service connected knee injury that causes him/her to walk with a limp and he/she subsequently develops arthritis in his/her hip. Although the arthritic condition was not incurred or aggravated by service, service connection could be established if the arthritis is a result of his/her knee condition.

5. **1151 Claims** Under Title 38 USC, Section 1151, benefits may be paid for:

- Injuries incurred while receiving VA sponsored medical treatment
- Injuries aggravated while receiving VA sponsored treatment
- Injuries incurred while pursuing a course of Vocational Rehabilitation

If eligibility is established under Section 1151, the disability is considered service connected for **payment purposes only.** The disability **IS NOT** service connected for other eligibility purposes. If otherwise eligible, veteran's receiving compensation under 38 USC, 1151 may be entitled to:

- Clothing allowance
- Specially adapted housing benefits, and
- Automobile or adaptive equipment.

A claimant is *not* entitled to the following ancillary benefits under 38 USC 1151:

- Service Disabled Veterans (RH) Insurance
- Waiver of the Loan Guaranty Funding Fee
- 38 USC Chapter 31 Education Benefits
- 38 USC Chapter 35 Education Benefits
- 10-point Civil Service Preference
- Special allowance under *Public Law (PL) 87-377*, Section 156, Restored Entitlement Program for Survivors (REPS)
- Civilian Health and Medical Program of VA (CHAMPVA)
- SC Burial Allowance, and
- Loan Guaranty Benefits for a Surviving Spouse.

Ratings Defined

A rating is a formal decision made by the VA based on available medical evidence. In disability compensation cases, the rating activity determines if the disability claim is service related and, if so, assigns a percentage of disability to each claimed condition. To receive a disability compensation payment, the veteran must be rated at least 10% disabled.

Some basic rating facts you need to know are:

- Congress establishes the payment amount of each rating
- Ratings increase according to the degree of disability (the higher the percentage, the more severe the disability)
- A veteran may be rated from 0% to 100% disabled, depending on the severity of the disability
- A veteran can have several individual ratings – one for each claimed disability that was found to be service connected. However, a veteran also has one "combined" rating.

The VA rating activity uses a 'Rating Schedule' as a guide to determine a percentage of disability. The rating schedule assigns specific percentages for disabilities depending on the degree of impairment. This percentage represents the **average impairment in earning capacity resulting from the injury or disease**.

Special Monthly Compensation SMC (38 CFR 3.350)

Special monthly compensation (SMC) is a rating for a special allowance for veterans with certain severe disabilities. Veterans awarded an SMC usually suffer the **loss or loss of use of a body part.** An SMC rating increases the veteran's rate of compensation payment by an amount depending on the severity of the disability. The SMC designators are: k, l, m, n, o, q, r, s, and t.

SMC (k) is payable for each service connected anatomical loss, or loss of use, of any of the following:

- One or more creative organs
- One foot
- One hand
- Both buttocks
- Blindness of one eye (having light perception)
- Complete organic aphonia with constant inability to communicate by speech
- Deafness in both ears
- The anatomical loss or partial loss of one or both breasts for a female

SMC (l) is payable for service connected anatomical loss, or loss of use, of any of the following:

- Both feet
- One hand and one foot
- Blindness in both eyes (with 5/200 visual acuity or less)

This rate also applies to veteran who are permanently bedridden or so helpless as to be in need of regular aid and attendance.

SMC (m) is payable for service connected anatomical loss, or loss of use, of any of the following:

- Both hands
- Both legs at a level, or with complications, preventing natural knee action with prosthesis in place
- One arm and one leg at levels, or with complications, preventing natural elbow and knee action with prosthesis in place
- Blindness in both eyes (light perception only) or blindness that renders the veteran so helpless as to be in need of regular aid and attendance

SMC (n) is payable for service connected anatomical loss, or loss of use, of any of the following:

- Both arms at levels preventing natural elbow action with prostheses in place
- Both legs so near the hip as to prevent prosthetic appliance use
- One arm and leg so near the shoulder and hip as to prevent prosthetic appliance use
- Both eyes
- Blindness in both eyes (without light perception in both eyes)

SMC (o) the highest paying rate, is payable to service connected disabilities where the veteran's has:

- Two or more of the "L", "M", or "N" rates, as long as no single condition is considered twice.
- Bilateral deafness with a rating of 60% or greater, in combination with service connected blindness with 20/200, or less, visual acuity.
- Total deafness in one ear or bilateral deafness rated at 40%, or more, in combination with service connected blindness (having light perception only)
- Suffered anatomical loss of both arms so near the shoulder as to prevent prosthetic appliance use
- Paralysis of both lower extremities, together with the loss of anal and bladder sphincter control

SMC (q) is unique in that it is no longer awarded. It is the rate for arrested tuberculosis which was repealed on August 19, 1968. Since then, no new "Q" awards have been made, however, veteran's who were receiving compensation for tuberculosis on that date continue to do so.

SMC (r) has two rates – R1 and R2. "R" is a special rate payable to veterans who require regular aid and attendance. Payment under these rates stops if the veteran is hospitalized at government expense.

- **r1** is for veterans who are receiving the maximum amount of compensation (the "o" rate) and are in need of regular aid and attendance.
- **r2** is a higher amount paid if the rating activity finds that in absence of regular aid and attendance, the veteran would require hospitalization, nursing home care, or other residential care.

SMC (s) is payable if the veteran has a single service connected disability rated 100% and:

- Has additional disability or disabilities independently rated at 60%, or more or,
- By reason of service connected disability or disabilities is housebound.

SMC rates also include "intermediate rates" which occur when the rating activity determines that the veteran's disabilities exceed the description of a certain rate, but do not qualify for the next higher rate.

SMC (t) When a veteran requires assistance with dressing, feeding, bathing, and other tasks of daily living as the result of TBI, they may be eligible for SMC (t).

SMC (t) pays at the highest rate for SMC. The current rate for SMC (t) for a single veteran with no dependents is $9,004.64. This rate is equal to the rate paid for SMC (r)(2). It is granted in place of a veteran's monthly VA disability rating, not in addition to.

Individual Unemployability Ratings (38 CFR 4.16)

Individual Unemployability (IU) is a provision where a veteran may receive payment as though he or she was rated at 100%. Under this provision, the veteran must be found unable to secure or maintain substantially gainful employment due to his or her service connected disability. The rating schedule defines total (100%) disability as an impairment of mind or body that is sufficient to make it impossible for the average person to follow a substantially gainful occupation. Marginal employment, such as odd jobs, is not considered substantial gainful employment for VA purposes.

To be considered for IU the veteran's must:

- Be rated with at least one service connected disability
- Provide evidence of past employment
- Be unemployable.

In addition, if the veteran has:

- One rated disability, it must be rated 60%, or
- Two or more disabilities, there must be at least one disability rated 40%, with a combined rating of 70% or more

Temporary Ratings (38 CFR 4.28, 4.29, 4.30 - Paragraphs 28, 29, and 30)

Under certain situations a veteran receiving disability compensation may receive a temporary rating increase.

1. **Paragraph 28** (38 CFR 4.28) or 'Prestabilization' ratings are normally given to veterans who were recently separated from service and have an unstable disability.

2. **Paragraph 29** (38 CFR 4.29) provides an increased rating for veterans who are hospitalized for **more than 21 days for their service connected disability(ies)**. In such cases the veteran's rating increases to 100% during the period of hospitalization because the veteran is considered 100% disabled during the hospital stay.

- For payment purposes, the effective date for this temporary increase is normally the first day of the month following the date of admission
- Entitlement ends on the last day of the month that the veteran was discharged
- If the veteran was hospitalized for more than 21 days in the same month, the 100% rate is provided for the entire month

3. **Paragraph 30** 38 CFR 4.30) is a temporary 100% rating assigned, usually following surgery, for a **service connected disability**. Circumstances that create this increase are:

- Surgery on or for a service connected disability that requires at least a one-month convalescence period
- Surgery on or for a service connected disability with severe post- operative residuals. Examples of a residual might be incompletely healed surgical wounds or one or more immobilized joints
- Immobilization by case of a service connected disability, with surgery, of at least one major joint.

Permanently and Totally Disabled (P&T) 38 CFR 4.15

Frequently referred to as P&T this rating is based solely on the severity of the disability. The rating schedule defines PERMANENT disability as: an impairment that is **reasonably certain to continue throughout the life** of the disabled person. A disability is considered 'permanent' when the rating activity determines that no change is anticipated in the condition and schedules no future evaluation for the disability.

The rating schedule defines TOTAL disability as: an impairment of mind or body that is **sufficient to make it impossible for the average person** to follow a substantially gainful occupation. For compensation purposes, a veteran is totally disabled when he or she receives compensation at the 100% rate. This is true regardless of how the rate was awarded – either by rating schedule or based on individual unemployability.

Scheduled Reviews/Future Exams (38 CFR 3.327)

Many disabilities, by their nature, are likely to improve with time or treatment. Because of this, VA schedules periodic reevaluations of the disability. The rating activity determines when and if future examinations are needed. Periodic re-examinations are NOT normally scheduled if any of the following circumstances exist:

- The veteran is over 55 years of age, except in unusual circumstances
- The disability is established as static (never changing)
- The disability or disease is permanent in character and is of such nature that there is no likelihood of improvement
- The combined rating would not change even if a future exam reduces an evaluation for one or more conditions
- Over a period of five or more years, the findings and symptoms have persisted without material improvement.

Confirmed and Continued Ratings (C&C)

As the name implies, a confirmed rating is one that confirms and continues the last rating made by the VA. The rating activity prepares a C&C when it considers evidence that does not warrant any change in the prior decision. Included under C&C ratings are those affected by the 10-year and 20-year protected rules.

- The **10-year protection rule** (38 CFR 3.957) states that service connection for any disability that has been in force for 10 or more years cannot be severed unless fraud is shown or if the veteran did not have the requisite service or character of discharge.
- The **20-year protection rule** (38 CFR 3.951) states that after a veteran has held a rating at or above a specific level continuously for 20 years or more, the percentage assigned to that disability cannot be reduced unless fraud is proven.

Disability Compensation Application Procedures

Application Documents

VA Form 21-526EZ 'Application for Disability Compensation and Related Compensation Benefits' is used by a veteran to file a claim for service connected disability benefits.

Use the following forms when applicable:

- South Dakota Department of Veterans Affairs Policy Statement for Representation and HIPAA Disclosure (VA Form21-4142) (Does not go to VA).
- Certified copy of DD Form 214 (or discharge document). Notarized copies are not acceptable for VA purposes, the document must be certified.
- VA Form 21-22 'Appointment of Veteran's Service Organization as Claimant's Representative'.
- VA Form 21-686c 'Declaration of Status of Dependents', if applicable
- VA Form 21-674 'Request for Approval of School Attendance', if applicable
- Dependency documentation (if applicable) e.g., copies of marriage certificates, birth certificates, divorce decrees, etc.
- VA Form 21-4142 and 21-4142a 'Authorization and Consent to Release Information to the Department of Veterans Affairs'. This form is used by the veteran to grant permission to the VA to obtain private treatment records from different organizations. (If applicable, submission will remove claim from fully developed status).
- Any medical evidence the veteran may have, such as: Copies of service medical records or private medical records which reflect any treatment the veteran has had for the claimed disabilities.

Military Discharge Documents

Veteran's with service after 1947 were issued a DD Form 214 upon release from active duty. Discharge documents issued prior to 1947 had various numbers.
Regardless of the actual form number the important part of a military separation document is that it contains:

- Veteran's full name
- Branch of Service
- Dates of entry and discharge from the military
- Character of Service

Medical Evidence

Medical evidence consists of Service Treatment Records (STR's) [old term was Service Medical Records (SMR's)], VA Medical Center Records, and private civilian medical records. If the veteran does not have his/her STR's the VA will automatically request them from the National Personnel Records Center (NPRC) once the claim has been submitted.

Civilian or private medical records can be very important documentation; especially if the veteran is trying to establish service connection more than one year from discharge. Even though a certain disability may not be well documented in the STR's, if the veteran can show continuous treatment for that disability since the time of discharge, there is a greater chance of the VA granting service connection.

To expedite processing of the claim, the veteran should obtain copies of his or her civilian medical records and submit them along with the claim. If the veteran is unable to get copies of the records, submit VA Forms 21-4142 and 21-4142a along with the claim. Note: You may submit up to three providers on the VA Form 21-4142a. You will need to fill out another form for providers exceeding the three.

Dependency Documentation

Veterans who have a combined service connected disability rating of 30% or higher are eligible for an additional monetary benefit for dependents. A veteran may claim spouse, children, and parents as dependents. When providing evidence of dependent relationships to the VA, it is important that the information be as clear and complete as possible so as to avoid questions and unnecessary delays in the processing of the claim. **For example:** if the veteran or spouse had any prior marriages, the application should include complete dates and places where the prior marriages took place and terminated. If incomplete information is submitted, the VA will require copies of the documents terminating the prior marriages.

In many cases the required information regarding dependents will be entered on the original application form, however, if there is a dependency change at a later date, it is the claimant's responsibility to inform the VA of the change. The information can be submitted to the VA on a VA Form 686c 'Declaration of Status of Dependents. If removing dependent, which causes a change in monetary amount include VA Form 4138 requesting action to be taken (i.e. divorce or death).

Spouse (38 CFR 3.50)

A person of the opposite sex whose marriage to the veteran is valid under the law of where they were married.

VBA Letter 20-14-08 dated 6/20/14 - On 9/4/13, the US Attorney General announced that the President had directed the Executive Branch to cease enforcement of 38 USC 101 (3) and 101 (31) to the extent they preclude provision of Veteran's' benefits to same-sex marriage couples.

For VA purposes, the marriage must be recognized under:

- The law of the place where at least one of the parties resided at the time of the marriage; or
- The law of the place where at least one of the parties resided when the claim or application was filed; or
- At a later date when eligibility requirements were met.

Children (38 CFR 3.57)

There are several veteran-child relationships that the VA accepts when establishing dependency. To establish children as dependents the veteran must submit the following for each child:

- Children under the age of 18: Child's full name, date and place of birth, Social Security Number (SSN)
- Children 18 to 23 years of age and attending school: Child's full name, date and place of birth, SSN, and VA Form 21-674 'Request for Approval of School Attendance'
- Stepchildren: Child's full name, date and place of birth, SSN
- Adopted children: Child's full name, date and place of birth, SSN, and copy of the adoption decree or adoptive placement agreement
- Helpless children: Child's full name, date and place of birth, SSN, and medical evidence that the child became incapable of self-support prior to their eighteenth birthday.

Parents (38 CFR 3.59)

A veteran who is 30% or more disabled may claim biological, adoptive, or foster parents as dependents. For VA benefit purposes, a 'dependent parent' is one who depends on the veteran for financial support. This DOES NOT necessarily mean that the parent is not self-supporting, but rather, that the parent's income is minimal or that the parent has high unreimbursed medical expenses (i.e., a nursing home patient). To establish a parent as a dependent the following documents must be submitted:

- Biological parents: copy of the veteran's birth certificate showing the names of the biological parent(s), SSN(s), and VA Form 21P-509 'Statement of Dependency of Parents'
- Adoptive parents: copy of final decree of adoption showing the veteran as adopted by the claimed parent(s), SSN(s), and VA Form 21P-509
- Foster parents: VA Form 21P-524 'Statement of Person Claiming to Have Stood in Relation of Parent', SSN(s), and VA Form 21P-509.

New or Reopened Claims (previously referred to as Reopened claims)

Once the veteran has completed an initial (original) claim, they may want to make additional claims. We need to correctly identify those types of claims. The terminology we use for the various types of claims is of little interest to veterans.

Original Claim vs. New or Reopened Claim

An original claim is the first claim for a service connected disability. For compensation purposes, each disability claimed is treated individually. Remember that an initial claim for compensation is made on VA Form 21- 526EZ. Each disability included on the initial application is the original claim for service connection for that disability. If the veteran claims service connection for a new or different disability at a later date, this is considered an original claim for that disability. A new VA Form 21-526EZ is required each time a veteran claims service connection for an additional disability.

New Claim

A new claim is a claim which includes new evidence which is reviewed based on a new application. A new claim does not involve reconsideration of the evidence submitted with a prior claim. New claims include:

- Claims for increased service connected disability benefits
- Claims for individual unemployability
- Claims for Special Monthly Compensation
- Claims for new conditions not previously filed for.

Supplemental Claim

A supplemental claim is a request to open a previously denied claim for service connection.

A supplemental claim is limited to the disability issue that was determined to be not service connected, AND the supplemental claim MUST be based on new and relevant evidence.

New and Relevant Evidence (38 CFR 3.156)

New evidence means existing evidence not previously submitted to the VA for rating purposes. New evidence means existing evidence that, by itself or when considered with previous evidence of record relates to an un-established fact necessary to substantiate the claim. New and relevant evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior final denial of the claim sought to be reopened and must raise a reasonable possibility of substantiating the claim.

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In order to reopen a claim, the veteran must submit:

- A written request, using VA Form 20-0995 asking for the new claim to be considered or a previous claim reopened
- Available documentation in support of the new or reopened claim, i.e., new medical evidence.

If a veteran is trying to establish service connection for a **disability that was previously denied,** include **new and relevant evidence** to assist with the reopening of the previously denied claim.

Again, remember photocopies or duplication of evidence previously considered by the VA is not new.

If a veteran is requesting consideration for an **increase for a previously awarded disability that has worsened** include dates and places of recent treatment for the condition along with new medical evidence and submit on VA Form 21-526EZ.

Medical Evidence Needed

In each of the three previously described cases, medical evidence is needed to support reopening the claim. This medical evidence must be new and relevant as stated earlier, the veteran must present evidence to justify reopening the claim to the VA.

If a veteran does not have medical evidence to submit, a statement from them describing the symptoms and requesting a reevaluation of the disability will most times be sufficient to see if the condition has increased in severity.

October 07, 2021

Subject: Interim Guidance to address the holding in *Military-Veterans Advocacy v. Secretary of Veterans Affairs, et al*

Introduction

On July 30, 2021, the United States Court of Appeals for the Federal Circuit (Court) issued a decision in *Military-Veterans Advocacy v. Secretary of Veterans Affairs, et al* regarding VA's regulations implementing the Veterans Appeals Improvement and Modernization Act of 2017 (AMA). This precedential opinion invalidated three regulations issued by the Department as inconsistent with the text of the AMA. Specifically, 38 C.F.R. § 14.636(c)(1)(i),which limits when a Veteran's representative may charge fees for work on supplemental claims; 38 C.F.R. § 3.2500(b), which bars the filing of a supplemental claim when adjudication of the same claim is pending before a federal court; and 38 C.F.R. § 3.155, which excludes supplemental claims from the intent-to-file (ITF) framework.

This interim guidance addresses the Court's holding and should be immediately disseminated to appropriate personnel.

VBA will be issuing a Policy Letter and an amendment to the regulation is underway. System updates, new training courses and needed updates to the M21-1 are in progress, with implementation anticipated within the next few months.

Interim Guidance

This interim guidance should be followed until more detailed and specific guidance is disseminated.

A. Intent to File (ITF) Framework Applies to all Supplemental Claims

The Court invalidated a portion of the introductory language to 38 C.F.R. § 3.155, which excluded supplemental claims from the ITF process. VA must now accept an ITF for a supplemental claim. Claim processors must consider whether an ITF of record is applicable to a subsequently received supplemental claim under § 3.155. This includes all supplemental claims, whether filed within one year of a decision or after the continuous pursuit period has ended. An ITF filed within one year of a VA decision may, therefore, operate to maintain continuous pursuit if the ITF is applicable to a supplemental claim filed after expiration of the one-year period following notice of a decision.

Effective immediately, claim processors must consider whether an active ITF of record applies to a subsequent supplemental claim. An ITF applies when an application for benefits is received within one year of the ITF and the application is for the same type of benefit identified on the ITF. There is no change to the practice that once VA associates

a specific application for benefits with a communication of an ITF, that communication is no longer active. For information on determining active status of an ITF, see M21-1, II.iii.2.A.1.d.

Note: This applies to supplemental claims received on or after July 30, 2021. There is potential for a scenario where the ITF may no longer show as "*Active*," rather it improperly shows "*Claim Received*" based upon a later claim that VBMS is programed to recognize.

Claim processors must consider whether an active ITF of record applies to a subsequent supplemental claim submitted on or after July 30, 2021, even if the ITF was filed prior to that date. VBMS will be updated soon so it is important to pay close attention to the ITF tab, dates of ITFs, claims associated with the ITF and supplemental claims.

Apply effective date provisions under 38 C.F.R. § 3.400 and § 3.2500. See M21-1, V.ii.4.A.2.c. for examples of selecting an effective date following receipt of an ITF.

It is important to note the ruling is specific to supplemental claims. An ITF now applies when a claim for the same benefit is properly filed on VA Form 21-0995, *Decision Review Request: Supplemental Claim*. Upon receipt of an ITF, notify the claimant and the claimant's representative, if any, of the information necessary to complete the appropriate prescribed application form per 38 C.F.C. § 3.155(b)(3).

As a reminder, once VA associates a specific application for benefits with a communication of an ITF, that communication is no longer active for the purpose of assigning an earlier effective date of entitlement to the same specific benefit for which the claimant might ***subsequently*** apply. This limitation applies even if VA receives the subsequent application(s) within one year of the date it received the communication of an ITF. See M21-1, II.iii.2.A.1.d.

Recent system functionality was released that allows the status of an ITF to change to "*Claim Received"* when an EP 040 is established based on a supplemental claim received more than a year after the prior decision on the issue. For EP 040s received within a year of the prior decision, claim processors must use the following system workarounds.

The steps below need to be followed by any claim processor that reviews a claim with an ITF.

- Independently review the ITF tab in VBMS to verify if there is a corresponding active ITF that should apply to the next received, valid claim submitted on VA Form 21-0995, *Decision Review Request: Supplemental Claim*.
    - Due to existing functionality, VBMS will not recognize an ITF Status as "*Claim Received"* when a supplemental claim under an EP 040 is received for the same benefit as identified on the ITF within one year of the prior decision.

    - This leaves potential for an ITF to not attach to the next received supplemental claim but rather improperly attach to a later claim that VBMS is currently programed to recognize.
- Associating documents, adding bookmarks and VBMS notes will aid in the application of the Court ruling. If a qualifying supplemental claim is identified, the claim processor must ensure ITF correspondence, when found in the documents screen, and the supplemental claim is clearly acknowledged in the record.
    - See VBMS Job Aid, Associating Documents to Claims (Tagging Documents) & Bookmarking Documents for specific information on the steps and visual aids.
    - Associate appropriate ITF documents to the applicable claim so the associated claim appears in the Tags column.
    - Add a working note bookmark in VBMS to any relevant document. For example:
        - If VBMS contains a 21-0995 that applies to an ITF, bookmark the 21-0995 with the following text:

          "ITF received [date of ITF] is applied to supplemental claim dated [date of supplemental claim]."

        - If VBMS contains an ITF letter, and the next claim received for the same benefit identified was filed on a 21-0995, add a bookmark with the above text to both the ITF letter and applicable claim.
    - The following permanent note should be entered in VBMS by any claim processor who identifies a 21-0995 that should apply to an ITF:

      "ITF applies to the supplemental claim received [date of supplemental claim] to comply with the Federal Circuit holding in MVA v. Secretary of Veterans Affairs."

        - A similar note should be added when the ITF incorrectly displays "*Claim Received*" with a later claim once the ITF was already subsumed by a 21-0995.
        - A note would also be warranted when the ITF applies to a supplemental claim, but still displays as "*Active*" under the ITF tab.
        - Information on adding notes may be found starting on page 201 of the VBMS Core User Guide.
    - Prior to rating a case, review the ITF tab, and pay close attention to the associated documents, bookmarks and notes in VBMS. Since the system may not provide the proper alerts or associate the correct claim to the ITF, the claim processor must be extra aware of the information in the claim file.

When assigning an earlier effective date for a supplemental claim issue based upon an ITF, claim processors should use the following language to support the assigned effective date:

> "Entitlement to service connection/an increased evaluation has been established from the date of the intent to file a claim for service connection/increase evaluation was received. When intent to file a claim for service connection/increase evaluation is received within one year prior to the date of receipt of the claim, the effective date of service connection/the increase is the date VA received the intent to file a claim."

If an earlier effective date for a supplemental claim is assigned based upon an ITF, on the profile page in VBMS-R, the following text should be added in the Special Notation box to authorization:

> "The assigned effective date is based upon the date of receipt of the ITF per AMA Court decision, MVA v. Secretary of Veterans Affairs."

Claim processors may discover decisions completed on or after July 30, 2021, which assigned an effective date that is improper based on this Court decision and interim guidance. In such cases where the ITF was not appropriately applied to the supplemental claim, corrective action under 38 C.F.R. § 3.105(a) should be taken.

B. Claimants can file supplemental claims while a claim for the same issue is pending at the Court.

The Court also invalidated 38 C.F.R. § 3.2500(b), which prohibited the filing of a supplemental claim when adjudication of the same issue was pending before a federal court.

Note: The Board of Veterans Appeals (BVA) does NOT fall under this definition of a federal court. The existing guidance in M21-1, II.i.2.A.3.a-c. still applies when determining if a claimed issue is duplicative of a legacy or BVA appeal.

To allow timely consideration of new and relevant evidence, effective immediately, claim processors must accept a supplemental claim filed on or after July 30, 2021, when the same issue has been appealed and is pending before a federal court when the supplemental claim is filed. This includes cases before the U.S. District Courts, the U.S. Courts of Appeals for Veterans Claims, and the U.S. Supreme Court.

If there is evidence submitted with the claim or is otherwise of record in the eFolder that the same issue on the supplemental claim is appealed and pending before a federal court, assuming the application for benefits is complete, accept the supplemental claim. See M21-1, II.iii.2.B.1.e. for information regarding the requirement for potentially new evidence with a supplemental claim.

If a supplemental claim was rejected based upon the finding that the same issue was appealed and pending before a federal court between July 30, 2021 and release of the interim guidance, corrective action is needed. Claim processors should establish the appropriate end produced (EP) to control the claim and notify the claimant of the acceptance of the supplemental claim. If a *Claim Already on Appeal Letter* or similar

correspondence was sent to the claimant, clarify to the claimant that the previously sent correspondence was in error.

C. Revision of Attorney Fee Eligibility Due to Invalidated Regulation.

The Court invalidated 38 C.F.R. § 14.636(c)(1)(i), which treated decisions on various types of claims as initial decisions in the case thereby making attorneys and agents ineligible for fees based on those decisions. The Court disagreed and explained that, for example, clear and unmistakable error claims and supplemental claims filed after the one-year continuous pursuit period are, for fee purposes, part of the same case as earlier proceedings adjudicating compensation for the same disability.

VA may no longer apply the regulation, 38 C.F.R. § 14.636(c)(1)(i). Under the Court's ruling and the relevant statute, 38 U.S.C. § 5904(c)(1) and (4), agents and attorneys may charge claimants or appellants for representation provided after an agency of original jurisdiction has issued notice of an initial decision on the claim or claims if the notice of the initial decision was issued on or after the effective date of the modernized review system as provided in 38 C.F.R. § 19.2(a), and the agent or attorney has complied with the power of attorney requirements in 38 C.F.R. § 14.631 and the fee agreement requirements in paragraph 38 C.F.R. § 14.636(g).

Under this ruling, once VA has initially adjudicated an issue, fees may be charged for work on later claims involving that issue without the requirement of a new initial decision. Attorney fee eligibility now applies to all supplemental claims. This applies to fee decisions on underlying claims processed under AMA required on or after July 30, 2021.

Agent and Attorney Fee Coordinators must review all claim forms submitted under AMA with a fee agreement, including supplemental claims filed more than one year after the prior decision on the same issue. Procedures in M21-1, I.i.2.C.2.b. should be applied. Considering the MVA case and prior case law, in addition to issuing fee eligibility decisions for claims where an attorney or agent is currently representing the claimant, VA should now also issue fee eligibility decisions for claims where there is no current attorney or agent of record, but an attorney or agent has represented the claimant at a prior time in the case.

Corrective action may be needed for attorney fee cases that have been processed between the date of the MVA decision and publication of this interim guidance. If an error is identified during a routine claim review and can be corrected, take action to do so.

Contact

Contact Compensation Service for questions on policy and procedures, including questions about attorney fee eligibility, at 211_Policy.Vbavaco@va.gov.

Contact Pension and Fiduciary Service for questions on survivor and pension benefits processed by Pension Management Centers, at Pension.Fiduciary.VBACO@va.gov.

Contact the Office of Administrative Review for questions on higher-level reviews and legacy appeals at OARADMIN.VBAWAS@va.gov.

Thank you,

Compensation Service

VA Disability Payment

The effective date determines when payment starts. If a claim for disability compensation is made within one year of release from active duty the payment will be effective the first day of the month following discharge. If a claim for disability compensation is made after one year of release from active duty the payment date will usually be effective the first day of the month following the month in which the claim is received by the VA.

Increased Benefit Payment

There are several situations which can cause compensation payment increases:

- Worsened disability resulting in an increased evaluation
- Temporary increases under 38 CFR 4.28, 4.29, and 4.30 (paragraphs 28-30)
- Established entitlement to Individual Unemployability or Special Monthly Compensation (SMC)
- The addition of dependents to the award

Reduction of Benefit Payment

Some situations that can cause a veteran's rate of compensation to be reduced are:

- Improved disability resulting in a decreased evaluation
- Loss of dependent(s)
- Incarceration for more than sixty days following a felony conviction
- Hospitalization (Benefits may be reduced for some veterans who receive Special Monthly Compensation)

Another instance where rate of compensation could be reduced is when it results from a request for an increase. Before you submit a claim for increase you should be sure that the requirements are met for a higher evaluation. If not, the veteran could possibly be reduced based on the medical evidence submitted or based on the results of the C&P examination.

Discontinuance of Benefit Payment

Reasons why compensation benefits may be discontinued:

- The disability no longer warrants a compensable rating, i.e., the rating drops to less than 10%
- The veteran returns to active duty status
- Severance of service connection is warranted by VA determination that service connection was fraudulent, in error, or in bad faith
- Veteran has a combined service connected rating of 10 % or higher, and is incarcerated for more than sixty days following a felony conviction
- Veteran is a fugitive from justice
- Veteran dies

Checklist for Filing an Original or New Compensation Claim

1. Application Forms
   - VA Form 21-22 POA
   - Intent to File 21-0966 if applicable
   - SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
   - Is VA Form 21-526EZ completed, signed and dated by the veteran?
   - Are all necessary forms and/or statements signed and dated by the veteran?
2. Military Records
   - Is a CERTIFIED copy of the veteran's DD Form 214(s)/discharge document attached? If no, is at least one of the following provided?
   - Uncertified photocopy (this cannot be used to verify service, but can be used to speed up verification of service)
   - Complete service dates, branch of service, and service number
   - If Guard/Reserve need to complete STRs
3. Medical Evidence
   - Does the veteran have a copy of his/her STRs to submit with the claim? If the veteran is in the National Guard, they must obtain a copy of their STRs from their unit to qualify for the fully developed claim program.
   - If the veteran has received treatment by a private doctor or hospital, for the claimed disability(ies), were copies of those treatment records provided? If not, did the veteran complete and sign VA Form 21-4142 and VA Form 21-4142a to allow the VA to obtain these records?
   - NOTE: One copy of the VA Form 21-4142 and VA Form 21-4142a may be completed for up to three doctors or hospitals where the veteran reports having had treatment for the claimed disability.
   - If the veteran has received treatment at a VA Medical Center for the claimed disability(ies), were dates and locations of treatment provided?
   - Note: A VA Form 21-4142 is not required to obtain VA treatment records as the VA can obtain these records without special authorization from the veteran.
4. Dependency Documentation

   Children
   - Is the date and place of birth (city and state) provided for each child?
   - Is VA Form 21-674 – 'Request for Approval of School Attendance' completed for each 18-23-year old child who is still attending approved schooling?
   - Is VA Form 21-686c complete?
   - Is a copy of the adoptive decree or adoptive placement agreement attached for each adopted child?
   - Is medical evidence for children who became incapable of self- support prior to their eighteenth birthday included?

   Spouse
   - Has the complete date and place of marriage been provided?
   - Have the complete dates and places of divorce from previous marriages been provided?

Parent(s)

- Was a VA Form 21P-509 'Statement of Dependency of Parent(s)' completed?
- Is a copy of the veteran's birth certificate showing the name(s) of the biological parents attached? or,
- If adopted, is a copy of the final decree of adoption attached? or,
- If a step-child, has VA Form 21P-524p 'Statement of Person Claiming to Have Stood in Relation of Parent' been completed?

Checklist for a Supplemental (Reopened) Compensation Claim

1. Application Forms

   VA Form 20-0995 completed, signed,and dated by the veteran.
   21-4138 completed, signed,and dated by the veteran.

2. Supporting Documentation
   - Was medical evidence provided with the veteran's claim?
   - If the veteran received treatment at a VA Medical Center, were dates and locations of treatment provided?
   - Was a VA Form 21-4142 'Authorization to Disclose Information to the Department of Veterans Affairs' and 21-4142a 'General Release for Medical Provider Information to the Department of Veterans Affairs' completed for up to three private doctors/facilities if the veteran did not have copies of these records?
   - Was the veteran's case reviewed to determine if updated dependency information is needed?

Traumatic Brain Injury

Traumatic brain injury (TBI) occurs when a sudden trauma, such as a blow or jolt to the head causes damage to the brain. Such injuries can result in impaired physical, cognitive, emotional, and behavioral functioning.

Explosive blasts (i.e., from IED's), automobile accidents, falls and assaults/ blows are common causes of TBI. Simply claiming TBI is not sufficient for granting of service connection. The VA needs to be informed of the symptoms the veteran's is now experiencing, when and where the incident occurred and what caused the TBI.

Diseases Subject to Presumptive Service Connection

Title 38, Code of Federal Regulations, provides that certain diseases may be service connected even if they were not diagnosed while the veteran was still on active duty as follows:

CHRONIC DISEASES (38 CFR 3.309(a))

Service connection may be granted for the following chronic diseases after completion of 90 days of active wartime duty or service after December 31, 1946, **if manifest to a compensable degree within one year** following release from active duty:

Anemia, primary
Arteriosclerosis
Arthritis
Atrophy, progressive, muscular
Brain thrombosis
Bronchiectasis
Calculi of the kidney, bladder or gall bladder
Cardiovascular-renal disease (1)
Cirrhosis of the liver
Coccidioidomycosis
Diabetes Melitus
Encephalitis lethargica residuals
Endocarditis (2)
Endocrinopathies
Elilepsies
Hansen's Disease
Hodgkin's disease
Leukemia
Lupus erythematosus, systemic
Myasthenia gravis
Myelitis
Myocarditis
Nephritis
Organic diseases of the nervous system brain hemorrhage
Osteitis deformans (Paget's disease)
Osteomalacia
Palsy, bulbar
Paralysis agitans
Psychoses
Purpura idiopathic, hemorrhagic
Raynaud's disease
Sarcoidosis
Scleroderma
Sclerosis, amyotrophic lateral
Sclerosis multiple
Stringomyelia
Thrombongitis obliterans (Buerger's Disease)
Tuberculosis, active
Tumors (3)
Ulcers, peptic (gastric or duodenal) (4)

NOTES

(1) Includes hypertension. (This term applies to combination involvement of the type of arteriosclerosis, nephritis and organic heart disease, and since hypertension is an early symptom, long preceding the development of those diseases in their more obvious forms; a disabling hypertension within the one-year period will be given the same benefit of service connection as any of the chronic diseases listed.)

(2) Endocarditis covers all forms of valvular heart disease.

(3) Tumors under this section means malignant tumors or tumors of the brain or spinal cord or of the peripheral nerves.

(4) A proper diagnosis of gastric or duodenal ulcer (peptic ulcer) is to be considered established if it represents a medically sound interpretation of sufficient clinical findings warranting such diagnosis and provides an adequate basis for a differential diagnosis

from other conditions with like symptomatology; in-short, where the preponderance of evidence indicates gastric or duodenal ulcer (peptic ulcer). Whenever possible, of course, laboratory findings should be used in corroboration of the clinical data.

EXTENDED PRESUMPTIVES (38 CFR 3.307 (3))

The statutory time limits for presumptive service connection for certain chronic diseases have been extended as follows:

- Hansen's disease (Leprosy) and Tuberculosis is extended to **three years following discharge,** and
- Multiple Sclerosis is extended to **seven years following discharge**.

TROPICAL DISEASES (38 CFR 3.309(b))

Service connection may be granted for the tropical diseases, if **manifested to a compensable degree within one year** following release from active duty.

Amebiases
Blackwater fever
Cholera
Dracontiasis
Dysentery
Filiariasis
Leishmaniasis, including Kala-azar
Loiasis
Malaria
Onchocerciasis
Oroya fever
Pinta
Plague
Yaws
Yellow fever

NOTE: Disorders or diseases originating because of therapy administered in connection with such diseases or as a preventive thereof may be service connected.

DISEASES SPECIFIC FOR FORMER PRISONERS OF WAR (38 CFR, 3.309(c))

If a veteran is a former prisoner of war, the following diseases shall be service connected if manifest to a degree of disability of 10 percent or more at any time after discharge.

- Psychosis
- Any of the anxiety states
- Dysthymic disorder (or depressive neurosis)
- Organic residuals of frostbite, if it is determined that the veteran was interned in climatic conditions consistent with the occurrence of frostbite
- Post-traumatic osteoarthritis
- Atherosclerotic heart disease or hypertensive vascular disease (including hypertensive heart disease) and their complications (including myocardial infarction, congestive heart failure, arrhythmia)
- Stroke and its complications.

If the veteran is a former prisoner of war and was interned or detained for not less than 30 days, the following diseases shall be service connected if manifest to a degree of 10 percent or more at any time after discharge:

- Avitaminosis
- Beriberi (including beriberi heart disease)
- Chronic dysentery
- Cirrhosis of the liver.
- Helminthiasis
- Irritable bowel syndrome
- Malnutrition (including optic atrophy associated with malnutrition).
- Osteoporosis (IF veteran's is service connected for PTSD)
- Other nutritional deficiency
- Pellagra
- Peptic ulcer disease
- Peripheral neuropathy except where directly related to infectious causes

DISEASES SPECIFIC TO RADIATION-EXPOSED VETERAN (38 CFR 3.309(d))

For purposes of this section the term *radiation-exposed veteran* means either a veteran who, while serving on active duty, or an individual who while a member of a reserve component of the Armed Forces during a period of active duty for training or inactive duty training, participated in a radiation-risk activity.

Bronchiolo-alveolar carcinoma
Cancer of the bile ducts
Cancer of the bone
Cancer of the brain
Cancer of the breast
Cancer of the colon
Cancer of the esophagus
Cancer of the pancreas
Cancer of the gall bladder
Cancer of the lung
Cancer of the ovary
Cancer of the pharynx
Cancer of the salivary gland
Cancer of the small intestine
Cancer of the stomach
Cancer of the thyroid
Cancer of the urinary tract
Lymphomas (except Hodgkin's disease)
Multiple myeloma
Primary liver cancer (except if cirrhosis or hepatitis B is indicated)

For the purposes of this section, the term *urinary tract* means the kidneys, renal pelvis, ureters, urinary bladder, and urethra.

Recent locations due to the passage of the PACT Act include:

- Cleanup of Enewetak Atoll, from January 1, 1977, through December 31, 1980.
- Cleanup of the Air Force B-52 bomber carrying nuclear weapons off the coast of Palomares, Spain, from January 17, 1966, through March 31, 1967.
- Response to the fire onboard an Air Force B-52 bomber carrying nuclear weapons near Thule Air Force Base in Greenland from January 21, 1968, to September 25, 1968.

DISEASES ASSOCIATED WITH EXPOSURE TO AGENT ORANGE (38CFR 3.309(e))

Veteran's exposed to Agent Orange, or other herbicide agents, may be service connected for any of the following diseases/disabilities:

- Acute and subacute peripheral neuropathy
- AL Amyloidosis
- Bladder cancer
- Chloracne or other acne form disease consistent with chloracne
- Chronic B cell leukemias, such as hairy cell leukemia
- Chronic lymphocytic leukemia
- Diabetes Mellitus -Type 2 (also known as adult-onset diabetes)
- Hodgkin's disease
- Hypertension
- Hypothyroidism
- Ischemic heart disease
- Monoclonal gammopathy of undetermined significance (MGUS)
- Multiple myeloma
- Non-Hodgkin's lymphoma
- Parkinson's disease
- Parkinson's like symptoms
- Porphyria cutanea tarda
- Prostate cancer
- Respiratory cancers (cancer of the lung, bronchus, larynx, or trachea)
- Soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma)

The term soft-tissue sarcoma includes the following:

- Adult fibrosarcoma
- Alveolar soft part sarcoma
- Angiosarcoma (hemangiosarcoma and lymphangiosarcoma)
- Clear cell sarcoma of tendons and aponeuroses
- Congenital and infantile fibrosarcoma
- Dermatofibrosarcoma protuberans
- Ectomesenchymoma
- Epithelioid leiomyosarcoma (malignant leiomyoblastoma)
- Epithelioid sarcoma
- Extraskeletal Ewing's sarcoma
- Leiomyosarcoma
- Liposarcoma
- Malignant fibrous histiocytoma
- Malignant ganglioneuroma
- Malignant giant cell tumor of tendon sheath
- Malignant glomus tumor
- Malignant granular cell tumor
- Malignant hemangiopericytoma
- Malignant mesenchymoma
- Malignant schwannoma, including malignant schwannoma with rhabdomyoblastic differentiation (malignant Triton tumor), glandular and epithelioid malignant schwannomas
- Proliferating (systemic) angioendotheliomatosis
- Rhabdomyosarcoma
- Synovial sarcoma (malignant synovioma)

The term acute and subacute peripheral neuropathy means transient peripheral neuropathy that appears within weeks or months of exposure to an herbicide agent and resolves within two years of the date of onset.

Chloracne or other acneform disease consistent with chloracne, and porphyria cutanea tarda, shall have become manifest to a degree of 10 percent or more within a year after the last date on which the veteran's was exposed to an herbicide agent during active military, naval, or air service. (38 CFR 3.307(a)(6)(ii))

For VA purposes, veteran presumed to be exposed to Agent Orange include those listed below. More detailed information is available at the VA website: www.publichealth.va.gov/exposures/agentorange/ militaryexposure.asp

Vietnam: All who served on land or on a ship operating on the inland waterways of Vietnam between February 8, 1961, and May 7, 1975, (who served in country Vietnam November 1, 1955, to February 28, 1961).

Blue Water Navy: Any ship operating withing 12 nautical miles of the coast of Vietnam between February 8, 1961, and May 7, 1975.

Personnel who served in the waters adjacent to Vietnam, but never set foot in Vietnam are eligible for service connection for Non-Hodgkin's lymphoma (NHL). The definition of NHL now includes chronic lymphocytic leukemia (of the B-cell type only) and small-cell lymphocytic leukemia. (38 CFR 3.313(b))

Thailand: Whose who served on any U.S. or Royal Thai military base in Thailand from January 9, 1962, through June 30, 1976.**Exposure:**

Laos from December 1, 1965, through September 30, 1969.

Cambodia at Mimot of Krek, Kampong Cham Province from April 16, 1969, through April 30, 1969.

Guam or American Samoa from January 9, 1962, through July 30, 1980.

Johnston Atoll or on a ship that called at Johnston Atoll from January 1, 1972, through September 30, 1977.

Any veteran who served in a unit determined by VA and the Department of Defense to have operated in an area in or near the Korean DMZ between April 1, 1968 and August 31, 1971.

See the list of units that meet this criteria on the next page.

Combat Brigade of the	**Division Reaction**	**3rd Brigade of the 7th Infan-**
1st Battalion, 38th Infantry	4th Squadron, 7th Cavalry, Counter Agent Company	1st Battalion, 17th Infantry
2nd Battalion, 38th Infantry		1st Battalion, 31st Infantry
1st Battalion, 23rd Infantry		1st Battalion, 32nd Infantry
2nd Battalion, 23rd Infantry		2nd Squadron, 10th Cavalry
3rd Battalion, 23rd Infantry		2nd Battalion, 17th Infantry
2nd Battalion, 31st Infantry ***Note***: Service records may show assignment to either the 2nd or the 7th Infantry		2nd Battalion, 31st Infantry ***Note***: Service records may show assignment to either the 2nd or the 7th Infantry Division
		2nd Battalion, 32nd Infantry
3rd Battalion, 32nd Infantry ***Note***: Service records may show assignment to either the 2nd or the 7th Infantry		3rd Battalion, 32nd Infantry ***Note***: Service records may show assignment to either the 2nd or the 7th Infantry
1st Battalion, 9th Infantry		1st Battalion, 73rd Armor
2nd Battalion, 9th Infantry		
1st Battalion, 72nd Armor		
2nd Battalion, 72nd Armor		
1st Battalion, 12th Artillery		
1st Battalion, 15th Artillery		
7th Battalion, 17th Artillery		
5th Battalion, 38th Artillery		
6th Battalion, 37th Artillery		
Other Qualifying Assignments		
2nd Military Police Company, 2nd Infantry Division		
13th Engineer Combat Battalion		
United Nations Command Security Battalion-Joint Security Area (UNCSB-JSA)		
Crew of the *USS Pueblo*		

BLUE WATER NAVY ELIGIBILITY INFORMATION

Public Law 116-23 (Blue Water Navy Vietnam Veterans Act 2019) was signed into law on June 25, 2019, and takes effect January 1, 2020. The law extends a presumption of herbicide exposure to Blue Water Navy Veterans who served in the Republic of Vietnam and the offshore waters. Blue Water Navy Survivors, and certain dependents may be entitled to benefits if the veteran was exposed. Under the law, certain veterans, who served in the offshore waters of the Republic of Vietnam and Cambodia, or who had service in the Korean Demilitarized zone (DMZ), may be entitled to disability compensation for conditions that are related to herbicide exposure. The law also provides benefits for children born with spina bifida whose parent was a veteran with verified herbicide exposure in Thailand. To be entitled to VA benefits, these veterans must have served between January 9, 1962, and May 7, 1975, and have one or more of the conditions that are listed in section 3.309(e) of title 38, Code of Federal Regulations.

(Interim Final Rule, See Federal Register Document Citation, 86 FR 42724)

With the passage of the PACT Act, the VA has added the following presumptive conditions related to particulate matter exposure for veterans of the Gulf War. These cancers are now presumptive conditions:

Brain cancer
Cancer of the paraurethral glands
Gastrointestinal cancer of any type Glioblastoma
Head cancer of any type
Kidney cancer
Lymphatic cancer of any type
Lymphoma of any type
Male breast cancer
Melanoma
Neck cancer
Pancreatic cancer
Reproductive cancer of any type
Respiratory (breathing-related) cancer of any type
Urethral Cancer

These illnesses are now presumptive conditions:
Asthma that was diagnosed after service
Chronic bronchitis
Chronic obstructive pulmonary disease (COPD)
Chronic rhinitis
Chronic sinusitis
Constrictive bronchiolitis or obliterative bronchiolitis
Emphysema
Granulomatous disease
Interstitial lung disease (ILD)
Pleuritis
Pulmonary fibrosis
Sarcoidosis

To be eligible for benefits, the veteran must have served in:

- The Southwest Asia theater of operations from August 2, 1990, to the present* in any of these locations: Bahrain, Iraq, Kuwait, Oman, Qatar, Saudi Arabia, Somalia, The United Arab Emirates (UAE), or the airspace above any of these locations, and/or;
- Afghanistan, Djibouti, Egypt, Jordan, Lebanon,Syria, and Uzbekistan, Yemen, and the airspace above any of thee locations during the Persian Gulf War, from September 19, 2001, to the present*

* Neither Congress nor the President has established an end date for the Gulf War.

DISABILITIES DUE TO UNDIAGNOSED ILLNESSES (38 CFR 3.317)

Disability that became manifest either during active military, naval, or air service in the Southwest Asia theater of operations during the Persian Gulf War, or to a degree of 10% or more not later than December 31, 2021, and by history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis.

Gulf war (Persian Gulf) veteran may be service connected for the following medically unexplained chronic multi-symptom illnesses that are defined by a cluster of signs or symptoms:

- Chronic fatigue syndrome
- Fibromyalgia
- Irritable bowel syndrome or
- Any other illness that the Secretary determines meets the criteria for a medically unexplained chronic multi-symptom illness.

For purposes of this section, the term medically unexplained chronic multi-symptom illness means a diagnosed illness without conclusive pathophysiology or etiology, that is characterized by overlapping symptoms and signs and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities. Chronic multi-symptom illnesses of partially understood etiology and pathophysiology will not be considered medically unexplained.

Signs or symptoms which may be manifestations of undiagnosed illness or medically unexplained chronic multi-symptom illness include, but are not limited to:

(1) Abnormal Weight Loss
(2) Cardiovascular signs or symptoms
(3) Fatigue
(4) Gastrointestinal signs or symptoms
(5) Headache
(6) Joint pain
(7) Menstrual disorders
(8) Muscle Pain
(9) Neurologic signs and symptoms
(10) Neuropsychological signs or symptoms
(11) Signs or symptoms involving skin
(12) Signs or symptoms involving the respiratory system (upper or lower)
(13) Sleep Disturbances

For purposes of this section:

(1) The term Persian Gulf veteran means a veteran who served on active military, naval, or air service in the Southwest Asia theater of operations during the Persian Gulf War.

(2) The Southwest Asia theater of operations includes Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above these locations.

AMYOTROPHIC LATERAL SCLEROSIS (38 CFR 3.318)

The development of ALS (also known as Lou Gehrig's disease) at any time after discharge or release from military service is sufficient to establish service connection if the veteran had active, continuous service of 90 days or more.

CAMP LEJEUNE

The presumption of service connection applies to active duty, Reserve and National Guard members who served at Camp Lejeune for a minimum of 30 days (cumulative) between August 1, 1953, and December 1, 1987, and are diagnosed with any of the following conditions:

Adult leukemia
Aplastic anemia and other myelodysplastic syndromes Bladder cancer
Kidney cancer
Liver cancer
Multiple myeloma
Non-hodgkin's lymphoma
Parkinson's disease

Dependents may also be eligible for reimbursement for any out-of-pocket exenses. Please visit this link: https://www.va.gov/disability/eligibility/hazardous-materials-exposure/camp-lejeune-water-contamination/.

Special Benefits for Service Connected Veteran

Clothing Allowance: (38 CFR 3.810)

Certain veterans are eligible for a once-a-year payment for clothing. They are entitled to a separate clothing allowance for each service connected disability that requires a prosthetic or orthopedic appliance. In order to receive a clothing allowance, the following conditions must be met:

1. The veteran must be receiving, or entitled to receive, compensation for a service connected disability

2. The disability must require the use of a prosthetic or orthopedic appliance and the appliance must cause the clothing to wear out or tear, or

3. The disability must require a prescribed medication that irreparably damages the veteran's outer garments

VA Form 10-8678 'Application for Annual Clothing Allowance' is used to apply for the clothing allowance. This form needs to be submitted and approved by Prosthetics

Automobile or Other Conveyances: (38 CFR 3.808)

Certain disabled veterans are entitled to a one-time payment*, toward the purchase of an automobile or other conveyance. (* An additional payment can be made if more than 30 years have passed since initial payment.) These veterans may also receive payment for the repair, replacement or re-installation of adaptive equipment. Generally, the VA will only pay for equipment for one, or two, vehicles within a four-year period. To qualify the veterans must have a service connected disability which involves one of the following:

- Loss, or permanent loss of use (LOU), of one or both feet
- Loss or permanent LUS, of one or both hands
- permanent impairment of vision in both eyes with a
    - central visual acuity of 20/200 or less in the better eye with corrective glasses, or
    - central visual acuity of more that 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field has an angular distance no greater than 20 degrees in the better eye, or
- a severe burn injury defined as disability caused by deep partial thickness or full thickness burns resulting in scar formation that causes contractures and limits motion of one or more extremities or the trunk and precludes effective operation of an automobile, or
- amyotrophic lateral sclerosis (ALS).

VA Form 21-4502 'Application for Automobile or Other Conveyance and Adaptive Equipment' is used to apply for the automobile allowance.

VA Form 10-1394 'Application for Adaptive Equipment - Motor Vehicles' is used to apply for adaptive equipment.

Specially Adapted Housing (38 CFR 3.809 & 3.809a)

Certain severely disabled veterans are entitled to a grant from the VA for adapting housing to their special needs. In order to qualify, the veterans must be entitled to compensation for **permanent and total service connected disabilities.**

The grant may be used for building or buying a specially adapted home or, for adapting an existing home. The purpose of the grant is to accommodate the seriously disabled veteran in a home that has special features and equipment essential to comfortable living for the veteran.

There are two different grants for which the veteran may apply, as follows:

1. **Specially Adapted Housing Grant** In order to qualify, the veteran's permanent and total service connected disability must involve one of the following conditions:

    - Loss or loss of use of both lower extremities, or
    - Blindness in both eyes having light perception only, **plus** loss or loss of use of one lower extremity, or
    - Loss or loss of use of one lower extremity together with other disabilities which precludes locomotion without the aid of braces, crutches, canes or a wheelchair.

2. **Special Home Adaptations Grant** It is available to veterans with permanent and total service connected disability due to one of the two following conditions:

    - Blindness in both eyes with 5/200 visual acuity or less, or
    - Loss or loss of use of both hands.

Application:

VA Form 26-4555 'Veteran's Application in Acquiring Specially Adapted Housing or Special Home Adaptation Grant' is used to apply for one of these housing grants.

Veterans who are approved for a Specially Adapted Housing Grant are also eligible for Veteran's Mortgage Life Insurance.

Concurrent Retirement and Disability Payment (CRDP) Title 10, USC, Subtitle A, Part II Chapter 71, Section 1414

Important Fact: This program is managed and funded by each service department. **It is not managed in any capacity by the Department of Veterans Affairs(VA).** Veterans experiencing difficulty with this program should address these issues with the point of contact listed after the CRSC Section.

Basic eligibility:

- **Retired with at least 20 years** of active duty service creditable for retired pay or retirement of Reservists and National Guard persons who have 20 years, or more, of service for retirement purposes. Reservists and National Guard persons are not eligible to receive pay under this program until they begin to receive retired pay at age 60.

- Veterans who were medically retired prior to attaining 20 years of active duty service are not eligible for this program.

- Have a VA combined service connected rating of at least 50% would then be eligible for both retirement pay and VA compensation.

If eligible for both the CDRP and CRSC programs, an annual election is sent to the veteran so they can choose the program they wish to be enrolled in.

Veterans may not draw benefits simultaneously from both programs.

CRDP does not have to be applied for – once the VA notifies Defense Finance and Accounting Service (DFAS) of a qualifying rating (50% SC or higher) action is taken by the finance department to initiate CRDP payment.

Important Notes

- CRDP Payment is considered taxable income
- CRDP is not paid retroactively
- There is no survivor benefit for CRDP

Point of contact

For any CRDP pay related issue contact the DFAS (Retired Pay Center) at TOLL FREE: 1-800-321-1080. This is the same phone number listed at the top of every retired veteran's Retired Account Statement. There are also numerous web sites that can be researched by simply searching the web for 'concurrent receipt disability payment' or 'CRDP'.

Combat Related Special Compensation (CRSC) Title 10, USC, Subtitle A, Part II.I Chapter 71, Section 1413a

This program is managed and funded by each service department. I**t is not managed in any capacity by the Department of Veterans Affairs (VA).** Veterans experiencing difficulty with this program should address these issues with the points of contact listed below.

Basic eligibility

- **Retired with at least 20 years** of active duty service creditable for retired pay; or

- Retirement of Reservist and National Guard persons who have 20 years, or more, of service for retirement purposes. Reservist and National Guard persons are not eligible to receive pay under this program until they begin to receive retired pay at age 60; or

- Medically retired with LESS than 20 years of active duty service; and

    1. Must waiver receipt of military retired pay in order to receive VA compensation payments; and

    2 Have a VA combined service connected rating of at least 10%.

Veterans CAN NOT draw benefits simultaneously from both programs. If eligible for both the CRSC and the CRDP programs, an annual election is sent to the veterans so they can choose the program they wish to be enrolled in.

Disabilities (with at least a 10% combined rating) must have been incurred as a **direct result of armed conflict, specialty hazardous military duty, training exercises that simulate war, or caused by an instrumentality of war.** Combat related cause must be proved by the veterans either through the award of specific medal or other means. The application form (DD Form 2860) provides detailed information on supporting documentation requirements.

Services are required to presume that disabilities awarded VA disability compensation based on service connected exposure to hazards, which are clearly combat related, are combat related for the purpose of CRSC. These include Agent Orange, Gulf War Illness, Radiation Exposure, Mustard Gas and Lewisite. PTSD will require combat-related documentation.

Important Notes

- CRSC Payment is considered non-taxable income
- CRSC can be paid retroactively
- There is no survivor benefit for CRSC.

Application

CRSC must be applied for utilizing a DD Form 2860. This form with all pertinent instruction is available at each of the below listed web sites.

Retroactive payment is based on the original claim submitted to the service branch. Veterans should research their service specific web site below for further clarification on retroactive payment.

CRSC Points of Contact for each branch of service are as follows:

ARMY
Department of the Army
US Army Human Resources Command
ATTN: CRSC Division
1600 Spearhead Division Avenue
Fort Knox, KY 40122
Toll Free: 1-888-276-9472

NAVY & USMC
Department of Navy
Secretary of the Navy Council of Review Boards (Attn: CRSC Board)
720 Kennon Street SE – Suite 309
Washington Navy Yard, DC 20374-5023
Toll Free: 1-877-366-2772

AIR FORCE
US Air Force Personnel Center
Disability Division (CRSC)
550 C Street West, Suite 6
Randolph AFB, TX 78150-4708
Toll Free: 1-800-525-0102

Coast Guard
Commander (PSC-PSD)
US Coast
Personnel Service Center
2703 Martin Luther King Jr. Avenue SE
Washington, DC 20593-7200
202-795-6631

Intent to File –ITF

21-22 & SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)

21-0966 for compensation (Claims Office can sign if we have POA) -Formalize within one year

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 7/31/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, Appointment of Individual as Claimant's Representative. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

SECTION I: VETERAN'S 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 of the form.

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

Joe P Veteran

2. SOCIAL SECURITY NUMBER *(SSN)*	3. VA FILE NUMBER *(If applicable)*	4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
123-23-3456	**123233456**	Month **09** - Day **08** - Year **1947**

5. VETERAN'S SERVICE NUMBER *(If applicable)*	6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

8. TELEPHONE NUMBER *(Include Area Code)*	9. EMAIL ADDRESS *(Optional)*
(605)123-2345	

SECTION II: CLAIMANT'S INFORMATION *(If other than veteran)*

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

11A. CLAIMANT'S DATE OF BIRTH	11B. RELATIONSHIP TO VETERAN
Month - Day - Year	

12. CURRENT 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 **US** ZIP Code/Postal Code

13. TELEPHONE NUMBER *(Include Area Code)*	14. EMAIL ADDRESS *(Optional)*

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

038 - South Dakota Department of Veterans Affairs

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*	16B. JOB TITLE OF PERSON NAMED IN ITEM 16A
Kevin Swanson	**Veterans Service Officer**
17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15	18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*
statevso.mailbox@va.gov	**03-28-2024**

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☑ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☑ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT (**Required**)	22B. DATE SIGNED *(MM/DD/YYYY)*
Jon P Vuckovich	**03-28-2024**
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (**Required**)	23B. DATE SIGNED *(MM/DD/YYYY)*
[signature]	**03-28-2024**

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

	COPY OF VA FORM 21-22 SENT TO:	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason and date (MM/DD/YYYY))*
VA USE ONLY	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

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 Control No. 2900-0826
Respondent Burden: 5 minutes
Expiration Date: 02/28/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. This form is used to notify VA of your intent to file for the general benefit(s). For more information, contact us online through ASK VA: https://ask.va.gov/. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable check box to expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER
123-23-3456

3. HAVE YOU EVER FILED A VA CLAIM?
☑ YES (If "YES," complete Item 4)
☐ NO

4. VA FILE NUMBER (If applicable)
123233456

5. DATE OF BIRTH (MM/DD/YYYY)
09-08-1947

6. VETERAN'S SERVICE NUMBER (If applicable)

7. MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number

City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

8.TELEPHONE NUMBER (Include Area Code)
(605)123-2345
Enter International Phone Number (If applicable)

9. E-MAIL ADDRESS (If applicable) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY if the claimant is NOT the veteran)

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

11. SOCIAL SECURITY NUMBER

12. HAVE YOU EVER FILED A VA CLAIM?
☐ YES (If "YES," complete Item 13)
☐ NO

13. VA FILE NUMBER (If applicable)

14. RELATIONSHIP TO VETERAN (Check one)
☐ SPOUSE ☐ CHILD ☐ FIDUCIARY ☐ VETERAN SERVICE OFFICER ☐ ALTERNATE SIGNER
☐ THIRD-PARTY ☐ OTHER (Specify)

15. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)

16. MAILING ADDRESS (If applicable) (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

17. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number (If applicable)

18. E-MAIL ADDRESS (If applicable) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III: GENERAL BENEFIT ELECTION

IMPORTANT: VA may not be able to use this form to establish an effective date for benefits if you do not select one or more of the general benefits listed below.

19. I INTEND TO FILE FOR THE GENERAL BENEFIT(S) CHECKED BELOW: (Choose all that apply)

☑ COMPENSATION ☐ PENSION

NOTE: Only check this box if you are a surviving dependent of the veteran.

☐ SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at www.va.gov. If you give VA a completed application for the selected general benefit within *one* year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the *first* completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file (VA Form 21-0966) for each general benefit. Please complete as much of this form as possible, as VA cannot process this form if we cannot identify the claimant and/or veteran.

SECTION IV: DECLARATION OF INTENT AND SIGNATURE

By filing this form, **I HEREBY INDICATE MY INTENT** to apply for one or more general benefits under the laws administered by VA.

I acknowledge that:

(1) this is **not a claim for benefits**,
(2) I must file a complete application for each general benefit with VA before VA will process my claim; and
(3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

20. SIGNATURE OF VETERAN/CLAIMANT/AUTHORIZED AGENT **(REQUIRED)**	21. DATE SIGNED (MM/DD/YYYY)
[signature]	**04/16/2024**

22. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION (VSO) (Please Print)

NOTE: This form may only be completed by a VSO, attorney, or agent if a valid power of attorney has been completed.

South Dakota Department of Veterans Affairs

Where to Send Correspondence - After completing this form, mail to:

Department of Veterans Affairs
Evidence Intake Center
P.O. Box 4444
Janesville, WI 53547- 4444

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.

PRIVACY ACT NOTICE: 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 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 only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by 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 the appropriate application and provide it to the claimant.

RESPONDENT BURDEN: We need this information to determine the intent of the claimant and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FDC Compensation
21-22 & SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
DD 214 - Certified
21-526EZ – All blanks completed
Copy of Voided Check or Deposit Slip
Reserve/National Guard members must provide Service Treatment Records (STRs)
Private treatment records
Dependency 21-686c if applicable
PTSD Claims – VA form 21-0781 or 21-0781a for MST Claims
IU – 8940 & 4192 (1 rating at least 60% or Combined 70% 1 being 40% or more) Specially Adapted Housing or Special Home Adaptation – 26-4555
Auto Allowance – 21-4502

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 7/31/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, Appointment of Individual as Claimant's Representative. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

SECTION I: VETERAN'S 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 of the form.

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

Joe P Veteran

2. SOCIAL SECURITY NUMBER *(SSN)*	3. VA FILE NUMBER *(If applicable)*	4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
123-23-3456	**123233456**	Month **09** - Day **08** - Year **1947**

5. VETERAN'S SERVICE NUMBER *(If applicable)*	6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

8. TELEPHONE NUMBER *(Include Area Code)*	9. EMAIL ADDRESS *(Optional)*
(605)123-2345	

SECTION II: CLAIMANT'S INFORMATION *(If other than veteran)*

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

11A. CLAIMANT'S DATE OF BIRTH	11B. RELATIONSHIP TO VETERAN
Month - Day - Year	

12. CURRENT 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 **US** ZIP Code/Postal Code

13. TELEPHONE NUMBER *(Include Area Code)*	14. EMAIL ADDRESS *(Optional)*

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

038 - South Dakota Department of Veterans Affairs

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*	16B. JOB TITLE OF PERSON NAMED IN ITEM 16A
Kevin Swanson	**Veterans Service Officer**
17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15	18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*
statevso.mailbox@va.gov	**03-28-2024**

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☑ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☑ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT (**Required**)	22B. DATE SIGNED *(MM/DD/YYYY)*
Jon P Vuckovich	**03-28-2024**
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (**Required**)	23B. DATE SIGNED *(MM/DD/YYYY)*
[signature]	**03-28-2024**

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

	COPY OF VA FORM 21-22 SENT TO:	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason and date (MM/DD/YYYY))*
VA USE ONLY	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

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 Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 11/30/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 14 before completing the form. Use this form to determine your eligibility for compensation. For more information, you can contact us online through Ask VA: https://ask.va.gov. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). If you prefer you may complete and submit the form online at www.va.gov. VA forms are available at www.va.gov/vaforms.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS THAT APPLIES TO YOU. **NOTE**: Your claim will be processed as described on pages 1 through 8 unless one of the following special programs is selected. See Instruction pages 1 through 3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process.

- [x] FDC PROGRAM
- [ ] STANDARD CLAIM PROCESS
- [ ] IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)
- [ ] BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

SECTION I: VETERAN'S IDENTIFICATION INFORMATION
(If claim is not an original claim, only Section I, IV (if applicable), V and a signature are required)

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly, insert one letter per box, and completely fill in each applicable check box to help expedite processing of the form.

2. VETERAN/SERVICEMEMBER'S NAME (First, Middle Initial, Last)
Joe P Veteran

3. VETERAN'S SOCIAL SECURITY NUMBER (SSN)	4. HAVE YOU EVER FILED A CLAIM WITH VA?	5. VA FILE NUMBER
123-23-3456	[x] YES [ ] NO (If "Yes," provide your file number in Item 5)	**123233456**

6. DATE OF BIRTH (MM-DD-YYYY)	7. VETERANS SERVICE NUMBER (if applicable)
09-08-1947	

8. **BDD CLAIMSONLY: PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY** (MM-DD-YYYY)	9. TELEPHONE NUMBER (Optional) (Include Area Code)
	(605)123-2345
	Enter International Phone Number (If applicable)

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

No. & Street: **123 Tenbucktwo Ave**

Apt./Unit Number:

City: **Sioux Falls**

State/Province: **SD** Country: **United States** ZIP Code/Postal Code: **57107**

11. E-MAIL ADDRESS (Optional) [ ] I agree to receive electronic correspondence from VA in regards to my claim.

[ ] 12. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX (Includes Work Study/Internship) (If you are not a VA employee skip to Section II, if applicable)

SECTION II: CHANGE OF ADDRESS

NOTE: If you are temporarily or permanently changing your address, complete Items 13A through 13C.

13A. TYPE OF ADDRESS CHANGE (Complete if applicable) (Check only one box)

- [ ] TEMPORARY
- [ ] PERMANENT

13B. NEW 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:

13C. EFFECTIVE DATE(S) OF NEW ADDRESS (If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent**, please enter your effective date in the beginning date only)

	Month	Day	Year		Month	Day	Year
BEGINNING DATE:				**ENDING DATE:**			

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 14A through 14F) should only be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

14A. ARE YOU CURRENTLY HOMELESS?

- ☐ YES (If "Yes," complete Item 14B regarding your living situation)
- ☑ NO

14B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

- ☐ LIVING IN A HOMELESS SHELTER
- ☐ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent)
- ☐ STAYING WITH ANOTHER PERSON
- ☐ FLEEING CURRENT RESIDENCE
- ☐ OTHER (Specify):

14C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

- ☐ YES (If "Yes," complete Item 14D regarding your living situation)
- ☑ NO

14D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:

- ☐ HOUSING WILL BE LOST IN 30 DAYS
- ☐ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeles shelter)
- ☐ OTHER (Specify)

14E. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)

14F. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

( )

Enter International Phone Number (If applicable)

SECTION IV: EXPOSURE INFORMATION

15A. ARE YOU CLAIMING ANY CONDITIONS RELATED TO TOXIC EXPOSURES? **NOTE**: See Page 4 of the Instructions for further information on the evidence needed to support your claim for presumptive service connection. (You can also refer to the following websites for more information: PACT ACT (https://www.va.gov/PACT) and PUBLIC HEALTH MILITARY EXPOSURES (https://www.publichealth.va.gov/exposures/index.asp))

☑ YES (If "Yes," complete Items 15B, 15C, 15D and 15E) ☐ NO (If "No," skip to Item 16, Section V: Claim Information)

15B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS?

Iraq; Kuwait; Saudi Arabia; the neutral zone between Iraq and Saudi Arabia; Bahrain; Qatar; the United Arab Emirates; Oman; Yemen; Lebanon; Somalia; Afghanistan; Israel; Egypt; Turkey; Syria; Jordan; Djibouti; Uzbekistan; the Gulf of Aden; the Gulf of Oman; the Persian Gulf; the Arabian Sea; and the Red Sea.

☐ YES ☑ NO

FROM: TO:

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)
Note: Please provide an approximate time frame (month and year).

15C. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE (e.g., Agent Orange) LOCATIONS?

Republic of Vietnam to include the 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a C-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves).

☑ YES ☐ NO Please list other location(s) where you served, if not listed above:

FROM: TO:

WHEN DID YOU SERVE IN THESE LOCATIONS? (MM-YYYY)
Note: Please provide an approximate time frame (month and year). **04-1968** **05-1969**

15D. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? (Check all that apply)

- ☐ ASBESTOS
- ☐ MUSTARD GAS
- ☐ RADIATION
- ☐ SHAD (Shipboard Hazard and Defense)
- ☐ MILITARY OCCUPATIONAL SPECIALTY (MOS)-related toxin
- ☐ CONTAMINATED WATER AT CAMP LEJEUNE
- ☐ OTHER (Specify)

FROM: TO:

WHEN WERE YOU EXPOSED? (MM-YYYY)
Note: Please provide an approximate time frame (month and year).

15E. IF YOU WERE EXPOSED MULTIPLE TIMES, PLEASE PROVIDE ALL ADDITIONAL DATES AND LOCATIONS OF POTENTIAL EXPOSURE

SECTION V: CLAIM INFORMATION
(For additional space, use Section XIII: Claim Information (Addendum))

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)

NOTE: List your claimed conditions below. **See the following three examples for guidance on how to complete Section V.**

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

SECTION V: CLAIM INFORMATION (Continued)
(For additional space, use Section XIII: Claim Information (Addendum))

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.	**Type II Diabetes**	**Agent Orange**	**Service in Vietnam**	**1968 - 1969**
2.	**Heart Condition**	**Agent Orange**	**Service in Vietnam**	**1968 - 1969**
3.	**Bilateral Hearing Loss**	**Noise**	**105 mm Howitzer Crew Member**	**1968 - 1969**
4.	**Tinnitus**	**Noise**	**105 mm Howitzer Crew Member**	**1968 - 1969**
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month andYear) OF TREATMENT. IF ADDITIONAL SPACE IS NEEDED ATTACH A SEPARATE SHEET AND INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND ITEM NUMBER.

NOTE: If treatment began from 2005 to present, you do not need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM-YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
Diabetes, Heart Sioux Falls VA Health Care	**10-2008**	☐ Don't have date
Hearing Sioux Falls VA Health Care	**07-1978**	☐ Don't have date
	0-	☐ Don't have date

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW. (VA forms are available at www.va.gov/vaforms)

For:	Required Form(s):
Supplemental Claims	VA Form 20-0995
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

SECTION VI: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES (If "Yes," complete Item 18B) ☑ NO (If "No," skip to Item 19A)

18B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

19A. BRANCH OFSERVICE
☑ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE
☐ NOAA ☐ USPHS

19B. COMPONENT
☑ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE DATES
Month Day Year
ENTRY DATE: **01-01-1968**
EXIT DATE: **09-30-1974**

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
Ft. Lewis, WA

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☐ YES ☑ NO

20D. ADDITIONAL PERIODS OF SERVICE
(Indicate enlistment and discharge date(s), if applicable)
Month Day Year
FROM:
TO:

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☐ YES (If "Yes," complete Items 21B through 21F)
☑ NO (If "No," skip to Item 22A)

21B. COMPONENT
☐ NATIONAL GUARD
☐ RESERVES

21C. OBLIGATION TERM OF SERVICE
Month Day Year
FROM:
TO:

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT (Include Area Code)
( )

21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☐ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES (If "Yes," complete Items 22B & 22C)
☑ NO

22B. DATE OF ACTIVATION:
Month Day Year

22C. ANTICIPATED SEPARATION DATE:
Month Day Year

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES (If "Yes," complete Item 23B)
☑ NO

23B. DATES OF CONFINEMENT

FROM:	TO:
Month Day Year	Month Day Year
Month Day Year	Month Day Year

SECTION VII: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?
☐ YES (If "Yes," complete Items 24C and 24D)
☑ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?
☐ YES (If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)
☑ NO

24C. BRANCH OF SERVICE
☐ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE
☐ NOAA ☐ USPHS

24D. MONTHLY AMOUNT
$

25. RETIRED STATUS
☐ RETIRED ☐ PERMANENT DISABILITY RETIRED LIST
☐ TEMPORARY DISABILITY RETIRED LIST

IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):
Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time ***may*** result in an overpayment, which ***may*** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26.**

Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.**

IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:
VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which **may** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?

☐ YES (If "Yes," complete Items 27B through 27D)
☑ NO

27B. DATE PAYMENT RECEIVED (MM-DD-YYYY)	27C. BRANCH OF SERVICE	27D. AMOUNT RECEIVED (Provide pre-tax amount)
	☐ ARMY ☐ NAVY ☐ MARINE CORPS ☐ AIR FORCE ☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA ☐ USPHS	$

IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:
You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which ***may*** be subject to collection.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.**

SECTION VIII: DIRECT DEPOSIT INFORMATION
(Note: If you have already signed up for direct deposit, skip to Section IX)

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, ***and*** attach either a voided personal check ***or*** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

☐ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT *(If you check this box skip to Section IX)*

30. ACCOUNT NUMBER (Check only one box below and provide the account number)

Account No.: **10102235698** ☑ CHECKING ☐ SAVINGS

31. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank whereyou want your direct deposit)	32. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)
First Dakota National Bank	**091400486**

SECTION IX: CLAIM CERTIFICATION AND SIGNATURE
VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not discloseable.

I certify I have received the notice attached to this application titled, ***Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits***.

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 1, on page 8, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE **(REQUIRED)**	33B. DATE SIGNED (MM-DD-YYYY)
	**04-16-2024**

SECTION X: WITNESSES TO SIGNATURE

34A. SIGNATURE OF WITNESS (**Note**: Only sign if veteran signed in Item 33A using an "X")	34B. PRINTED NAME AND ADDRESS OF WITNESS
35A. SIGNATURE OF WITNESS (**Note**: Only sign if veteran signed in Item 33A using an "X")	**35B. PRINTED NAME AND ADDRESS OF WITNESS**

SECTION XI: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

NOTE: An alternate signer signature **will not** be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

36A. ALTERNATE SIGNER SIGNATURE **(REQUIRED)**	36B. DATE SIGNED (MM-DD-YYYY) **04-16-2024**

SECTION XII: POWER OF ATTORNEY (POA) SIGNATURE (NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature *will not* be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual As Claimant's Representative,* indicating the appropriate POA is of record with VA.

37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE	37B. DATE SIGNED (MM-DD-YYYY) **04-16-2024**

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

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at 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.

SECTION XIII: CLAIM INFORMATION (ADDENDUM)

(Please submit this page with the completed application if you have additional disabilities to add to your claim. If more space is needed, please make additional copies of this page to submit with your application.)

LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY (If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)

NOTE: List your claimed conditions below. **See the following three examples on guidance on how to complete Section XIII**.

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation, burn pits)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

OMB Approved No. 2900-0043
Respondent Burden: 30 minutes
Expiration Date: 08/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION REQUEST TO ADD AND/OR REMOVE DEPENDENTS

INSTRUCTIONS: Make sure you sign and date this form in Items 26A and 26B.
Note: Unless the claimant is the veteran's surviving spouse or a designated "alternate signer", the veteran *must* sign in Item 26A. When you have completed this form, you can mail it to the address shown at the bottom of Page 2. If you prefer you may complete and submit the form online at www.va.gov.

SECTION I: VETERAN/CLAIMANT'S IDENTIFICATION INFORMATION
(Note: Completion of this section is REQUIRED to process your request; any omission may delay processing)

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

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

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. VETERAN'S DATE OF BIRTH
123-23-3456	**123233456**	**09-08-1947**

5. CLAIMANT'S NAME ***(If other than veteran)*** *(First, Middle Initial, Last)*

6. CLAIMANT'S SOCIAL SECURITY NUMBER	7. VETERAN'S SERVICE NUMBER *(If applicable)*	8. TELEPHONE NUMBER *(Include Area Code)*
		(605)123-2345 Enter International Phone Number *(If applicable)*

9. E-MAIL ADDRESS *(Optional)* ☐ I agree to receive electronic correspondence from VA in regards to my claim.

10. COMPLETE MAILING ADDRESS OF VETERAN/CLAIMANT *(Number and Street or Rural Route, P. O. Box, City, State, ZIP Code and Country)*
No. & Street **123 Tenbucktwo Ave**
Apt./Unit Number City **Sioux Falls**
State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

SECTION II: INFORMATION NEEDED TO ADD SPOUSE

11A. SPOUSE'S NAME (First, Middle Initial, Last)
Ann Marrie Veteran

11B. SPOUSE'S DATE OF BIRTH	11C. SPOUSE'S SOCIAL SECURITY NUMBER (SSN)	11D. DATE OF MARRIAGE
Month Day Year **09-03-1946**	*(If your spouse does not have an SSN, explain why in Section IX, Item 25, Remarks)* **666-66-6666**	Month Day Year **10-15-1975**

11E. PLACE OF MARRIAGE *(City and State, County and State, or City and Country)*
City or County **Sioux Falls, SD** State/Province Country **US**

11F. HOW WERE YOU MARRIED? *(Check one)* ☐ CIVIL CEREMONY *(i.e. Justice of the Peace)* ☑ RELIGIOUS CEREMONY *(i.e. Minister, Priest, Rabbi, etc.)*
☐ TRIBAL ☐ PROXY ☐ COMMON LAW ☐ OTHER *(Explain)*

12A. IS YOUR SPOUSE ALSO A VETERAN?	12B. SPOUSE'S VA FILE NUMBER *(If applicable)*	12C. SPOUSE'S SERVICE NUMBER *(If applicable)*
☐ YES *(If "YES," complete Items 12B and 12C)* ☑ NO		

NOTE: If you are a veteran that VA is paying additional benefits for a stepchild and you no longer live with the stepchild's biological or adoptive parent, complete Section V.

13A. DO YOU LIVE TOGETHER?	13B. REASON FOR SEPARATION *(For example, marital problems, job requirements, health, etc.)*
☑ YES ☐ NO (If "NO," complete Items 13B and 13C)	

13C. CURRENT MAILING ADDRESS OF SPOUSE (Number and Street or Rural Route, P.O. Box, City, State, ZIP Code and Country)
No. & Street **123 Tenbucktwo Ave**
Apt./Unit Number City **Sioux Falls**
State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

NOTE: You ***must*** provide complete information about ***your prior marriages and your current spouse's prior marriages***.

14. VETERAN/CLAIMANT'S PREVIOUS MARITAL INFORMATION
(If no prior marriages, this section may be left blank)

14A. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*

14A. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*

City or County | State/Province | Country

14A. (3) REASON FOR TERMINATION

☐ Death ☐ Divorce ☐ Annulment ☐ Other (Explain):

14A. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*

City or County | State/Province | Country

14B. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*

14B. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*

City or County | State/Province | Country

14B. (3) REASON FOR TERMINATION

☐ Death ☐ Divorce ☐ Annulment ☐ Other (Explain):

14B. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*

City or County | State/Province | Country

14C. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*

14C. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*

City or County | State/Province | Country

14C. (3) REASON FOR TERMINATION

☐ Death ☐ Divorce ☐ Annulment ☐ Other (Explain):

14C. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*

City or County | State/Province | Country

14D. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*

14D. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*

City or County | State/Province | Country

14D. (3) REASON FOR TERMINATION

☐ Death ☐ Divorce ☐ Annulment ☐ Other (Explain):

14D. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*

City or County | State/Province | Country

15. CURRENT SPOUSE'S PREVIOUS MARITAL INFORMATION (If no prior marriages, this section may be left blank)		
15A. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*		
15A. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*		
City or County	State/Province	Country
15A. (3) REASON FOR TERMINATION ☐ Death ☐ Divorce ☐ Annulment ☐ Other (Explain):		
15A. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*		
City or County	State/Province	Country
15B. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*		
15B. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*		
City or County	State/Province	Country
15B. (3) REASON FOR TERMINATION ☐ Death ☐ Divorce ☐ Annulment ☐ Other (Explain):		
15B. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*		
City or County	State/Province	Country
15C. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*		
15C. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*		
City or County	State/Province	Country
15C. (3) REASON FOR TERMINATION ☐ Death ☐ Divorce ☐ Annulment ☐ Other (Explain):		
15C. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*		
City or County	State/Province	Country
15D. (1) TO WHOM MARRIED *(First, Middle Initial, Last Name)*		
15D. (2) DATE AND PLACE OF MARRIAGE *(MM-DD-YYYY)*		
City or County	State/Province	Country
15D. (3) REASON FOR TERMINATION ☐ Death ☐ Divorce ☐ Annulment ☐ Other (Explain):		
15D. (4) DATE AND PLACE MARRIAGE TERMINATED *(MM-DD-YYYY)*		
City or County	State/Province	Country

SECTION III: INFORMATION NEEDED TO ADD CHILD(REN)
(If claiming more than four children, fill out addendum (Page 15) and submit with application)

16A. NAME OF **FIRST** CHILD TO ADD *(First, Middle Initial, Last)*

16B. SOCIAL SECURITY NUMBER

16C. DATE OF BIRTH *(MM-DD-YYYY)*

16D. PLACE OF BIRTH (Provide City and State, County and State, or City and Country)

City or County | State/Province | Country

16E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

16F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

16G. CHILD STATUS *(Check all that apply)*

☐ BIOLOGICAL ☐ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ☐ ADOPTED ☐ CHILD INCAPABLE OF SELF-SUPPORT

☐ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 16H)* ☐ STEPCHILD *(If checked, complete Item 16I)*

16H. HOW AND WHEN MARRIAGE ENDED

DATE *(MM-DD-YYYY)* ☐ DIVORCE ☐ OTHER *(Explain)* ☐ ANNULLED

16I. IF YOU CHECKED "STEPCHILD" IN ITEM 16G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

☐ YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)*

☐ NO

17A. NAME OF **SECOND** CHILD TO ADD *(First, Middle Initial, Last)*

17B. SOCIAL SECURITY NUMBER

17C. DATE OF BIRTH *(MM-DD-YYYY)*

17D. PLACE OF BIRTH (Provide City and State, County and State, or City and Country)

City or County | State/Province | Country

17E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

17F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

17G. CHILD STATUS *(Check all that apply)*

☐ BIOLOGICAL ☐ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ☐ ADOPTED ☐ CHILD INCAPABLE OF SELF-SUPPORT

☐ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 16H)* ☐ STEPCHILD *(If checked, complete Item 16I)*

17H. HOW AND WHEN MARRIAGE ENDED

DATE *(MM-DD-YYYY)* ☐ DIVORCE ☐ OTHER *(Explain)* ☐ ANNULLED

17I. IF YOU CHECKED "STEPCHILD" IN ITEM 16G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

☐ YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)*

☐ NO

SECTION III: INFORMATION NEEDED TO ADD CHILD(REN) *(Continued)*
(If claiming more than four children, fill out addendum (Page 15) and submit with application)

18A. NAME OF **THIRD** CHILD TO ADD *(First, Middle Initial, Last)*

18B. SOCIAL SECURITY NUMBER

18C. DATE OF BIRTH *(MM-DD-YYYY)*

18D. PLACE OF BIRTH (Provide City and State, County and State, or City and Country)

City or County | State/Province | Country

18E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

18F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

18G. CHILD STATUS *(Check all that apply)*

☐ BIOLOGICAL ☐ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ☐ ADOPTED ☐ CHILD INCAPABLE OF SELF-SUPPORT

☐ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 16H)* ☐ STEPCHILD *(If checked, complete Item 16I)*

18H. HOW AND WHEN MARRIAGE ENDED

DATE *(MM-DD-YYYY)* ☐ DIVORCE ☐ OTHER *(Explain)* ☐ ANNULLED

18I. IF YOU CHECKED "STEPCHILD" IN ITEM 16G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

☐ YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)*

☐ NO

19A. NAME OF **FOURTH** CHILD TO ADD *(First, Middle Initial, Last)*

19B. SOCIAL SECURITY NUMBER

19C. DATE OF BIRTH *(MM-DD-YYYY)*

19D. PLACE OF BIRTH (Provide City and State, County and State, or City and Country)

City or County | State/Province | Country

19E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

19F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

19G. CHILD STATUS *(Check all that apply)*

☐ BIOLOGICAL ☐ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ☐ ADOPTED ☐ CHILD INCAPABLE OF SELF-SUPPORT

☐ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 16H)* ☐ STEPCHILD *(If checked, complete Item 16I)*

19H. HOW AND WHEN MARRIAGE ENDED

DATE *(MM-DD-YYYY)* ☐ DIVORCE ☐ OTHER *(Explain)* ☐ ANNULLED

19I. IF YOU CHECKED "STEPCHILD" IN ITEM 16G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

☐ YES *(If "Yes," provide the date the child entered veteran's household)* DATE *(MM-DD-YYYY)*

☐ NO

SECTION IV: VETERAN REPORTING DIVORCE FROM FORMER SPOUSE
(If you have stepchild(ren), also complete Section V)

NOTE: If marriage ended as an annulment or declared void, use Section IX, Item 25, "Remarks" to explain.

20A. NAME OF FORMER SPOUSE *(First, Middle Initial, Last)*

20B. PLACE OF DIVORCE *(Provide city and state, county and state, or city and country)*

City or County | State/Province | Country

20C. DATE OF DIVORCE

SECTION V: VETERAN/CLAIMANT REPORTING ON STEPCHILD(REN)

21A. (1) DID YOU HAVE A STEPCHILD(REN) THAT WAS THE BIOLOGICAL OR ADOPTED CHILD(REN) OF THE FORMER SPOUSE LISTED IN ITEM 20A?

☐ *YES (If "YES," list the name(s) of the stepchild(ren) here):*

☐ *NO (If "NO," skip to Section VI)*

21A. (2) NAME(S) OF STEPCHILD(REN) *(First, Middle Initial, Last)*

21B. ARE YOU STILL SUPPORTING YOUR STEPCHILD(REN) LISTED IN ITEM 21A?

☐ YES *(If "YES," complete Items 21C through 21L)*

☐ NO *(If "NO," complete Item 21F and then continue to Section VI)*

21C. NAME OF STEPCHILD YOU ARE SUPPORTING

21D. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE THE NAME OF PERSON WITH WHOM STEPCHILD RESIDES

21E. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE A COMPLETE ADDRESS

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

21F. DATE STEPCHILD LEFT VETERAN'S HOUSEHOLD *(MM-DD-YYYY)*

21G. FINANCIAL SUPPORT PROVIDED ☐ More than half ☐ Half ☐ Less than half

21H. NAME OF STEPCHILD YOU ARE SUPPORTING

21I. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE THE NAME OF PERSON WITH WHOM STEPCHILD RESIDES

21J. IF STEPCHILD DOES NOT LIVE WITH YOU, PROVIDE A COMPLETE ADDRESS

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

21K. DATE STEPCHILD LEFT VETERAN'S HOUSEHOLD *(MM-DD-YYYY)*

21L. FINANCIAL SUPPORT PROVIDED ☐ More than half ☐ Half ☐ Less than half

SECTION VI: VETERAN/CLAIMANT REPORTING DEATH OF A DEPENDENT

22A. (1) DEPENDENT TYPE *(Check all that apply)*

☐ SPOUSE ☐ MINOR CHILD (UNDER 18 YEARS OLD ☐ STEPCHILD ☐ ADOPTED ☐ DEPENDENT PARENT
☐ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT ☐ 18-23 YEARS OLD AND IN SCHOOL

22B. NAME OF DEPENDENT*(First, Middle Initial, Last)*

22C. DATE OF DEATH *(MM/DD/YYYY)*

22D. PLACE OF DEATH (City & State, County & State, or City & Country)

City or County | State/Province | Country

22A. (2) DEPENDENT TYPE *(Check all that apply)*

☐ SPOUSE ☐ MINOR CHILD (UNDER 18 YEARS OLD ☐ STEPCHILD ☐ ADOPTED ☐ DEPENDENT PARENT
☐ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT ☐ 18-23 YEARS OLD AND IN SCHOOL

22B. NAME OF DEPENDENT*(First, Middle Initial, Last)*

22C. DATE OF DEATH *(MM/DD/YYYY)*

22D. PLACE OF DEATH (City & State, County & State, or City & Country)

City or County | State/Province | Country

SECTION VII: VETERAN/CLAIMANT REPORTING MARRIAGE OF CHILD

23A. NAME OF CHILD *(First, Middle Initial, Last)*

23B. DATE OF MARRIAGE *(MM-DD-YYYY)*

SECTION VIII: VETERAN/CLAIMANT REPORTING A SCHOOLCHILD OVER 18 HAS STOPPED ATTENDING SCHOOL

24A. NAME OF SCHOOLCHILD (First, Middle Initial, Last)

24B. DATE SCHOOLCHILD STOPPED ATTENDING SCHOOL

SECTION IX: REMARKS

25. REMARKS *(If any)*

SECTION X: BENEFICIARY/CLAIMANT'S CERTIFICATION AND SIGNATURE
(Note: Completion of this section is REQUIRED to process your request)

IMPORTANT: The primary purpose of this form is to gather information or statements that may result in a change to your VA benefits. By signing this form you have given permission to make benefit payment changes that could result in the creation of an overpayment. If such adverse actions are taken you will receive additional notification from VA regarding repayment options.

I HEREBY CERTIFY THAT the information I have given above is true and correct to the best of my knowledge and belief.

26A. SIGNATURE OF BENEFICIARY/CLAIMANT OR ALTERNATE SIGNER* (REQUIRED)	***(FOR USE BY VA ONLY)***	**26B. DATE *(MM/DD/YYYY)***
Jon P Vaden		**04-16-2024**

*ALTERNATE SIGNER: By signing on behalf of the beneficiary/claimant, I certify that the claimant is:
- under the age of 18
- mentally incompetent to provide substantially accurate information needed to complete the form or to certify that the statements made on the form are true and complete, or
- physically unable to sign the form

*ALTERNATE SIGNER: By signing on behalf of the beneficiary/claimant, I certify that I am:
- a court-appointed representative,
- an attorney in fact or agent authorized to act on behalf of the claimant under a durable power of attorney,
- a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative, or
- a manager or principal officer acting on behalf of an institution which is responsible for the care of the claimant.

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

PRIVACY ACT INFORMATION: 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 and your dependents' SSN account information is mandatory. Applicants are required to provide their SSN and the SSN of any dependents for whom benefits are claimed under Title 38 USC 5101 (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 Federal Statute of law in effect prior to January 1, 1975, and still in effect. 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 marital status and eligibility for an additional allowance for dependents under 38 U.S.C. 1115. Title 38, United States Code, 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.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.

SECTION XI: ADDITIONAL CHILD(REN) (Addendum)

(Please submit this page with the completed application if you have additional children to add to your claim. If more space is needed, please make additional copies of this page to submit with your application.)

1A. NAME OF **ADDITIONAL** CHILD TO ADD *(First, Middle Initial, Last)*

1B. SOCIAL SECURITY NUMBER

1C. DATE OF BIRTH *(MM-DD-YYYY)*

1D. PLACE OF BIRTH *(Provide City and State, County and State, or City and Country)*

City or County | State/Province | Country

1E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

1F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

1G. CHILD STATUS *(Check all that apply)*

☐ BIOLOGICAL ☐ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ☐ ADOPTED ☐ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT

☐ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 1H)* ☐ STEPCHILD *(If checked, complete Item 1I)*

1H. HOW AND WHEN MARRIAGE ENDED

DATE *(MM-DD-YYYY)*

☐ DIVORCED ☐ OTHER *(Explain)*

☐ ANNULLED

1I. IF YOU CHECKED "STEPCHILD" IN ITEM 1G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

☐ YES (If "Yes," provide the date the child entered veteran's household) DATE *(MM/DD/YYYY)*

☐ NO

2A. NAME OF **ADDITIONAL** CHILD TO ADD *(First, Middle Initial, Last)*

2B. SOCIAL SECURITY NUMBER

2C. DATE OF BIRTH *(MM-DD-YYYY)*

2D. PLACE OF BIRTH *(Provide City and State, County and State, or City and Country)*

City or County | State/Province | Country

2E. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE NAME OF PERSON THE CHILD RESIDES WITH

2F. IF THE CHILD DOES NOT LIVE WITH THE CLAIMANT, PROVIDE COMPLETE PHYSICAL ADDRESS WHERE CHILD RESIDES

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code

2G. CHILD STATUS *(Check all that apply)*

☐ BIOLOGICAL ☐ 18-23 YEARS OLD AND IN SCHOOL *(If checked, fill out VA Form 21-674)* ☐ ADOPTED ☐ CHILD PERMANENTLY INCAPABLE OF SELF-SUPPORT

☐ CHILD PREVIOUSLY MARRIED *(If checked, provide the date marriage ended and how the marriage ended in Item 2H)* ☐ STEPCHILD *(If checked, complete Item 2I)*

2H. HOW AND WHEN MARRIAGE ENDED

DATE *(MM-DD-YYYY)*

☐ DIVORCED ☐ OTHER *(Explain)*

☐ ANNULLED

2I. IF YOU CHECKED "STEPCHILD" IN ITEM 2G, IS STEPCHILD THE BIOLOGICAL CHILD OF YOUR SPOUSE?

☐ YES (If "Yes," provide the date the child entered veteran's household) DATE *(MM/DD/YYYY)*

☐ NO

OMB Approved No. 2900-0659
Respondent Burden: 45 minutes
Expiration Date: 03/31/2027

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIMED MENTAL HEALTH DISORDER(S) DUE TO AN IN-SERVICE TRAUMATIC EVENT(S)

INSTRUCTIONS: Before completing this form, we encourage you to read the Privacy Act and Respondent Burden on page 7. Use this form to provide a statement in support of a claimed mental health disorder(s) due to an in-service traumatic event(s). For more information, you can contact us online through Ask VA: https://ask.va.gov/ or call us toll-free at 1-800-698-2411 (TTY:711). VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN/SERVICE MEMBER'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly and insert one letter per box to help expedite processing of the form.

1. VETERAN/SERVICE MEMBER'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)	4. DATE OF BIRTH (MM/DD/YYYY)
123-23-3456	123233456	09-08-1947

5. VETERAN'S SERVICE NUMBER (If applicable)	6. TELEPHONE NUMBER (Include Area Code)
	(605)123-2345 Enter International Phone Number (If applicable)

7. E-MAIL ADDRESS (Optional)

SECTION II: TRAUMATIC EVENT(S) INFORMATION

8. SELECT THE TYPE OF IN-SERVICE TRAUMATIC EVENT(S) YOU EXPERIENCED (Check more than one, if applicable)

- [X] COMBAT TRAUMATIC EVENT(S)
- [ ] PERSONAL TRAUMATIC EVENT(S) (not involving military sexual trauma (MST)
- [ ] PERSONAL TRAUMATIC EVENT(S) (involving MST) (if checked review Section VI)
- [ ] OTHER TRAUMATIC EVENT(S)

IMPORTANT: It is helpful, but not required, to complete all applicable sections of the form. Please provide information about where and when the in-service traumatic event(s) occurred. Including this information will help to identify records and sources of information that may support your claim. If you are unable to include this information or only provide approximate dates or locations, VA will still review and consider all the evidence available to support your claim. **See the following three examples for guidance on how to complete Items 9A through 9C**.

EXAMPLES OF BRIEF DESCRIPTION OF THE TRAUMATIC EVENT(S)	EXAMPLES OF LOCATION OF THE TRAUMATIC EVENT(S)	EXAMPLES OF DATES THE TRAUMATIC EVENT(S) OCCURED
Example 1. Corpsman on medical ship in Da Nang harbor, Vietnam	STATIONED ON U.S.S. XYZ	SUMMER OF '70
Example 2. Mugged	BACK ALLEY IN BIG TOWN, USA	JUNE 2007
Example 3. Sexually assaulted by drill instructor	FORT XYZ	BOOT CAMP

Note: Briefly summarize the nature of the traumatic event(s) you experienced. While providing this information may be difficult, this information may help identify evidence to support your claim. If you provide name(s) of other individuals who were involved or present during the traumatic event(s), VA will not contact these individual(s). Please know providing name(s) is not required for VA to continue processing your claim. **Use Section V: "Remarks" if additional space is needed**.

	9A. BRIEF DESCRIPTION OF THE TRAUMATIC EVENT(S) (e.g., injury in warfare, physical assault, sexual harassment, witnessed the death or injury of a person, etc.)	9B. LOCATION OF THE TRAUMATIC EVENT(S) (e.g., unit assignment, residence, off-base, duty station or state, if known)	9C. DATE(S) THE TRAUMATIC EVENT(S) OCCURED (e.g., month(s) or year(s), if known, or approximate dates are acceptable)
1.	Sniper fire where Sgt Duck was killed.	6th Battalion, 15th Artillery Regiment	July 1968
2.			
3.			

SECTION II: TRAUMATIC EVENT(S) INFORMATION (Continued)			
4.			
5.			
6.			

SECTION III: ADDITIONAL INFORMATION ASSOCIATED WITH THE IN-SERVICE TRAUMATIC EVENT(S)

IMPORTANT: This information will help us identify records or sources of evidence that may support your claim. If you are unable to include this information, VA will still review and consider all the evidence available to support your claim. **If additional space is needed, use Section V: "Remarks"**.

Note: VA understands that in-service traumatic event(s) may not have been reported or documented. In these situations, other information, such as behavioral changes and/or sources of evidence, may be used to support the in-service traumatic event(s).

10. INDICATE ANY BEHAVIORAL CHANGES FOLLOWING THE IN-SERVICE PERSONAL TRAUMATIC EVENT(S) (Note: Behavioral changes can include but are not limited to the examples listed in Items 10A through 10C. If your traumatic event(s) is combat only, you may skip to Item 11.)

A. BEHAVIORAL CHANGES EXPERIENCED FOLLOWING THE TRAUMATIC EVENT(S) (Check any box that applies).		B. ADDITIONAL INFORMATION ABOUT THE BEHAVIORAL CHANGES (If applicable) (e.g., approximate time change occurred, documentation, or record)
☐	INCREASED/DECREASED VISITS TO A HEALTHCARE PROFESSIONAL, COUNSELOR, OR TREATMENT FACILITY	
☐	REQUEST FOR A CHANGE IN OCCUPATIONAL SERIES OR DUTY ASSIGNMENT	
☐	INCREASED/DECREASED USE OF LEAVE	
☐	CHANGES IN PERFORMANCE OR PERFORMANCE EVALUATIONS	
☐	EPISODES OF DEPRESSION, PANIC ATTACKS, OR ANXIETY	
☐	INCREASED/DECREASED USE OF PRESCRIPTION MEDICATIONS	
☐	INCREASED/DECREASED USE OF OVER-THE-COUNTER MEDICATIONS	
☐	INCREASED/DECREASED USE OF ALCOHOL OR DRUGS	
☐	DISCIPLINARY OR LEGAL DIFFICULTIES	
☐	CHANGES IN EATING HABITS, SUCH AS OVEREATING OR UNDEREATING, OR SIGNIFICANT CHANGES IN WEIGHT	

SECTION III: ADDITIONAL INFORMATION ASSOCIATED WITH THE IN-SERVICE TRAUMATIC EVENT(S) (Continued)

☐	PREGNANCY TESTS AROUND THE TIME OF THE TRAUMATIC EVENT(S)	
☐	TESTS FOR SEXUALLY TRANSMITTED INFECTIONS	
☐	ECONOMIC OR SOCIAL BEHAVIORAL CHANGES	
☐	CHANGES IN OR BREAKUP OF A SIGNIFICANT RELATIONSHIP	

C. AS NEEDED, LIST ANY ADDITIONAL BEHAVIORAL CHANGES FOLLOWING THE IN-SERVICE PERSONAL TRAUMATIC EVENT(S) THAT WERE **NOT LISTED** IN ITEM 10A.

11. WAS AN OFFICIAL REPORT FILED? (**Note**: When reporting a sexual assault during military service, the Department of Defense offers two different reporting options, restricted or unrestricted. Knowing the report type will help VA take the necessary steps to obtain a copy of the report. If you are unsure which report was filed, VA may send you a follow up letter with additional information. Submitting a restricted or unrestricted report was not an option prior to 2005.)

☐ YES (If "Yes," check the appropriate box below indicating which type of report was filed)

☐ NO (If "No," skip to Item 12)

☐ RESTRICTED ☐ UNRESTRICTED ☐ NEITHER

☐ POLICE REPORT (Provide location, if known)

☐ OTHER (e.g., After Action Report (AAR), incident report, formal complaint, Judge Advocate General (JAG), Criminal Investigative Division (CID), Naval Criminal Investigative Service (NCIS), etc.)

12. POSSIBLE SOURCES OF EVIDENCE FOLLOWING THE TRAUMATIC EVENT(S) (Check all that apply) (**Note**: The following sources of evidence may provide additional information for your claim. This list is not all inclusive. If you have any individual(s)/witness(es) who know(s) about the in-service traumatic event(s) or would have knowledge of a behavioral change you experienced after the personal traumatic event(s), and wants to provide a statement on your behalf, use VA Form 21-10210, *Lay/Witness Statement*. If your individual(s)/witness(es) is a veteran, they may be requested to provide their DD Form 214, or other evidence of service.)

☐ A RAPE CRISIS CENTER OR CENTER FOR DOMESTIC ABUSE
☐ A COUNSELING FACILITY OR HEALTH CLINIC
☐ FAMILY MEMBERS OR ROOMMATES
☐ A FACULTY MEMBER
☐ CIVILIAN POLICE REPORTS
☐ MEDICAL REPORTS FROM CIVILIAN PHYSICIANS OR CAREGIVERS WHO TREATED YOU IMMEDIATELY FOLLOWING THE INCIDENT OR SOMETIME LATER
☐ A CHAPLAIN OR CLERGY
☐ FELLOW SERVICE MEMBER(S)
☐ PERSONAL DIARIES OR JOURNALS
☐ NONE
☐ OTHER (Specify below):

SECTION IV: TREATMENT INFORMATION

13A. HAVE YOU RECEIVED TREATMENT RELATED TO THE IMPACT OF THE TRAUMATIC EVENT(S) LISTED IN ITEM 9A?

☒ YES (If "Yes," complete Items 13B through 13E) ☐ NO (If "No," skip to Item 14)

13B. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check all that apply)

☐ PRIVATE HEALTHCARE PROVIDER (including non-Federal records)
☐ VA VET CENTER
☐ COMMUNITY CARE (Paid for by VA)
☒ VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPATIENT CLINICS (CBOC)
☐ DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)

Note: VA has access to VAMC, CBOC, and MTF records. A consent form is not needed. However, if you would like VA to attempt to obtain your **private provider (excluding community care (paid for by VA)) or VA Vet Center health records**, VA requires your consent by completing VA Form 21-4142, and VA Form 21-4142a. VA forms are available at www.va.gov/vaforms

SECTION IV: TREATMENT INFORMATION (Continued)

Note: If VAMC, CBOC, or MTF treatment began from 2005 to present, you do not need to provide dates in Item 13D.

13C. NAME AND LOCATION OF THE TREATMENT FACILITY	13D. DATE(S) OF TREATMENT (Approximate dates are acceptable) (MM-YYYY)	13E. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
Black Hills VA Health Care	07 – 2023	☐ Don't have date
	–	☐ Don't have date
	–	☐ Don't have date

SECTION V: REMARKS

Note: This section is optional and can be left blank. However, if additional space is needed to fully answer a previous question or if needed, use this section to provide any additional information that you feel is important for us to know that may support your claim.

14. REMARKS (If any)

SECTION VI: OPTION FOR VETERANS BENEFIT ADMINISTRATION (VBA) TO NOTIFY VETRANS HEALTH ADMINISTRATION (VHA) ABOUT CERTAIN UPCOMING EVENTS DURING THE CLAIM AND/OR APPEAL PROCESS
(Note: This section only applies if you checked personal traumatic event(s) (involving MST) in Item 8)

15. If you are filing a claim for compensation for a condition due to a personal traumatic event(s) (involving MST) and you are registered and/or enrolled for VHA health care, you have the option for VBA to electronically notify VHA about certain upcoming event(s) during your claim and/or appeal process. These events are any scheduled compensation and pension (C&P) examination, hearing before the Board of Veterans' Appeals, and any decision notification. When notified, VHA will place an indicator in your medical record to alert VA health care providers that these events are scheduled to occur. Notifications to VHA would only indicate the type of event and potential time frame, not any details specific to your claim. The indicator in your medical record would not identify your claim as MST-related, but at this time, only claimants filing MST-related claims are provided this notification option. For this reason, providers may know that the indicator is in relation to an MST-related claim. The decision to **consent**, **not consent**, or **revoke prior consent** into the automatic notification system will not affect the status or outcome of your claim. If you would like VBA to send these electronic notifications to VHA, please indicate your consent by selecting a check box below.

☐ A. I **CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that an indicator for these events will appear in my VHA medical record)

☐ B. I **DO NOT CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that an indicator for these events will not appear in my VHA medical record)

☐ C. I **REVOKE PRIOR CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that in the future, notice of these events will no longer appear in my VHA medical record)

☐ D. **NOT APPLICABLE AND/OR NOT ENROLLED OR REGISTERED IN VHA HEALTHCARE**

Note: You have the option to modify your previous selection at any time. Mail your correspondence to: **Department of Veterans Affairs, Compensation Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION VII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

16A.VETERAN/SERVICE MEMBER'S SIGNATURE	16B. DATE SIGNED (MM/DD/YYYY)
	07-17-2024

SECTION VIII: WITNESSES TO SIGNATURE (Note: Only use this section if the veteran/service member signed Item 16A with an "X")	
17A. SIGNATURE OF WITNESS	17B. PRINTED NAME AND ADDRESS OF WITNESS
18A. SIGNATURE OF WITNESS	18B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION IX: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (Note: Only required if Item 16A is blank)	
NOTE: An alternate signer signature will not be accepted unless a valid VA Form 21-0972, Alternate Signer Certification, is of record or attached to this request.	
I CERTIFY THAT by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form. I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.	
19A. ALTERNATE SIGNER'S SIGNATURE	19B. DATE SIGNED (MM/DD/YYYY)

SECTION X: POWER OF ATTORNEY (POA) SIGNATURE (Note: Only required if Item 16A is blank)	
I CERTIFY THAT the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge. **Note**: A POA's signature will not be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual as Claimant's Representative*, indicating the appropriate POA is of record with VA.	
20A. POA/AUTHORIZED REPRESENTATIVE'S SIGNATURE	20B. DATE SIGNED (MM/DD/YYYY)
20C. ACCREDITATION NUMBER	20D. DATE LAST VA FORM 21-22 OR VA FORM 21-22A WAS SUBMITTED (If known)

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 VA system of records, 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Completion and submission of this form is voluntary. However, the requested information is important to assist VA in thoroughly researching your military record and other sources to obtain supporting evidence of traumatic event(s) in service. The responses you submit are considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control Number. The OMB control number for this project is 2900-0659, and it expires 03/31/2027. Public reporting burden for this collection of information is estimated to average 45 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden to VA Reports Clearance Officer at VACOPaperworkReduAct@VA.gov. Please refer to OMB Control No. 2900-0659 in any correspondence. Do not send your completed VA Form 21-0781 to this email address.

OMB Approved No. 2900-0404
Respondent Burden: 45 minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

VETERAN'S APPLICATION FOR INCREASED COMPENSATION BASED ON UNEMPLOYABILITY

IMPORTANT: This is a claim for compensation benefits based on unemployability. When you complete this form you are claiming total disability because of a service-connected disability(ies) which has/have prevented you from securing or following any substantially gainful occupation. Answer all questions fully and accurately. See mailing information on page 4 of this form.

Social Security Benefits: Individuals who have a disability and meet medical criteria may qualify for Social Security of Supplemental Security Income disability benefits. If you would like more information about Social Security benefits, contact your nearest Social Security Administration (SSA) office. You can locate the address of the nearest SSA office in your telephone book blue pages under "United States Government, Social Security Administration" or call 1-800-772-1213 (Hearing Impaired TDD line 1-800-325-0778). You may also contact SSA by Internet at http://www.ssa.gov/ .

SECTION I - VETERAN IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand print the information requested in ink, neatly, and legibly, insert one letter per box, and completely fill each applicable circle to help expedite processing of the form.

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

2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. DATE OF BIRTH (Month Day Year)
123-23-3456	**123233456**	**09-08-1947**

5. MAILING ADDRESS (No. and street or rural route, city or P.O., State, ZIP Code and Country)

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number

City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

6. E-MAIL ADDRESS *(If applicable)* ☐ I agree to receive electronic correspondence from VA in regards to my claim.

7. TELEPHONE NUMBER *(Include Area Code)*
(605)123-2345

Enter International Phone Number (If applicable)

SECTION II - DISABILITY AND MEDICAL TREATMENT

8. WHAT SERVICE-CONNECTED DISABILITY PREVENTS YOU FROM SECURING OR FOLLOWING ANY SUBSTANTIALLY GAINFUL OCCUPATION?
PTSD Anxiety

9. HAVE YOU BEEN UNDER A DOCTOR'S CARE AND/OR HOSPITALIZED WITHIN THE PAST 12 MONTHS?
☑ Yes ☐ No

10. DATE(S) OF TREATMENT BY DOCTOR(S)
(Go to Item 26 - Remarks - for additional dates)
FROM **10-20-1994**
TO **04-16-2024**

11. NAME AND ADDRESS OF DOCTOR(S)
Dr Sigmund Freud
20174 Sleigh Rd
Pierre SD 57501

12. NAME AND ADDRESS OF HOSPITAL
Hot Springs VA Health Care

Hot Springs SD

13. DATE(S) OF HOSPITALIZATION
(Go to Item 26 - Remarks - for additional dates)
FROM **10-20-2023**
TO **12-19-2023**

SECTION III - EMPLOYMENT STATEMENT

14. DATE YOUR DISABILITY AFFECTED FULL-TIME EMPLOYMENT (Month Day Year)	15. DATE YOU LAST WORKED FULL-TIME (Month Day Year)	16. DATE YOU BECAME TOO DISABLED TO WORK (Month Day Year)
03-17-2007	**12-08-2022**	**12-08-2022**

17A. WHAT IS THE MOST YOU EVER EARNED IN ONE YEAR?	17B. WHAT YEAR?	17C. OCCUPATION DURING THAT YEAR
$ **30000.00**	**2022**	**Pipe Fitter**

SECTION III - EMPLOYMENT STATEMENT *(Continued)*

18. LIST ALL YOUR EMPLOYMENT INCLUDING SELF-EMPLOYMENT FOR THE LAST FIVE YEARS YOU WORKED
(Include any military duty including inactive duty for training) (Note: For additional employment information use Section V, Remarks)

NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK		HOURS PER WEEK
Pipes R Us		**Pipe Fitter**		**40**
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH	
FROM	TO			
05-22-2002	**12-08-2022**	**125 days**	$ **2500.00**	
NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK		HOURS PER WEEK
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH	
FROM	TO			
			$	
NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK		HOURS PER WEEK
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH	
FROM	TO			
			$	
NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK		HOURS PER WEEK
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH	
FROM	TO			
			$	
NAME AND ADDRESS OF EMPLOYER (OR UNIT)		TYPE OF WORK		HOURS PER WEEK
DATES OF EMPLOYMENT		TIME LOST FROM ILLNESS	HIGHEST GROSS EARNINGS PER MONTH	
FROM	TO			
			$	

VETERAN'S SOCIAL SECURITY NO. **123-23-3456**

SECTION III - EMPLOYMENT STATEMENT *(Continued)*

19. IF YOU ARE CURRENTLY SERVING IN THE RESERVE OR NATIONAL GUARD, DOES YOUR SERVICE CONNECTED DISABILITY PREVENT YOU FROM PERFORMING YOUR MILITARY DUTIES?

☐ YES ☐ NO

20A. INDICATE YOUR TOTAL EARNED INCOME FOR THE PAST 12 MONTHS	20B. IF PRESENTLY EMPLOYED, INDICATE YOUR CURRENT MONTHLY EARNED INCOME
$	$

21A. DID YOU LEAVE YOUR LAST JOB/SELF-EMPLOYMENT BECAUSE OF YOUR DISABILITY?	21B. DO YOU RECEIVE/EXPECT TO RECEIVE DISABILITY RETIREMENT BENEFITS?	21C. DO YOU RECEIVE/EXPECT TO RECEIVE WORKERS COMPENSATION BENEFITS?
☑ YES ☐ NO *(If "Yes," give the facts in Item 26,"Remarks")*	☐ YES ☑ NO	☐ YES ☑ NO

22. HAVE YOU TRIED TO OBTAIN EMPLOYMENT SINCE YOU BECAME TOO DISABLED TO WORK?

☐ YES ☑ NO *(If "Yes," complete Items 22A, 22B, and 22C)*

22A	22B	22C
NAME AND ADDRESS OF EMPLOYER	TYPE OF WORK	DATE APPLIED
NAME AND ADDRESS OF EMPLOYER	TYPE OF WORK	DATE APPLIED
NAME AND ADDRESS OF EMPLOYER	TYPE OF WORK	DATE APPLIED

SECTION IV - SCHOOLING AND OTHER TRAINING

23. EDUCATION *(Check highest year completed)*

GRADE SCHOOL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 HIGH SCHOOL ☐ 9 ☐ 10 ☐ 11 ☐ 12 COLLEGE ☐ Fresh ☐ Soph ☐ Jr ☑ Sr

24A. DID YOU HAVE ANY OTHER EDUCATION AND TRAINING BEFORE YOU WERE TOO DISABLED TO WORK?

☐ YES ☑ NO (If "Yes," complete Items 24B, and 24C)

24B. TYPE OF EDUCATION OR TRAINING	24C. DATES OF TRAINING	
	BEGINNING (MM/DD/YYYY)	COMPLETION (MM/DD/YYYY)

25A. HAVE YOU HAD ANY EDUCATION AND TRAINING SINCE YOU BECAME TOO DISABLED TO WORK?

☐ YES ☑ NO *(If "Yes," complete Items 25B, and 25C)*

25B. TYPE OF EDUCATION OR TRAINING	25C. DATES OF TRAINING	
	BEGINNING (MM/DD/YYYY)	COMPLETION (MM/DD/YYYY)

SECTION V - REMARKS

26. REMARKS

SECTION VI - AUTHORIZATION, CERTIFICATION, AND SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the person or entity, including but not limited to any organization, service provider, employer, or Government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

CERTIFICATION OF STATEMENTS: I CERTIFY THAT as a result of my service-connected disabilities, I am unable to secure or follow any substantially gainful occupation and that the statements in this application are true and complete to the best of my knowledge and belief. I understand that these statements will be considered in determining my eligibility for VA benefits based on unemployability because of service-connected disability.

I UNDERSTAND THAT IF I AM GRANTED SERVICE-CONNECTED TOTAL DISABILITY BENEFITS BASED ON MY UNEMPLOYABILITY, I MUST IMMEDIATELY INFORM VA IF I RETURN TO WORK. I ALSO UNDERSTAND THAT TOTAL DISABILITY BENEFITS PAID TO ME AFTER I BEGIN WORK MAY BE CONSIDERED AN OVERPAYMENT REQUIRING REPAYMENT TO VA.

27. SIGNATURE OF CLAIMANT *(Required)*	28. DATE SIGNED (MM/DD/YYYY)
Jan P Veteran	**04-16-2024**

WITNESSES NEEDED IF "X" MARK IS MADE (Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known and the signature and address of such witnesses must be shown in Items 29A & 29B and 30A & 30B.

29A. SIGNATURE OF WITNESS *(Sign in ink)*	29B. ADDRESS OF WITNESS
30A. SIGNATURE OF WITNESS *(Sign in ink)*	30B. ADDRESS OF WITNESS

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

SECTION VII - WHERE TO SEND CORRESPONDENCE

MAIL TO:

Department of Veterans Affairs
Evidence Intake Center
PO Box 4444
Janesville, WI 53547-4444

PRIVACY ACT NOTICE: 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 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 SSN account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5101(c)(1). 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 submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0858
Respondent Burden: 5 minutes
Expiration Date: 07/31/2024

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to provide your written authorization to obtain your treatment records, so the VA can get the information required to process your claim. 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 relaynumber is 711. VA forms are available at www.va.gov/vaforms . For mailing information see page 3.

SECTION I - VETERAN IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly, and insert one letter per box, to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. DATE OF BIRTH (MM/DD/YYYY)
123-23-3456	**123233456**	**09-08-1947**

5. VETERAN'S SERVICE NUMBER (If applicable)

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number

City **Sioux Falls**

State/Province **SD**

Country **United States**

ZIP Code/Postal Code **57107**

7. TELEPHONE NUMBER (Include Area Code)
(605)123-2345
Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS (Optional)
kevin.swanson@state.sd.us

☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION II - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING (If other than veteran)

9. PATIENT'S NAME (First, Middle Initial, Last)

10. SOCIAL SECURITY NUMBER

11. VA FILE NUMBER (If applicable)

SECTION III - INFORMATION REGARDING SOURCE OF RECORD(S)

SOURCE OF RECORD(S):

- **ALL** medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities,
- Social workers/rehabilitation counselors,
- Consulting examiners used by VA,
- Employers, insurance companies, workers' compensation programs, and
- Others who may know about my condition (family, neighbors, friends, public officials).

SECTION IV - RECORDS TO BE RELEASED TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of: ***All* my medical records; including information related to my ability to perform tasks of daily living. This includes specific permission to release:**

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including,* but not limited to:
   a. Psychological, psychiatric, or other mental impairment(s) excluding "psychotherapy notes" as defined in 45 C.F.R. §164.501,
   b. Drug abuse, alcoholism, or other substance abuse,
   c. Sickle cell anemia,
   d. Records which may indicate the presence of a communicable or non-communicable disease; and tests for or records of HIV/AIDS,
   e. Gene-related impairments (including genetic test results).
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months *after* the date this authorization is signed in Item 13, as well as past information.

YOU SHOULD NOT COMPLETE THIS FORM UNLESS YOU WANT THE VA TO OBTAIN PRIVATE TREATMENT RECORDS ON YOUR BEHALF. IF YOU HAVE ALREADY PROVIDED THESE RECORDS OR INTEND TO OBTAIN THEM YOURSELF, THERE IS NO NEED TO FILL OUT THIS FORM. DOING SO WILL LENGTHEN YOUR CLAIM PROCESSING TIME.

IMPORTANT - In accordance with 38 C.F.R. §3.159(c), **"VA will not pay any fees charged by a custodian to provide records requested."**

SECTION V- AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO VA AND SIGNATURE

12. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE (If this space is left blank, there is no limitation to records):

TO WHOM: The Department of Veterans Affairs (VA).
PURPOSE: Determining my eligibility for benefits, and whether I can manage such benefits.
EXPIRES: This authorization is good for 12 months from the date shown in Item 14.

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above in Section I.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties (See page 2 for details).
- I may write to VA and my source(s) to revoke this authorization at any time (See page 2 for details).
- VA will give me a copy of this form, if I ask; I may also ask the source(s) to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed. See Patient Acknowledgment below.**

13. SIGNATURE OF PERSON AUTHORIZING DISCLOSURE **(Required)**	14. DATE SIGNED (MM/DD/YYYY) **(Required)**
Joe P Veteran	**04-16-2024**

15. PRINTED NAME OF PERSON SIGNING (First, Middle Initial, Last)
Joe P Veteran

16. RELATIONSHIP TO VETERAN/CLAIMANT (If other than self, please provide full name, title, organization, city, State, and ZIP code. All court appointments must include docket number, county, and State)

NOTE: This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical and other information under P.L. 104-191 ("HIPAA"); 45 C.F.R. parts 160 and 164; 42 U.S.C. §290dd-2; 42 C.F.R. part 2, and State Law.

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 voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the source to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. 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 Federal Statute of law in effect prior to January 1, 1975 and still in effect.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of material fact knowing it to be false.

If you do not revoke this authorization, it will automatically expire in 12 months from the date you sign and date the form. Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by VA without your consent if authorized by Federal laws such as the Privacy Act

Under the Government Paperwork Elimination Act (GPEA) (Public Law 105-277), the Office of Management and Budget (OMB) ensures that agencies, when practicable, provide for the option of electronic maintenance, submission of disclosure of information and for the use and acceptance of electronic signatures. GPEA states that electronic records submitted or maintained in accordance with the procedures developed by OMB, or electronic signature or other forms of electronic authentication used in accordance with such procedures, "shall not be denied legal effect, validity, or enforceability merely because such records are in electronic form" (Public Law 105-277, section 1707).

RESPONDENT BURDEN: We need this information and your written authorization to obtain your treatment records to help us get the information required to process your claim. Title 38, United States Code, allows us to ask for this information. You can provide this authorization by signing VA Form 21-4142. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations. We estimate that you will need an average of 5 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. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain . If desired, you may call 1-800-827-1000 to get information on where to send comments or suggestions about this form. If you use the Telecommunications Device for the Deaf (TDD), the Federal relay number is 711.

PATIENT ACKNOWLEDGMENT: I HEREBY AUTHORIZE the sources listed in Section IV, to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the source being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it provides me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my source sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization in writing, at any time except to the extent a source of information has already relied on it to take an action. To revoke, I must send a written statement to the VA Regional Office handling my claim or the Board of Veterans' Appeals (if my claim is related to an appeal) and also send a copy directly to any of my sources that I no longer wish to disclose information about me. I understand that VA may use information disclosed prior to revocation to decide my claim.

NOTE: For additional information regarding VA Form 21-4142, refer to the following website: https://www.benefits.va.gov/privateproviders/.

OMB Control No. 2900-0858
Respondent Burden: 5 minutes
Expiration Date: 07/31/2024

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

GENERAL RELEASE FOR MEDICAL PROVIDER INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to provide the name of the provider or facility you have received treatment from to the VA. 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 completed by hand, print the information requested in ink, neatly, and legibly, and insert one letter per box, to help expedite processing of the form.

1. VETERAN/BENEFICIARY'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. DATE OF BIRTH *(MM/DD/YYYY)*
123-23-3456	**123233456**	**09-08-1947**

5. VETERAN'S SERVICE NUMBER (If applicable)

SECTION II - PATIENT IDENTIFICATION FOR RECORDS VA IS REQUESTING (If other than veteran)

6. PATIENT'S NAME *(First, Middle Initial, Last)*
Sully County Sheriffs Office

7. SOCIAL SECURITY NUMBER	8. VA FILE NUMBER *(If applicable)*

SECTION III - MEDICAL PROVIDER INFORMATION

9A. PROVIDER OR FACILITY NAME	9B. CONDITIONS YOU ARE BEING TREATED FOR	9C. DATE(S) OF TREATMENT: (Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)
Avera Health	**Hypertension**	From: **05-27-2008** To **04-16-2024**

9D. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. & Street **3900 W Avera Dr**

Apt./Unit Number

City **Sioux Falls**

State/Province **SD**

Country **United States**

ZIP Code/Postal Code **57108**

10A. PROVIDER OR FACILITY NAME	10B. CONDITIONS YOU ARE BEING TREATED FOR	10C. DATE(S) OF TREATMENT: (Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)
		From: To:

10D. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

VETERAN'S SOCIAL SECURITY NO. **123-23-3456**

11A. PROVIDER OR FACILITY NAME	11B. CONDITIONS YOU ARE BEING TREATED FOR	11C. DATE(S) OF TREATMENT: (Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)
		From: To:

11D. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

12A. PROVIDER OR FACILITY NAME	12B. CONDITIONS YOU ARE BEING TREATED FOR	12C. DATE(S) OF TREATMENT: (Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)
		From: To:

12D. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

13A. PROVIDER OR FACILITY NAME	13B. CONDITIONS YOU ARE BEING TREATED FOR	13C. DATE(S) OF TREATMENT: (Include the time period (MM/DD/YYYY) for the treatment by the provider listed in Item 9A)
		From: To:

13D. PROVIDER/FACILITY STREET ADDRESS *(Number and street, P.O. or rural route)*

No. &
Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal 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 voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. 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 Federal Statute of law in effect prior to January 1, 1975 and still in effect.

RESPONDENT BURDEN: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 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. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/ PRAMain . If desired, you may 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 or evidence of a material fact knowing it to be false.

OMB Control No. 2900-0067
Respondent Burden: 15 Minutes
Expiration Date: 07/31/2024

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

APPLICATION FOR AUTOMOBILE OR OTHER CONVEYANCE AND ADAPTIVE EQUIPMENT (UNDER 38 U.S.C. 3901-3904)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent on page 3. Use this form to apply for automobile or other conveyance and adaptive equipment allowance (38 U.S.C. Chapter 39). 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/SERVICEMEMBER IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN/SERVICEMEMBER'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)	4. DATE OF BIRTH
123-23-3456	**123233456**	**09-08-1947**

5. VETERAN'S SERVICE NUMBER(If applicable)	6. TELEPHONE NUMBER (Include Area Code)	7. E-MAIL ADDRESS
	(605)123-2345 Enter International Phone Number (If applicable)	☐ I agree to receive electronic correspondence from VA in regards to my claim.

NOTE: A servicemember planning early release should give both present military address and planned address following release from active duty, in Items 8A and 8B.

8A. CURRENT ADDRESS *(No. and Street or rural route, City or P.O., State and Zip Code)*

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number

City **Sioux Falls**

State/Province **SD**

Country

ZIP Code/Postal Code **57107**

8B. SERVICEMEMBER'S PLANNED ADDRESS FOLLOWING RELEASE FROM ACTIVE DUTY *(No. and Street or rural route, City or P.O., State and Zip Code)*

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

SECTION II - APPLICATION INFORMATION

9. BRANCH OF SERVICE
☑ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ SPACE FORCE ☐ OTHER (Specify)

10. ARE YOU ON ACTIVE DUTY?
☐ YES ☑ NO

11A. PLACE OF ENTRY INTO ACTIVE DUTY	11B. DATE
Sioux Falls, SD	**01-01-1968**

11C. PLACE OF RELEASE FROM ACTIVE DUTY (If applicable)	11D. DATE OF RELEASE
Ft. Lewis, WA	**09-30-1974**

12A. HAVE YOU APPLIED FOR VA DISABILITY COMPENSATION? (If "Yes," give place)	12B. DATE YOU APPLIED	13. LOCATION OF VA OFFICE THAT HAS YOUR FILE (If known)
☑ YES ☐ NO **Sioux Falls SD**	**03-17-2007**	**Sioux Falls Regional Office**

14. TYPE OF CONVEYANCE APPLIED FOR (Check one)
☐ AUTOMOBILE ☐ STATION WAGON ☐ VAN ☑ TRUCK ☐ OTHER *(Specify)*

15. HAVE YOU PREVIOUSLY APPLIED FOR AN AUTOMOBILE OR OTHER CONVEYANCE? (This is a once-per-lifetime grant)
☐ YES ☑ NO (If "Yes," give date and place)

I hereby apply for the conveyance checked in Item 14 above and the equipment required because of my disability. I agree that before operating the vehicle I shall hereafter apply to the proper authority for the necessary license to operate it. If I am unable to qualify for a license, I certify that a person licensed to operate a similar vehicle in the state of my residence will operate the vehicle for me. I further certify that VA has not previously paid an automobile grant on my behalf.

16. SIGNATURE OF VETERAN OR SERVICEMEMBER **(REQUIRED)**	17. DATE SIGNED
Joe P Veteran	**04-16-2024**

VETERAN/SERVICEMEMBER'S SOCIAL SECURITY NO. **123-23-3456**

SECTION III - CERTIFICATE OF ELIGIBILITY (To be completed by VA)

QUALIFYING DISABILITIES (Check appropriate box(es))

18A. LOSS OF FOOT	18B. LOSS OF HAND	18C. PERMANENT LOSS OF USE OF FOOT	18D. PERMANENT LOSS OF USE OF HAND
☐ RIGHT ☐ LEFT ☐ BOTH	☐ RIGHT ☐ LEFT ☐ BOTH	☐ RIGHT ☐ LEFT ☐ BOTH	☐ RIGHT ☐ LEFT ☐ BOTH

19. PERMANENT IMPAIRMENT OF VISION	20. SEVERE BURN INJURY	21. AMYOTROPHIC LATERAL SCLEROSIS (ALS)
☐ CENTRAL VISUAL ACUITY 20/200 OR LESS IN THE BETTER EYE WITH CORRECTIVE GLASSES ☐ CONTRACTION OF THE PERIPHERAL FIELD OF VISION TO 20 DEGREES OR LESS IN THE BETTER EYE	☐ YES ☐ NO	☐ YES ☐ NO

22. **Authorization for Allowance for Automobile or Other Conveyance:** The above-named applicant is eligible under 38 U.S.C. 3901-3904 to purchase the automobile or conveyance shown in Item 9, subject to certain payment limitations. VA cannot pay more than the rate in effect when VA receives the claim for payment from the seller. The allowance includes applicable taxes when included in the purchase price. The allowance does not include payment for any adaptive equipment specified for the qualifying disabilities.

Adaptive Equipment: The cost of adaptive equipment and its installation may be reimbursed. Adaptive equipment is not provided if the claimant is blind, requires a driver, or doesn't have a valid State driver's license or learner's permit. See the attached list for the adaptive equipment that is authorized for the qualifying disabilities shown above. All additional add-on equipment must be approved by VA.

☐ I CERTIFY THAT the veteran has not previously received an allowance for automobile or other conveyance under 38 U.S.C. 3901-3904.

23. NAME AND LOCATION OF VA OFFICE	24A. SIGNATURE OF CERTIFYING OFFICIAL TITLE OF CERTIFYING OFFICIALL	24B. DATE SIGNED (MM/DD/YYYY)

SECTION IV - RECEIPT FOR AUTOMOBILE OR OTHER CONVEYANCE AND ADAPTIVE EQUIPMENT (To be completed by veteran or serviceperson)

25. MAKE AND MODEL		26. YEAR
27. VEHICLE IDENTIFICATION NO. (VIN)	28. TOTAL PURCHASE PRICE $	29. DATE OF SALE (MM/DD/YYYY)

30A. I WILL OPERATE THIS VEHICLE	30B. I HAVE A VALID STATE DRIVER'S LICENSE OR LEARNER'S PERMIT
☐ YES ☐ NO	☐ YES ☐ NO
31. NAME OF SELLER	32. ADDRESS OF SELLER

I hereby acknowledge receipt of the automobile or other conveyance with the adaptive equipment specified on attached invoice.

33A. SIGNATURE OF VETERAN OR SERVICEPERSON **(REQUIRED)**	33B. DATE OF RECEIPT (MM/DD/YYYY)

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

PRIVACY ACT INFORMATION: 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 SSN account information is mandatory. Applicants are required to provide their SSN under Title 38 USC 5101 (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 under the law. The responses you submit are considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: We need this information in order to determine eligibility for automobile or other conveyance and adaptive equipment allowance (38 U.S.C. Chapter 39). Title 38, United States Code, allows us to ask for this information if this number is not displayed. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. Valid OMB control numbers can be located on the OMB Internet Page at 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.

OMB Number: 2900-0188
Estimated Burden: 15 minutes

Department of Veterans Affairs

APPLICATION FOR ADAPTIVE EQUIPMENT MOTOR VEHICLE

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38, U.S.C., Veterans Benefits, and will be used to determine your eligibility/entitlement and reimbursement of individual claims for automotive adaptive equipment, and identify your medical records. Additional information may be solicited during the course of processing your application. The information you supply may also be disclosed outside the VA as permitted by law or as stated in the "Notices of Systems of VA Records" 24VA136, published in the Federal Register. Disclosure is voluntary, however, failure to furnish the information will result in our inability to process your request promptly and serve your medical needs. Failure to furnish the information will have no adverse effect on any other benefits to which you may be entitled.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 15 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

PART I - *(To be completed by applicant-If more space is needed, attach a separate sheet and identify by item number.)*

1. VETERAN'S NAME AND ADDRESS (This is a mandatory field.)	3. Last 4 DIGITS OF SSN. (This is a mandatory field.)

4. DRIVER'S LICENSE VERIFICATION (Check applicable block)	5. YEAR YOU RECEIVED GRANT FOR VEHICLE *(If prior to January 11, 1971)*	6. DATE OF VA CERTIFICATE OF ELIGIBILITY *(If January 11, 1971 or after)*
☐ VALID LICENSE OR PERMIT IN POSSESSION ☐ NOT LICENSED		

7. DISABILITIES - Check applicable box(es)

EXTREMITY AND LEVEL	AMPUTATION		ANKYLOSIS		LOSS OF USE	
	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
A. ARM AE	☐	☐			☐	☐
B. ARM BE	☐	☐			☐	☐
C. LEG AK (hip)	☐	☐	☐	☐	☐	☐
D. LEG BK (knee)	☐	☐	☐	☐	☐	☐

E. OTHER DISABILITIES AFFECTING DRIVING

8. DESCRIPTION OF VEHICLE FOR WHICH ADAPTIVE EQUIPMENT IS REQUIRED

8A. DATE PURCHASED	8B. YEAR	8C. MAKE	8D. MODEL

8E. VEHICLE IDENTIFICATION NUMBER

9. LAST VEHICLE FOR WHICH ADAPTIVE EQUIPMENT WAS PROVIDED	9A. YEAR	9B. MAKE	9C. MODEL

9D. VEHICLE IDENTIFICATION NUMBER	9E. DATE ADAPTIVE EQUIPMENT PROVIDED (mm/dd/yyyy)

10. LIST OF ADAPTIVE EQUIPMENT REQUESTED (Check items required)

***NOTE: ALL VAN MODIFICATIONS REQUIRE PRIOR AUTHORIZATION BEFORE PURCHASE**

X	DESCRIPTION	ESTIMATED COST $	X	DESCRIPTION	ESTIMATED COST $
☐	A. AUTOMATIC TRANSMISSION		☐	K. TRANSFER OF CONTROLS	
☐	B. POWER BRAKES		☐	L. HAND CONTROLS--ACCELERATOR & BRAKE	
☐	C. POWER STEERING		☐	M. *SENSITIZED/LOW EFFORT BRAKE	
☐	D. POWER SEAT (6 way/2 way)		☐	N. *SENSITIZED/LOW EFFORT STEERING	
☐	E. POWER WINDOWS		☐	O. *DROP FLOOR	
☐	F. TILT STEERING WHEEL		☐	P. *RAISED ROOF	
☐	G. CRUISE CONTROL		☐	O. *POWER DOOR OPENERS	
☐	H. REAR WINDOW DEFROSTER		☐	R. *VAN LIFT	
☐	I. FOOT/HAND OPERATED PARKING BRAKE		☐	S. *POWER TRANSFER SEAT	
☐	J. AIR CONDITIONER		☐	T. MINI-VAN CONVERSION	
			☐	U. *OTHER (Describe)	

V. JUSTIFICATION *(Include full description and estimated cost of item T, if applicable)*

11. MAKE PAYMENT TO THE FOLLOWING *(Check appropriate box(es) and attach a certified invoiced:)*	AMOUNT TO BE PAID
☐ A. AUTOMOTIVE DEALER	
☐ B. ADAPTIVE EQUIPMENT SUPPLIER	
☐ C. PERSONAL REIMBURSEMENT	

D. FULL NAME AND ADDRESS WHERE PAYMENT SHOULD BE MADE	E. FULL NAME AND ADDRESS WHERE PAYMENT SHOULD BE MADE

12. STATUS OF APPLICANT (Check one)	13. SIGNATURE OF APPLICANT	14. DATE (mm/dd/yyyy)
☐ VETERAN ☐ MEMBER OF ARMED FORCES		

PART II - ELIGIBILITY *(To be completed by Eligibility Clerk or Designee)*

15. APPLICANT IS ELIGIBLE UNDER *(Check one)*	16. SIGNATURE AND TITLE OF ELIGIBILITY CLERK OR DESIGNEE	17. DATE
☐ INELIGIBLE ☐ PUB. L. 97-66 for Ankylosis veterans ☐ PUB. L. 91-666 (VAF 4-4502) ☐ OTHER ☐ PUB. L. 96-466 for vets in Voc Rehab *(Specify)*		

PART III - APPROVAL AND AUTHORIZATION *(TO BE COMPLETED BY PROSTHETIC REPRESENTATIVE)*

18. The following adaptive equipment is approved for inclusion with or installation on the specific vehicle described in item 8 on the front of this form. Costs including installation, unless authorized separately, will not exceed the total amount indicated for each item.

ITEMS AUTHORIZED	MAXIMUM COST	ITEMS AUTHORIZED	MAXIMUM COST

19. REIMBURSEMENT OR PAYMENT TO THE VENDOR(S) OR INDIVIDUAL(S) NAMED BELOW, IN THE TOTAL AMOUNTS SPECIFIED FOR EACH, IS AUTHORIZED AS A PROPER CHARGE FOR ADAPTIVE EQUIPMENT PREVIOUSLY PURCHASED BY THE APPLICANT UNDER AUTHORITY OF CFR 3.808:

19A. NAME AND ADDRESS OF PAYEE	19B. AMOUNT	19C. NAME AND ADDRESS OF PAYEE	19D. AMOUNT

20. NAME AND ADDRESS OF VA FIELD FACILITY	21. SIGNATURE AND TITLE OF AUTHORIZING OFFICIAL	22. DATE (mm/dd/yyyy)

PART IV - CERTIFICATION OF RECEIPT *(TO BE COMPLETED BY APPLICANT)*

I CERTIFY THAT I have received the items or services authorized in item 18 above.	23. SIGNATURE OF APPLICANT	24. DATE (mm/dd/yyyy)

"I certify that the amounts billed hereon do not exceed the usual and customary costs for the items or services furnished."

Signature of Company Official	

INSTRUCTIONS TO VETERAN OR SERVICEPERSON

The information requested on this form is solicited under authority of Title 38, U.S.C., Veterans Benefits, and will be used to determine your eligibility for prosthetic benefits and provide basic data for your treatment. Disclosure is voluntary. However, failure to furnish the information will result in our inability to process your request promptly. Failure to furnish this information will have no adverse effect on any other benefits to which you may be entitled.

1. Contact should be made with the Prosthetics Service at your local VA medical center or outpatient clinic prior to any purchase of equipment.
2. Complete all item in Part I of this form in duplicate and sign the form.
3. If you are requesting adaptive equipment or services, VA will determine your eligibility and complete Part II.
4. After approval, you may give the original of this form to the seller/vendor of your choice, who will deliver the equipment or services authorized (see also paragraphs 3 and 4 below).
5. In the event you must obtain some of the equipment on a mail-order basis, or cannot use this authorization for any other reason, you may pay for an authorized item or service and apply for reimbursement from VA. In such cases, you must present a paid invoice properly certified (see paragraph 2 below).
6. After receipt of the items or services authorized, sign and date the receipt in items 23 and 24, and direct the seller/vendor's attention to the instructions below. This certification signifies that the adaptive equipment, installation, or service is satisfactory, the servicing information on the invoice has been verified to the best of your ability and the charges appear to be reasonable.

INSTRUCTIONS TO SELLER/VENDOR

1. This is to inform you that if Part II and III of this form have been completed and signed by VA, the individual who is designated in this form as the applicant has been authorized the services or items in Item 18 of this form. Note that the applicant is not entitled to services that exceed the maximum costs, specified on item 18 of this form or approved on your quote.

2. After you and the applicant have entered into an agreement for the repair of items or services listed in item 18, and you have completed those repairs or services, you may use the following reimbursement procedures. For repairs, items or services, prepare your own invoice, itemizing each separate item or service provided with the cost of each. Identify the make, model, and year of the automobile or other conveyance and include the following certification statement on your own invoice.

3. Attach a copy of your certified invoice to the original of this form and mail to the VA Office shown in item 20.
4. Ensure that the applicant has signed in items 13 and 23 for receipt of the items or services.
5. VA expressly disavows any intent to enter into a contract with the seller; any agreement as to repairs or other services is between the seller/vendor and the applicant.

CLAIM FOR COMBAT-RELATED SPECIAL COMPENSATION (CRSC)

SECTION I - PERSONAL INFORMATION

1. NAME *(Last,First, Middle Initial)* **Duck Joseph Michael**		7. MAILING ADDRSS	
2. SOCIAL SECURITY OR EMPLOYEE ID NUMBER **123-45-6789**	3. RETIRED RANK/RATE **PO1**	a. STREET *(Include apartment number or P.O. Box)* **123 Main Street**	
4. DATE OF BIRTH *(YYYY/MM/DD)* **03-17-1932**	5. TELEPHONE *(Include area code)* **(605) 333-3333**	b. CITY **Sioux Falls**	c. STATE **SD**
6. E-MAIL ADDRESS **joeduck@yahoo.com**			d. ZIP CODE **57101**

SECTION II - PRELIMINARY REQUIREMENTS

8. MARK (X) NEXT TO THE APPROPRIATE ANSWER FOR EACH QUESTION.

QUALIFICATION BEFORE JANUARY 1, 2008

	YES	NO
a. Were you entitled to retired pay for regular service, having completed at least 20 years of service prior to January 1, 2008?	☐	☐
OR		
b. Were you entitled to retired pay for reserve service, having completed at least 20 years of combined active and reserve service and having reached age 60 prior to January 1, 2008?	☐	☐
OR		
c. Were you entitled to retired pay for reserve service under the Reserve TERA program having completed at least 15 but less than 20 years of combined active and reserve service and having reached age 60 prior to January 1, 2008? **NOTE:** You must provide proof of the retirement authority by attaching a copy of your Retirement Orders and/ or a copy of your 15 year letter. Evidence must clearly state that you were a reservist and you retired under Section 12731a of title 10, United States Code.	☐	☐

QUALIFICATION ON OR AFTER JANUARY 1, 2008

	YES	NO
d. Are you currently entitled to military retired pay for any reason, other than early reserve retirement for physical disabilities not incurred in line of duty (i.e., other than section 12731b of title 10, United States	☐	☐

NOTE: If you answered NO to all questions a through d above, you are not eligible for CRSC.

SECTION III - SERVICE HISTORY

You must provide copies of evidence needed to verify this information (i.e., DD214's, awards, evaluations, etc.).

9. FROM WHICH SERVICE DID YOU RETIRE? Provide a copy of your retirement orders or "retirement" DD214. To expedite this claim it is important that you mail your claim to the service you retired from.

ARMY ☐	NAVY/USMC ☑	AIR FORCE ☐
NOAA CORPS ☐	COAST GUARD ☐	PUBLIC HEALTH ☐

10. DID YOU SERVE IN ANY OF THE FOLLOWING WARS OR COMBAT OPERATIONS? *(X all that apply) (Provide a copy of a DD214/award citation or any other evidence that verifies ANY combat service.)*

WWI	WWII	KOREAN WAR	VIETNAM	GULF WAR	OIF/OEF	OTHER (e.g., a SF Ops mission - explain where and when and provide evidence.)
☐	☐	☐	☐	☐	☑	☐

11. WERE YOU EVER A PRISONER OF WAR (POW)?

YES	NO
☐	☑

If YES, indicate Where/When/How long *(Provide any official evidence available)*:

CLAIM FOR COMBAT-RELATED SPECIAL COMPENSATION (CRSC)

NAME *(Last, First, Middle Initial)*	**SOCIAL SECURITY OR EMPLOYEE ID NUMBER**
Duck Joseph Michael	123-45-6789

NOTE: To ensure the review of all of your requested disabilities, limit ONE disability for each page. You are authorized to make additional copies of this page for any additional disabilities. You may list any secondary conditions that are connected to a disability on the bottom of the sheet that it has been connected to. In order to award any disability as secondary we must have a copy of the evidence from VA or from your medical records which clearly states that the condition is the result of the primary condition you are requesting. Good evidence could include a VA rating decision that clearly states (for example), "hypertension is secondary to diabetes."

It is your responsibility to supply any evidence necessary to verify this disability is combat-related.

SECTION IV - REQUEST FOR COMBAT-RELATEDNESS DETERMINATION

12. VA FILE NUMBER *(If known)*

13. DISABILITY DESCRIPTION

a. TITLE OF DISABILITY *(As written on the VA rating decision.)*		b. BODY PART AFFECTED. (e.g., right knee)	
PTSD			
c. VA DISABILITY CODE *(If known)*	d. DATE AWARDED BY VA *(YYYYMMDD)*	e. INITIAL RATING % BY THE VA	f. CURRENT RATING % BY THE VA
9400	04-01-1967	70	70

g. COMBAT-RELATED CODE *(Mark (X) the code that best describes what caused the disability.) (See Appendix A for code descriptions.)*

PH PURPLE HEART	**AC** ARMED CONFLICT	**HS** HAZARDOUS SERVICE	**SW** SIMULATING WAR	**IN** INSTRUMENT OF WAR	**AO** AGENT ORANGE	**RE** RADIATION	**GW or MG** GULF WAR or MUSTARD GAS
☐	☐	☐	☐	☐	☐	☐	☐

h. UNIT OF ASSIGNMENT WHEN INJURED	i. LOCATION/AREA OF ASSIGNMENT WHEN INJURED

j. IN YOUR OWN WORDS, DESCRIBE THE EVENTS SURROUNDING THE DISABILITY AND HOW IT MEETS THE GUIDELINES OF COMBAT-RELATED

k. DID YOU RECEIVE A PURPLE HEART (PH) FOR THIS INJURY? If YES, attach documentation to verify that you were awarded a PH and any evidence that proves what occurred or what body part was injured. **NOTE:** Proof of being awarded a PH does not always allow us to award a disability as PH. We need to know what the PH was awarded for. For example, send the medevac report and DD214.	**YES** ☐	**NO** ☐	**N/A** ☐
l. DID VA EVER DOCUMENT THAT THIS CONDITION CAUSED SECONDARY DISABILITIES? If YES, you must provide evidence from VA or your medical records which state that the conditions listed in item 13.m., below, are indeed caused by the primary condition listed above. We cannot award any condition as secondary without evidence to support the claim. Attach the VA rating decision for all secondary conditions. **NOTE:** If YES, list all secondary conditions in item 13.m., below.	**YES** ☐	**NO** ☐	

m. VA DETERMINED THAT THE FOLLOWING CONDITIONS ARE SECONDARY CONDITIONS TO THE PRIMARY DISABILITY *(Listed in item 13.a., above).*

(1) DISABILITY CODE	(2) DESCRIPTION	(3) % AWARDED BY VA	(4) DATE AWARDED *(YYYYMMDD)*

CLAIM FOR COMBAT-RELATED SPECIAL COMPENSATION (CRSC)	
NAME *(Last, First, Middle Initial)* Duck Joseph Michael	**SOCIAL SECURITY OR EMPLOYEE ID NUMBER** 123-45-6789

SECTION V - REQUIRED DOCUMENTATION

14. In order to process your claim the following records (if applicable) must be submitted with this claim. Do not send ANY original documents - COPIES only!

a. All DD214's and DD215's (especially if for retirement or showing combat ribbons).

b. Retirement orders and supporting documents.

c. Reserve Retirement point computation including any 15-year or 20-year letter (if applicable).

d. Copies of ALL VA Rating Decisions, letters, and code sheets (current and prior). Do NOT remove any pages. All VA documents discussing changes in benefits including Special Monthly Compensation (SCM) and/or Individual Unemployability (IU).

e. Medical records or notes that verify how the injury/disability occurred. (Do NOT send EKGs, lab slips, CDs, diskettes or other electronic media.)

f. Physical Evaluation Board (MEB-PEB) results and/or summaries.

g. Any evidence which can be used to verify the events or circumstances.

SECTION VI - CERTIFICATION AND WAIVER OF CONCURRENT RETIREMENT AND DISABILITY PAYMENTS (CRDP)

15. Complete this section to enable the Defense Finance and Accounting Service (DFAS) or the applicable pay center for non-DoD retirees to make any CRSC payments you qualify to receive.

a. I understand that if I am eligible for both Concurrent Retirement and Disability Payments (CRDP) under 10 U.S.C., section 1414 and Special Compensation for Certain Combat-Related Disabled Uniformed Service Retirees under 10 U.S.C., section 1413a (CRSC), I may not receive both, but must elect which to receive.

b. I understand that if my election results in any retroactive payments, any previously paid amounts of CRDP, SCSD, or CRSC for that period of time will be deducted from any amount due for that period.

c. Under penalties of perjury, the information provided above is true to the best of my knowledge and belief and provided with the full knowledge of the penalties for making false statements (18 U.S.C. 287 and 1001 provide for a penalty of not more than $10,000 fine, or 5 years in prison, or both; 31 U.S.C. 3279 provides civil penalties; and 31 U.S.C. 3802 provides administrative penalties).

d. I hereby understand that payments will be deposited to my account of record for Uniformed Services retired pay if I am currently receiving such payments. Otherwise, they will be made to the account of record for my VA disability compensation. After payments begin, I must advise DFAS or the applicable non-DoD pay center of any changes to my account.

e. SIGNATURE	f. DATE SIGNED *(YYYYMMDD)* 08-23-2017

OMB Approved No. 2900-0198
Respondent Burden: 10 minutes
Expiration Date: 5/31/2018

Department of Veterans Affairs

APPLICATION FOR ANNUAL CLOTHING ALLOWANCE

PRIVACY ACT INFORMATION: No benefits may be granted unless this form is completed fully as required by law (38 C.F.R. 3.810). Responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 24VA136 "Patient Medical Record - VA", published in the Federal Register. Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-877-222-8387 for mailing information on where to send your comments.

ELIGIBLITY / ENTITLEMENT FOR AN ANNUAL CLOTHING ALLOWANCE: A Veteran who wears or uses a prescribed prosthetic, orthopedic appliance, and/or skin medication for a service connected disability may be eligible for an annual clothing allowance. To be entitled, the prosthetic, orthopedic appliance must cause wear / tear; skin medication must cause irreparable staining to your outergarments.

WHO IS ELIGIBLE FOR MORE THAN ONE ANNUAL CLOTHING ALLOWANCE? Effective December 16, 2011, Veterans who wear or use more than one qualifying prescribed prosthetic or orthopedic appliance and/or prescription medication for more than one service-connected disability or skin condition may be eligible for more than one clothing allowance. To be eligible for more than one clothing allowance, the qualifying appliances must wear or tear more than one type of article of the Veteran's clothing and/or medications must irreparably damage more than one type of the Veteran's clothing or outergarment.

WHAT TYPES OF CLOTHING ARE INCLUDED? Clothing such as shirts, blouses, pants, skirts, shorts and similar garments permanently damaged by qualifying appliances and/or skin medications are considered in clothing allowance decisions. Shoes, hats, scarves, underwear, socks, and similar garments are not included.

WHERE TO FILE A CLAIM? If you have previously submitted a claim for disability compensation, send this application (VA Form 10-8678) to the Prosthetic and Sensory Aids Service (121) at your local VA Medical Center. If you have not made an application for disability compensation, complete VA Form 21-526 and send to the VBA regional office nearest your home.

INSTRUCTIONS: This application should be submitted to the Prosthetic and Sensory Aids Service at your nearest VA Medical Center on or before August 1st of the benefit year for which you are applying. For example: If you are applying for the 2014 benefit, this application should be received on or before August 1, 2014.

1. LAST NAME, FIRST NAME, MIDDLE NAME OF VETERAN	2. VETERAN'S SSN

3. MAILING ADDRESS OF VETERAN *(No. and Street or Rural Route, City or P.O., State and Zip Code) If new address check box.* ☐

4. VETERAN'S DAYTIME TELEPHONE NUMBER (include area code)	4a. EVENING TELEPHONE NUMBER (include area code)
4b. VETERAN'S EMAIL ADDRESS	**5. CALENDAR YEAR FOR APPLICATION**

CERTIFICATION: I hereby apply for the annual clothing allowance benefit authorized under 38 USC §1162. In doing so I certify that because of my service-connected disability or disabilities, I regularly (1) wear or use the prosthetic or orthopedic appliance(s) listed in section 7 which tends to wear out or tear my clothing; or (2) use a skin medication(s) listed in section 7 which causes irreparable staining to my outergarments. Note: If I have multiple prostheses, orthopedic appliances, or skin medications as listed in section 7, the combination of these items causes me to replace my outergarments faster than if I used a single item.

ACKNOWLEDGEMENT: I acknowledge that by applying or receiving more than one clothing allowance benefit, an application for the annual clothing allowance benefit requires a yearly submission to the nearest Prosthetic and Sensory Aids Office on or before August 1st of the calender year.

6. SIGNATURE OF VETERAN (Sign in ink)	DATE

7. Type of Appliance or Name of Skin Medication (Artificial leg, metal brace, wheelchair, etc.)		8. List of **Service-Connected** Disability/Disabilities Requiring Use of Appliance(s) or Skin Medication(s)	9. Month and Year Appliance or Skin Medication was issued (MM/YYYY)	10. Name and location of VA facility that issued appliance or skin medication (if not a VA facility include facility's phone number)	11. List all impacted location(s) (Chest, Back, Buttock, Left or Right Leg, Left or Right Arm)	FOR VA USE ONLY **APPROVED?**	
Example A	Prostheses	Missing Limb	01/2005	Tampa VA Medical Center	Left Arm	☒ Yes	☒ No
Example B	Steriod Cream	Skin Disorder	09/2009	Walter Reed Army MC 202-782-6866	Chest and Back	☒ Yes	☒ No
1.						☐ Yes	☐ No
2.						☐ Yes	☐ No
3.						☐ Yes	☐ No
4.						☐ Yes	☐ No
5.						☐ Yes	☐ No

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

FOR VA USE ONLY

12. AMOUNT OF CLOTHING ALLOWANCES # ELIGIBLE # NOT ELIGIBLE ___ # UPPER Extremity (2 maximum) ___ # LOWER Extremity (2 maximum)

13. EXAMINATION/EVALUATION DATE *(If applicable)*

14. NOTES:

15. GENERATED BY: DATE

16. AUTHORIZED BY: DATE

Dependency and Indemnity Compensation (DIC) Quick Reference Sheet

A monthly VA benefit paid to dependents based on a veteran's service-connected death.

Eligibility

Widows/widowers married to veteran at least one year prior to death or a child born of the union. Minor children or children between the ages of 18 and 23 attending an approved educational institution. Veteran's death must have been result of service connected disability and listed as cause of death or a contributing factor on death certificate.

Surviving spouse may also be eligible if the veteran was 100% P&T service connected for ten years proceeding death or; 100% P&T service-connected for five years immediately following date of discharge or; a POW 100% P&T service-connected for one year immediately following date of discharge.

Filing Deadline

If filed within one-year of death, payments go back to that date or back to date of claim if filed more than one-year after death.

Payment Rates

Current monthly payment rates can be found at: https://www.va.gov/disability/survivor-dic-rates/

Additional Rates: can be added for:

Surviving spouse with one or more minor children (Not per child).

For each minor child.

For spouse of 100% disabled veteran's if they were married to same spouse for at least eight years immediately preceding death.

If surviving spouse is a patient in nursing home or in need of regular A&A.

If surviving spouse is housebound.

Miscellaneous Information

If the surviving spouse remarries before age 55, DIC payments stop. DIC payments can be restored if the survivor's remarriage ends in divorce, death, or annulment before age 55. No restriction if survivor remarries after age 55.

Surviving spouse/and eligible dependents may also be entitled to Chapter 35 benefits (education) and ChampVA.

Forms to File

DIC

21-22	POA and SDDVA SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
21P-534EZ	Fill in all blanks and have all spouse/dependent information (Birth date and SSN)

Death Certificate
Marriage/Divorce/Birth Certificates

CHAMPVA

21-22	POA and SDDVA Policy Statement
10-7959c	ChampVA Other Health Insurance Certification
10-10d	Application for ChampVA
DD-214	Certified copy
	Copy of Voided Check or Deposit Slip

P&T Letter or Rating Decision Granting Chapter 35
Copy of other health insurance cards

Dependency and Indemnity Compensation (DIC) (38 CFR 3.5, 3.10, and 3.22)

DIC is a monthly benefit paid to eligible survivors of a service member or veteran who:

- Died while on active duty, or
- Whose death resulted from a service-related injury or disease, or
- Whose death resulted from a nonservice-related injury or disease, and who was receiving, or entitled to receive, VA Compensation for service-connected disability that was rated as totally disabling:
    - For at least ten years immediately before death, or
    - From the time of the veteran's release from active duty and for at least five years immediately preceding death, or
    - For at least one year before death if the veteran was a former prisoner of war who died after September 30, 1999.

Eligibility Requirements

The Surviving Spouse if he or she:

- Validly married the veteran before January 1, 1957, or
- Was married to a service member who died on active duty, or
- Married the veteran within 15 years of discharge from the period of military service in which the disease or injury that caused the veteran's death began or was aggravated, or
- Was married to the veteran for at least one year, or
- Has a child with the veteran, or
- Cohabited with the veteran continuously until the veteran's death, if separated, was not at fault for the separation, and
- Is not currently remarried.

A surviving spouse who remarries on or after December 16, 2003, and on or after attaining age 55, is entitled to continue to receive DIC.

The Surviving Child(ren)**,** if he/she is:

- Not included on the surviving spouse's DIC
- Unmarried and
- Under age 18, or between the ages of 18 and 23 and attending school.

Certain helpless adult children are entitled to DIC.

Application Documents

VA Form 21P-534EZ 'Application for Dependency and Indemnity Compensation, Death Pension, and Accrued Benefits by a Surviving Spouse or Child.'

Accompanying this form should be:

- VA Form 21-22 'Appointment of a Accredited Representative
- Intent to File 21-0966 if applicable
- SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
- Copy of the Veteran's Death Certificate

Other forms that may be needed if not already established in the claims folder are:

- Certified Copy of the Veteran's Discharge Record or Casualty Report
- Certificate of Marriage
- Birth Certificates of children

Additional benefits

There is a transitional benefit to the surviving spouse's monthly DIC if there are children under age 18. Click here to see rates. The amount is based on a family unit, not individual children. It is paid for two years from the date that entitlement to DIC commences, but is discontinued earlier when there are no children under age 18 or no children on the surviving spouses DIC for any reason. You do not file for this benefit. If eligible, the VA will automatically adjudicate a grant for it.

If veteran was P&T for eight years and marriage was valid for those eight years prior to death, they are eligible for increased DIC amount. House Bound and Aid and Attendance are also available.

DIC recipients rates may also be eligible for:

- Home Loan Guaranty benefits
- CHAMPVA
- Chapter 35 educational benefits

Parent's Dependency and Indemnity Compensation (DIC) (38 CFR 3.25)

Parents' DIC is an income-based monthly benefit for the parents, or parent, of a military service member or veteran who died from:

- A disease or injury incurred or aggravated while on active duty or active duty for training, or
- An injury incurred or aggravated in line of duty while on inactive duty for training, or
- A service connected disability.

The term 'parent' includes a biological, adoptive, and foster parent. A foster parent is a person who stood in the relationship of a parent to the veteran's for at least one year before the veteran's last entry into active duty.

Eligibility Requirements

Eligibility to Parents' DIC is based on need. When countable income exceeds the limit set by law, no benefit is payable. Eligible parents must report all sources of income to VA. The spouse's income must also be included if living with a spouse.

Application documents

VA Form 21P-535 'Application for Dependency and Indemnity Compensation by Parents'

Accompanying this form should be:

- VA Form 21-22 'Appointment of an Accredited Representative'
- Intent to File 21-0966 if applicable
- SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
- Copy of the Veteran's Death Certificate or Casualty Report
- Birth Record of the veteran stating the parent's names, or adoption papers

FDC DIC

21-22 & SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
DD 214 – Certified
21P-534EZ
Copy of Voided Check or Deposit Slip
21P-535 – (Parent's DIC) All blanks/ boxes must be filled out & Must have spouse/dependent's birthdays and SSN Death Certificate
Marriage/ Divorce/ birth certificates

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 7/31/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, Appointment of Individual as Claimant's Representative. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

SECTION I: VETERAN'S 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 of the form.

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

Joe P Veteran

2. SOCIAL SECURITY NUMBER *(SSN)*	3. VA FILE NUMBER *(If applicable)*	4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
123-23-3456	**123233456**	Month **09** - Day **08** - Year **1947**

5. VETERAN'S SERVICE NUMBER *(If applicable)*	6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

8. TELEPHONE NUMBER *(Include Area Code)*	9. EMAIL ADDRESS *(Optional)*
(605)123-2345	

SECTION II: CLAIMANT'S INFORMATION *(If other than veteran)*

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

11A. CLAIMANT'S DATE OF BIRTH	11B. RELATIONSHIP TO VETERAN
Month - Day - Year	

12. CURRENT 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 **US** ZIP Code/Postal Code

13. TELEPHONE NUMBER *(Include Area Code)*	14. EMAIL ADDRESS *(Optional)*

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

038 - South Dakota Department of Veterans Affairs

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*	16B. JOB TITLE OF PERSON NAMED IN ITEM 16A
Kevin Swanson	**Veterans Service Officer**
17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15	18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*
statevso.mailbox@va.gov	**03-28-2024**

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☑ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☑ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT (**Required**)	22B. DATE SIGNED *(MM/DD/YYYY)*
Jon P Vuckovich	**03-28-2024**
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (**Required**)	23B. DATE SIGNED *(MM/DD/YYYY)*
[signature]	**03-28-2024**

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

	COPY OF VA FORM 21-22 SENT TO:	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason and date (MM/DD/YYYY))*
VA USE ONLY	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

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.

South Dakota Division of Veteran Affairs
Policy Statement for Representation

Thank you for choosing the South Dakota Department of Veterans Affairs (SDDVA) to assist you with your claim for benefits from the United States Department of Veterans Affairs (VA). The SDDVA serves as the accredited representative for the following organizations.

American Legion	SD Department of Veteran Affairs
Veterans of Foreign Wars of the United States	The Retired Enlisted Association

We can best serve your interest if you work directly with our Service Officers and/or your local County/Tribal Veterans Service Officer. The purpose of having a representative is to have an advocate skilled in veterans' benefits, working for you, and involved in every step of the claims process. Please do not take any action directly with the VA, and do not try to work the claim yourself. You must understand that the SDDVA and your local Veterans Service Officer is not responsible for any actions taken by the claimant directly with the VA. Let us help you.

What You Need to Do to Assist SDDVA

- Be truthful with your VSO and the VA at all times.
- Provide adequate information in a timely manner whenever requested by the VSO or the VA.
- Be alert for time-sensitive deadlines.
- Provide any and all legal documentation or evidence required for the processing of your claim directly to our office.
- Report to all examinations requested by the VA.
- Reply to any VA requests for information through our office.
- Notify us immediately of any change in your address and/or telephone number.

What SDDVA Will Do For You

As your advocate, we will review the facts and circumstances of your claim and develop it for presentation to the VA. We will ensure that your claim is properly filed and will monitor it as it proceeds through the VA claims process. We will advise you of significant developments with respect to your claim and do all we ethically can to see that your claim is decided in your favor. If the VA decides against you, we will, at your request, advise you about the appellate process and, based on controlling laws and regulations, the probable outcome of your particular case. The decision to appeal is your decision and right, but it is vital that you fully understand the process. We will capture your electronic signature and with your permission respond to VA development on your behalf.

We are pleased to serve as your representative; however, we will withdraw representation if you:

- Threaten abuse, mistreat, or harass any employee of the SDDVA or affiliated VSO
- Knowingly present a fraudulent claim or provide false information
- Initiate any action that would result in a conflict of interest in pursuing benefits with the VA
- Fail to cooperate with SDDVA or affiliated VSO in the prosecution of your claim
- Create or become involved in any situation that makes it inappropriate for SDDVA to continue as your representative.

Your understanding and cooperation with the SDDVA's policy for representation is appreciated. Be assured that our Service Officers want to assist you and that we will work hard for you. We appreciate the confidence you have placed in the SDDVA.

	**123233456**	Name: **Kevin Swanson** Title: **Veterans Service Officer**	**04-16-2024**
Applicant	Claim #	Veterans Service Officer	Date

Revised 2022

OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: 07/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 18. Use this form to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. For additional information or questions contact us online at https://www.va.gov/contact-us or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms. If submitting by mail, send completed form to: **Department of Veterans Affairs, Pension Intake Center, P.O. Box 5365, Janesville, WI 53547-5365**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

NOTE: You may *either* complete the form by typing the information in on the computer or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1A. VETERAN'S NAME (First, Middle Initial, Last)
Joe P Veteran

1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VETERAN'S DATE OF BIRTH (MM/DD/YYYY)	1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?
123-23-3456	**09-08-1947**	☑ YES ☐ NO (If "YES," provide the file number in Item 1E)

1E. VA FILE NUMBER (If known)	1F. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?	1G. VETERAN'S SERVICE NUMBER
123233456	☐ YES ☑ NO	

1H. VETERAN'S DATE OF DEATH? (MM/DD/YYYY)
04-17-2024

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

2A. YOUR NAME (First, Middle Initial, Last)
Ann M Veteran

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)

☑ SURVIVING SPOUSE ☐ CHILD 18-23 IN SCHOOL ☐ CUSTODIAN FILING FOR CHILD UNDER 18 ☐ HELPLESS ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER	2D. YOUR DATE OF BIRTH (MM/DD/YYYY)	2E. ARE YOU A VETERAN?
666-66-6666	**09-03-1946**	☐ YES ☐ NO

2F. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

2G. YOUR TELEPHONE NUMBER (Include Area Code)
(605)123-2345 Enter International Phone Number (If applicable)

2H. E-MAIL ADDRESS (Optional)

2I. WHAT ARE YOU CLAIMING? (Check all that apply)

☑ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☐ SURVIVORS PENSION ☐ ACCRUED BENEFITS

SECTION III: VETERAN'S SERVICE INFORMATION

(Skip to Section IV if the veteran was receiving VA compensation or pension benefits at the time of their death)

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME?

☐ YES ☑ NO (If "YES," list other names the veteran served under below)

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)

3B. DATE VETERAN ENTERED ACTIVE DUTY (MM/DD/YYYY)
01-01-1968

3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY)
09-30-1974

3D. BRANCH OF SERVICE
☑ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS
☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA ☐ USPHS

3E. PLACE OF LAST SEPARATION
Ft. Lewis, WA

3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard)
☐ YES ☑ NO (If "NO," skip to Item 3J)

3G. DATE OF ACTIVATION (MM/DD/YYYY)

3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

3J. WAS THE VETERAN EVER A PRISONER OF WAR?
☐ YES ☑ NO (If "NO," skip to Section IV)

3K. DATES OF CONFINEMENT (MM/DD/YYYY)
START:
END:

SECTION IV: MARITAL INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?
☐ YES ☑ NO (If "YES," provide explanation below)

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF THE VETERAN'S DEATH?
☑ YES ☐ NO (If "NO," complete Item 4C)

4C. HOW DID YOUR MARRIAGE TO THE VETERAN END?
☑ DEATH ☐ DIVORCE ☐ OTHER (Explain)

4D. DATES OF YOUR MARRIAGE TO THE VETERAN (MM/DD/YYYY)
START: **10-15-1975**
END: **04-17-2024**

4E. PLACE OF MARRIAGE (City/State or Country)
Sioux Falls, SD

4F. PLACE OF MARRIAGE TERMINATION (City/State or Country)
Sioux Falls SD

4G. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.)
☑ CEREMONIAL ☐ OTHER (Explain):

4H. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?
☐ YES ☑ NO

4I. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?
☐ YES ☑ NO

4J. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF THE VETERAN'S DEATH?
☑ YES ☐ NO (If "YES," skip to Item 4L)

4K. WAS THE SEPARATION DUE TO MARITAL DISCORD, MEDICAL, OR FINANCIAL REASONS?
☐ YES ☐ NO (If "YES," provide explanation in space provided)
NOTE: Give, the reason, date(s), and duration of the separation
(If the separation was by court order, attach a copy of the order)

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4L. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?
☐ YES ☑ NO (If "NO," skip to Item 5A)

4M. WHAT ARE THE DATES OF YOUR REMARRIAGE? (MM/DD/YYYY)
START:
END:

4N. HOW DID YOUR REMARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ DID NOT END ☐ OTHER (Explain)

4O. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH?
☐ YES ☐ NO (If "YES," please submit a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for each marriage)

SECTION V: MARITAL HISTORY

TELL US ABOUT ANY OTHER MARRIAGES YOU AND/OR THE VETERAN HAD. IF YOU AND THE VETERAN DID NOT HAVE ANY ADDITIONAL MARRIAGES SKIP TO SECTION VI.

VETERAN'S PRIOR MARRIAGES (If none skip to Item 5L)

5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START:
END:

5D. PLACE OF MARRIAGE (City/State or Country)

5E. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START:
END:

5I. PLACE OF MARRIAGE (City/State or Country)

5J. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
☐ YES ☐ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN (If none skip to Section VI)

5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5M. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE?(MM/DD/YYYY)
START:
END:

5O. PLACE OF MARRIAGE (City/State or Country)

5P. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5R. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE?(MM/DD/YYYY)
START:
END:

5T. PLACE OF MARRIAGE (City/State or Country)

5U. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
☐ YES ☐ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

SECTION VI: CHILD OF THE VETERAN INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)
(Skip to Section VII if you are NOT claiming benefits for a child(ren) of the veteran)

NOTE: Please refer to instructions page 2, under "*Special Circumstances*" for what is considered a dependent child. In most circumstances, children over the age of 23 are not considered dependent for VA purposes.

6A. HOW MANY DEPENDENT CHILDREN DO YOU HAVE?
0 (**NOTE**: Please complete a VA Form 21-686c, *Application Request to Add and/or Remove Dependents*, if you need more space for additional dependents)

6B. CHILD'S NAME (First, Middle Initial, Last)

6C. CHILD'S DATE OF BIRTH (MM/DD/YYYY)	6D. CHILD'S SOCIAL SECURITY NUMBER

6E. PLACE OF BIRTH (City/State or Country)

6F. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT **$ .00**

6G. CHILD'S NAME (First, Middle Initial, Last)

6H. CHILD'S DATE OF BIRTH (MM/DD/YYYY)	6I. CHILD'S SOCIAL SECURITY NUMBER

6J. PLACE OF BIRTH (City/State or Country)

6K. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT **$ .00**

6L. CHILD'S NAME (First, Middle Initial, Last)

6M. CHILD'S DATE OF BIRTH (MM/DD/YYYY)	6N. CHILD'S SOCIAL SECURITY NUMBER

6O. PLACE OF BIRTH (City/State or Country)

6P. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT **$ .00**

6Q. DO YOUR CHILDREN WHO DO NOT LIVE WITH YOU (If listed above) RESIDE AT THE SAME ADDRESS?

☐ YES ☐ NO (If "YES," please complete Item 6R) (If "NO," please complete a VA Form 21-4138, Statement in Support of Claim, with the following information. Name of person the child is currently living with, and the full address where the child resides)

6R. PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHILD(RENS) CUSTODIAN BELOW:
Custodian's Name (First, Middle Initial, Last)

Custodian's 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 VII: DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Skip to Section VIII if you are NOT claiming DIC)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

☑ DIC ☐ DIC under 38 U.S.C. 1151 (Note: DIC under 38 U.S.C. 1151 is a rare benefit. Please refer to Instructions page 5 for guidance on 38 U.S.C 1151) ☐ DIC due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 (PACT Act) (Note: Please refer to Instructions page 6 for guidance on PACT Act)

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: END:
	START: END:
	START: END:

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

☐ YES ☑ NO *(If "YES," please complete a VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP/CRNP), or Clinical Nurse Specialist (CNS))*

8B. ARE YOU NOW IN A NURSING HOME?

☐ YES ☑ NO *(If "YES," complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance. For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC")* (If "NO," skip to Item 9A)

SECTION IX: INCOME AND ASSETS
(Skip to Section X if you are NOT claiming survivors pension benefits)

NOTE: **Assets** are all the money and property you or your dependents own. Assets ***do not*** include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER $25,000.00 IN ASSETS? (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)

☐ YES ☐ NO If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC))*

(If "No," provide an estimate of the total value of your assets below)

$

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC))*

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

☐ YES ☐ NO (If "NO," skip to Item 9G)

9D. IS THE VALUE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

☐ YES ☐ NO (If "NO," skip to Item 9G)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF THE LAND OVER 2 ACRES?
(Do **NOT** include the value of the residence or the first 2 acres)

$

9F. IS THE LAND OVER 2 ACRES (87,120 SQ FT) MARKETABLE?

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969)

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969, and ONLY report your Social Security income in Item 9I)

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969)

SECTION IX: INCOME AND ASSETS
(Skip to Section X if you are NOT claiming survivors pension benefits)

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9I(2) SPECIFY THE TYPE OF INCOME	9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9I(4) CURRENT GROSS MONTHLY INCOME **$**
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9J(2) SPECIFY THE TYPE OF INCOME	9J(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9J(4) CURRENT GROSS MONTHLY INCOME **$**
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9K(2) SPECIFY THE TYPE OF INCOME	9K(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9K(4) CURRENT GROSS MONTHLY INCOME **$**
9L(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9L(2) SPECIFY THE TYPE OF INCOME	9L(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9L(4) CURRENT GROSS MONTHLY INCOME **$**

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid.

Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child, educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES OR OTHER EXPENSES?

☐ YES ☐ NO (If "NO," skip to Section XI)

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10B (1). WHOSE EXPENSES WERE PAID?	10B (2). NAME OF PROVIDER AND TYPE OF CARE	10B (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) **$ .00** Hours Worked (Per Week)

10B (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10B (5). PAYMENT FREQUENCY	10B (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10B (5))
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	**$**

IN-HOME CARE OR CARE FACILITY (Continued)

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10C (1). WHOSE EXPENSES WERE PAID?	10C (2). NAME OF PROVIDER AND TYPE OF CARE	10C (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) **$ .00** Hours Worked (Per Week)

10C (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10C (5). PAYMENT FREQUENCY	10C (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10C (5))
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	**$**

10D (1). WHOSE EXPENSES WERE PAID?	10D (2). NAME OF PROVIDER AND TYPE OF CARE	10D (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) **$** .00 Hours Worked (Per Week)

10D (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10D (5). PAYMENT FREQUENCY	10D (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10D (5))
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	**$**

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E (1). WHOSE EXPENSES WERE PAID? (Check one)	10E (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☐ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: Purpose:

10E (3). DATE COSTS PAID (MM/DD/YYYY)	10E (4). PAYMENT FREQUENCY	10E (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10E (4))
	☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME	**$**

10F (1). WHOSE EXPENSES WERE PAID? (Check one)	10F (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☐ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: Purpose:

10F (3). DATE COSTS PAID (MM/DD/YYYY)	10F (4). PAYMENT FREQUENCY	10F (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10F (4))
	☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME	**$**

10G (1). WHOSE EXPENSES WERE PAID? (Check one)	10G (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☐ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: Purpose:

10G (3). DATE COSTS PAID (MM/DD/YYYY)	10G (4). PAYMENT FREQUENCY	10G (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10G (4))
	☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME	**$**

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES (Continued)

10H (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10H (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10H (3). DATE COSTS PAID (MM/DD/YYYY)

10H (4). PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY
☐ ONE-TIME

10H (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10H (4))
$

10I (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10I (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10I (3). DATE COSTS PAID (MM/DD/YYYY)

10I (4). PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY
☐ ONE-TIME

10I (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10I (4))
$

10J (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10J (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10J (3). DATE COSTS PAID (MM/DD/YYYY)

10J (4). PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY
☐ ONE-TIME

10J (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10J (4))
$

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and** attach either a voided personal check or a deposit slip. If you do not have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)
First Dakota National Bank

11B. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)
091400486

11C. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

☑ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.: **10102235698**

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 12A, indicating that I **DO NOT** want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

12A. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ **I DO NOT want my claim considered for paid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE) (Continued)	
12B. CLAIMANT'S SIGNATURE OR MARK WITH AN "X" IF UNABLE TO SIGN **(REQUIRED)**	12C. DATE SIGNED (MM/DD/YYYY) **04-19-2024**

SECTION XIII: WITNESSES TO SIGNATURE (TWO (2) WITNESS SIGNATURES ARE REQUIRED ONLY IF ITEM 12B IS SIGNED WITH AN "X")	
13A. SIGNATURE OF WITNESS (Sign in INK) (NOTE: Only sign if claimant signed in Item 12B using an "X")	13B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:
13C. SIGNATURE OF WITNESS (Sign in INK) (NOTE: Only sign if claimant signed in Item 12B using an "X")	13D. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED (MM/DD/YYYY) **04-19-2024**

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your response is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above. 13A. SIGNATURE OF WITNESS (Sign in INK) (NOTE: Only sign if claimant signed in Item 12B using an "X")

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 40 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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/Postal Code

7. WHAT IS THE FACILITY'S WEBSITE 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)
04-19-2024

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/Postal 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)
04-19-2024

OMB Control No. 2900-0219
Respondent Burden: 10 Minutes
Expiration Date: 10/31/2024

Department of Veterans Affairs

APPLICATION FOR CHAMPVA BENEFITS

Champ VA Program Office, Office of Integrated Veteran Care, CHAMPVA Eligibility, PO Box 469028, Denver CO 80246-9028
Customer Service Center: 1-800-733-8387 | FAX: 303-331-7809

ATTENTION: Please refer to the information on the following pages for assistance completing this form in its entirety (print or type only). Return the form and any additional, requested information to the address shown above. If applicants indicate in Section II that they have Medicare or other health insurance, each applicant must submit VA Form 10-7959c, *CHAMPVA Other Health Insurance (OHI) Certification*. If additional space is needed, complete another VA Form 10-10d in its entirety, sign and submit.

SECTION I - SPONSOR INFORMATION

VETERAN'S LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	VA FILE NUMBER *(Claim Number)*
Veteran	**Joe**	**P**	**123-23-3456**	**123233456**

STREET ADDRESS	CITY	STATE	ZIP CODE
123 Tenbucktwo Ave	**Sioux Falls**	**SD**	**57107**

PHONE NUMBER *(Include Area Code)*	DATE OF BIRTH *(MM/DD/YYYY)*	DATE OF MARRIAGE *(MM/DD/YYYY)*
(605)123-2345	**09-08-1947**	**10-15-1975**

IS THE VETERAN DECEASED?	IF "YES," CONTINUE IF "NO," GO TO SECTION II	DATE OF DEATH *(MM/DD/YYYY)*	DID THE VETERAN DIE WHILE ON ACTIVE MILITARY SERVICE?
☐ YES ☑ NO			☐ YES ☐ NO

SECTION II - APPLICANT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*
Veteran	**Ann**	**M**	**666-66-6666**	**09-03-1946**

STREET ADDRESS	CITY	STATE	ZIP CODE
123 Tenbucktwo Ave	**Sioux Falls**	**SD**	**57107**

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
	(605)123-2345	☐ MALE ☑ FEMALE

☑ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*
		Spouse

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*

STREET ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
		☐ MALE ☐ FEMALE

☐ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*

STREET ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
		☐ MALE ☐ FEMALE

☐ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*

SECTION III - CERTIFICATION

I declare under penalty of perjury that the foregoing is true and accurate to the best of my knowledge. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to title 18, United States Code, Sections 287 and 1001. *(Sign and date below.)*

SIGNATURE:	DATE *(MM/DD/YYYY)*
	04-16-2024

If certification is signed by a person other than an applicant, complete the following:

LAST NAME	FIRST NAME	MI	RELATIONSHIP TO APPLICANT(S)	
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**	**PHONE NUMBER *(Include Area Code)***

OMB Control Number: 2900-0219
Estimated Burden: 10 minutes
Expiration Date: 10/31/2024

Department of Veterans Affairs

CHAMPVA Other Health Insurance (OHI) Certification

Chief Business Office Purchased Care, PO Box 469063, Denver CO 80246-9063
Customer Service Center: 1-800-733-8387 | FAX: 303-331-7808 | Website: http://www.va.gov/purchasedcare

ATTENTION: Please read the instructions on the reverse side before completing this form. Failure to provide the requested information will result in a delay or denial of reimbursement until OHI information is received. Return the form and any requested information to the address shown above. This form is also used to report any changes in your OHI status. Updates can be sent by FAX or call by phone.

SECTION I: BENEFICIARY INFORMATION – Please use a separate form for each family member

Last Name	First Name	MI	Social Security Number
Veteran	**Ann**	**M**	**666-66-6666**

Street Address (Number, Street name/PO Box, Apt #)	City	State	Zip Code
123 Tenbucktwo Ave	**Sioux Falls**	**SD**	**57107**

Phone Number (with area code)		Gender
(605)123-2345	☐ Check if this is a new address	☐ Male ☐ Female

SECTION II: MEDICARE BENEFICIARIES – Attach a copy of your Medicare card

Part A: ☑ Yes ☐ No	Part B: ☑ Yes ☐ No	Part D: ☑ Yes ☐ No
Effective Date *(mm-dd-yyyy)* **12-31-2011**	Effective Date *(mm-dd-yyyy)* **12-31-2011**	Effective Date *(mm-dd-yyyy)* **12-31-2011**
Part A Carrier Name	Part B Carrier Name	Part Carrier Name
Medicare	**Medicare**	**Humana**

Does your Medicare coverage provide pharmacy benefits? ☑ Yes ☐ No

Do you have health insurance other than MEDICARE? ☐ Yes ☑ No

Did you choose a Medicare Advantage Plan for your Medicare coverage? ☑ Yes ☐ No

If NO, go to Section IV.

SECTION III: OTHER HEALTH INSURANCE

Provide all periods of OHI coverage since becoming CHAMPVA eligible and attach a copy of any active health insurance cards (front and back).

Name of insurance #1

Effective Date *(mm-dd-yyyy)* | Termination Date *(mm-dd-yyyy)*

Only input the termination date if the policy is inactive.

Is this insurance through employment? ☐ Yes ☐ No

Does the insurance cover prescriptions? ☐ Yes ☐ No

Does the insurance provide an explanation of benefits for prescriptions? ☐ Yes ☐ No

What type of insurance is it? ☐ HMO ☐ PPO ☐ Medicaid / State Assistance ☐ Medigap (if Medigap, specify [A-J]) **(A-J)** ☐ Prescription Discount ☐ Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)

Comments:

Name of insurance #2

Effective Date *(mm-dd-yyyy)* | Termination Date *(mm-dd-yyyy)*

Only input the termination date if the policy is inactive.

Is this insurance through employment? ☐ Yes ☐ No

Does the insurance cover prescriptions? ☐ Yes ☐ No

Does the insurance provide an explanation of benefits for prescriptions? ☐ Yes ☐ No

What type of insurance is it? ☐ HMO ☐ PPO ☐ Medicaid / State Assistance ☐ Medigap (if Medigap, specify [A-J]) **(A-J)** ☐ Prescription Discount ☐ Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)

Comments:

SECTION IV: CERTIFICATION BY BENEFICIARY, SPONSOR OR LEGAL GUARDIAN

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious or fraudulent statements of claims. I certify that the above information is correct to the best of my knowledge and belief. If there is any change in insurance status for the above person, I agree to promptly notify the Chief Business Office Purchased Care.

SIGNATURE (type if electronic):

DATE: **04-16-2024**

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 09/30/2026

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 on page 2. VA uses this form to determine eligibility for pension and aid and attendance benefits based on nursing home status. For more information you can contact us online through **Ask VA**: https://ask.va.gov, or call us toll-free at 1-800-827-1000 (TTY: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 checkbox to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. DATE OF BIRTH (MM/DD/YYYY)
123-23-3456	**123233456**	**09-08-1947**

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
Good Samaritan Society - Luther Manor

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

No. & Street **1500 W 38th St**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57105**

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?
11-15-2023	☑ YES ☐ NO

13. HAS THE PATIENT APPLIED FOR MEDICAID?	14A. IS THE PATIENT COVERED BY MEDICAID?	14B. DATE MEDICAID PLAN BEGAN (MM/DD/YYYY)
☑ YES ☐ NO	☑ YES ☐ NO (If "YES," complete Item 14B)	**01-23-2024**

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)
	04-16-2024

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.

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 Veteran Readiness 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: VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. 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.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0062

APPLICATION FOR SURVIVORS BENEFITS (PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT)

(DO NOT WRITE IN THIS SPACE) VA DATE STAMP

IMPORTANT-- Read instructions before completing form. Detach and retain ONLY the instruction sheet

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	2. DATE OF DEATH

NOTE: If the veteran's Social Security No. is unknown, complete Items 4, 5, 6, and 7 about veteran.

3. SOCIAL SECURITY NO. OF VETERAN	4. DATE OF BIRTH	5. PLACE OF BIRTH

6. NAME OF FATHER	7. MAIDEN NAME OF MOTHER	8. DID THE VETERAN WORK IN THE RAILROAD INDUSTRY AT ANY TIME AFTER 1936? ☐ YES ☐ NO

NOTE: The following information should be furnished for each period of the veteran's active service (regular or reserves) after September 7, 1939, in the military service of the United States or service as a commissioned officer in the Public Health Service or the National Oceanic and Atmospheric Administration or during WWII, Philippine or Filipino or Allied country military service. If additional space is needed, attach a separate sheet.

9A. DATE ENTERED ACTIVE SERVICE	9B. SERVICE NO.	9C. DATE SEPARATED FROM ACTIVE SERVICE	9D. GRADE, RANK, OR RATING, ORGANIZATION AND BRANCH OF SERVICE

10. RELATIONSHIP OF APPLICANT TO VETERAN ☐ SURVIVING SPOUSE OR SURVIVING DIVORCED SPOUSE ☐ CHILD ☐ PARENT	11. DATE OF BIRTH OF APPLICANT	12. VA FILE NO.

CHILDREN: Show names of surviving children (including adopted children and stepchildren) or dependent grandchildren (including stepgrandchildren) who at any time since the veteran died, were unmarried and (a) under age 18; (b) age 18 to 19 and attending secondary school; (c) disabled or handicapped (18 or over and disability began before age 22).

13A.	13B.
13C.	13D.

I know that anyone who makes or causes to be made a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both. I affirm that all information I have given in this document is true.

14. DATE *(Month, day, year)*	15. SIGNATURE OF APPLICANT *(First name, middle initial, last name) (Sign in ink)*

16. MAILING ADDRESS OF APPLICANT *(No. and street or rural route, city or P.O., State and ZIP)*	17. TELEPHONE NO. *(Include Area Code)*

WITNESSES REQUIRED ONLY IF SIGNATURE OF APPLICANT IS MADE BY "X" MARK ABOVE

18A. SIGNATURE OF WITNESS	18B. ADDRESS OF WITNESS *(No. and street, city, State and ZIP Code)*
19A. SIGNATURE OF WITNESS	19B. ADDRESS OF WITNESS *(No. and street, city, State and ZIP Code)*

ITEMS BELOW TO BE COMPLETED BY THE DEPARTMENT OF VETERANS AFFAIRS Use reverse for "Remarks"

20. PROOFS RECEIVED		21. PROOFS REQUESTED FROM CLAIMANT OR OTHER *(Specify)*	
☐ DEATH	(NAME)	☐ DEATH	(NAME)
☐ MARRIAGE	(NAME)	☐ MARRIAGE	(NAME)
☐ AGE		☐ AGE	
☐ OTHER *(Specify)*	(NAME)	☐ OTHER *(Specify)*	(NAME)

22. DATE	23. NAME AND ADDRESS OF TRANSMITTING VA OFFICE

IMPORTANT: PLEASE READ THE FOLLOWING BEFORE YOU COMPLETE THE SSA-24.
INSTRUCTIONS FOR COMPLETING FORM SSA-24, APPLICATION FOR SURVIVORS BENEFITS (Payable Under Title II of the Social Security Act)

This application form, SSA-24, is an Application for Survivors Benefits Payable under Title II of the Social Security Act, as amended. Under authority of section 202(o) of the Social Security Act, the application requests information in order to determine eligibility to social security benefits.
You do not have to complete this application; there are no penalties under the law if you do not complete part or all of the SSA-24. However, it is usually to your advantage to provide the information because not providing it could prevent an accurate and timely decision on your claim or could result in the loss of some benefits or insurance coverage.

If you do wish to supply the information requested on the SSA-24, this information will be forwarded to the Social Security Administration and used by them to determine whether social security benefits may be payable to surviving dependent(s) of the veteran. Social Security will then contact you regarding any social security benefits payable based on information given on this form.

If you should have any question about entitlement to social security benefits or the information you have provided on this form, please contact your local social security office.
Complete each item of the attached application, Form SSA-24, (except Items 20 through 23). When signed and dated the form SHOULD BE LEFT ATTACHED to your completed

- **VA FORM 21-534, Application for Dependency and Indemnity Compensation, Death Pension and Accrued Benefits by a Surviving Spouse or Child (Including Death Compensation if Applicable) or**

- **VA FORM 21-535, Application for Dependency and Indemnity Compensation by Parent(s) (Including Accrued Benefits and Death Compensation When Applicable).**

Privacy Act Statement
Collection and Use of Personal Information

Section 202(o) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to determine whether social security benefits may be payable to survivors of a veteran.

The information you furnish on this form is voluntary. However, failure to provide the requested information could prevent an accurate and timely decision on your claim or could result in the loss of some benefits or insurance coverage.

We generally use the information you supply to determine whether social security benefits may be payable to survivors of a veteran. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information about this form, and any other information regarding our systems and programs, is available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

Champ VA
21-22 & SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
DD214 - Certified
P&T letter or Rating Decision Granting Ch 35 10-7959c
10-10d
Copy of other health insurance card

OMB Control Number: 2900-0219
Estimated Burden: 10 minutes
Expiration Date: 10/31/2024

Department of Veterans Affairs

CHAMPVA Other Health Insurance (OHI) Certification

Chief Business Office Purchased Care, PO Box 469063, Denver CO 80246-9063
Customer Service Center: 1-800-733-8387 | FAX: 303-331-7808 | Website: http://www.va.gov/purchasedcare

ATTENTION: Please read the instructions on the reverse side before completing this form. Failure to provide the requested information will result in a delay or denial of reimbursement until OHI information is received. Return the form and any requested information to the address shown above. This form is also used to report any changes in your OHI status. Updates can be sent by FAX or call by phone.

SECTION I: BENEFICIARY INFORMATION – Please use a separate form for each family member

Last Name	First Name	MI	Social Security Number
Veteran	**Ann**	**M**	**666-66-6666**

Street Address (Number, Street name/PO Box, Apt #)	City	State	Zip Code
123 Tenbucktwo Ave	**Sioux Falls**	**SD**	**57107**

Phone Number (with area code)		Gender
(605)123-2345	☐ Check if this is a new address	☐ Male ☐ Female

SECTION II: MEDICARE BENEFICIARIES – Attach a copy of your Medicare card

Part A: ☑ Yes ☐ No	Part B: ☑ Yes ☐ No	Part D: ☑ Yes ☐ No
Effective Date *(mm-dd-yyyy)* **12-31-2011**	Effective Date *(mm-dd-yyyy)* **12-31-2011**	Effective Date *(mm-dd-yyyy)* **12-31-2011**
Part A Carrier Name	Part B Carrier Name	Part Carrier Name
Medicare	**Medicare**	**Humana**

Does your Medicare coverage provide pharmacy benefits? ☑ Yes ☐ No

Do you have health insurance other than MEDICARE? ☐ Yes ☑ No

Did you choose a Medicare Advantage Plan for your Medicare coverage? ☑ Yes ☐ No

If NO, go to Section IV.

SECTION III: OTHER HEALTH INSURANCE

Provide all periods of OHI coverage since becoming CHAMPVA eligible and attach a copy of any active health insurance cards (front and back).

Name of insurance #1

Effective Date *(mm-dd-yyyy)* | Termination Date *(mm-dd-yyyy)*

Only input the termination date if the policy is inactive.

Is this insurance through employment? ☐ Yes ☐ No

Does the insurance cover prescriptions? ☐ Yes ☐ No

Does the insurance provide an explanation of benefits for prescriptions? ☐ Yes ☐ No

What type of insurance is it? ☐ HMO ☐ PPO ☐ Medicaid / State Assistance ☐ Medigap (if Medigap, specify [A-J]) **(A-J)** ☐ Prescription Discount ☐ Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)

Comments:

Name of insurance #2

Effective Date *(mm-dd-yyyy)* | Termination Date *(mm-dd-yyyy)*

Only input the termination date if the policy is inactive.

Is this insurance through employment? ☐ Yes ☐ No

Does the insurance cover prescriptions? ☐ Yes ☐ No

Does the insurance provide an explanation of benefits for prescriptions? ☐ Yes ☐ No

What type of insurance is it? ☐ HMO ☐ PPO ☐ Medicaid / State Assistance ☐ Medigap (if Medigap, specify [A-J]) **(A-J)** ☐ Prescription Discount ☐ Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)

Comments:

SECTION IV: CERTIFICATION BY BENEFICIARY, SPONSOR OR LEGAL GUARDIAN

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious or fraudulent statements of claims. I certify that the above information is correct to the best of my knowledge and belief. If there is any change in insurance status for the above person, I agree to promptly notify the Chief Business Office Purchased Care.

SIGNATURE (type if electronic):

DATE: **04-16-2024**

OMB Control No. 2900-0219
Respondent Burden: 10 Minutes
Expiration Date: 10/31/2024

Department of Veterans Affairs

APPLICATION FOR CHAMPVA BENEFITS

Champ VA Program Office, Office of Integrated Veteran Care, CHAMPVA Eligibility, PO Box 469028, Denver CO 80246-9028
Customer Service Center: 1-800-733-8387 | FAX: 303-331-7809

ATTENTION: Please refer to the information on the following pages for assistance completing this form in its entirety (print or type only). Return the form and any additional, requested information to the address shown above. If applicants indicate in Section II that they have Medicare or other health insurance, each applicant must submit VA Form 10-7959c, *CHAMPVA Other Health Insurance (OHI) Certification*. If additional space is needed, complete another VA Form 10-10d in its entirety, sign and submit.

SECTION I - SPONSOR INFORMATION

VETERAN'S LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	VA FILE NUMBER *(Claim Number)*
Veteran	**Joe**	**P**	**123-23-3456**	**123233456**

STREET ADDRESS	CITY	STATE	ZIP CODE
123 Tenbucktwo Ave	**Sioux Falls**	**SD**	**57107**

PHONE NUMBER *(Include Area Code)*	DATE OF BIRTH *(MM/DD/YYYY)*	DATE OF MARRIAGE *(MM/DD/YYYY)*
(605)123-2345	**09-08-1947**	**10-15-1975**

IS THE VETERAN DECEASED?	IF "YES," CONTINUE IF "NO," GO TO SECTION II	DATE OF DEATH *(MM/DD/YYYY)*	DID THE VETERAN DIE WHILE ON ACTIVE MILITARY SERVICE?
☑ YES ☐ NO		**04-17-2024**	☐ YES ☑ NO

SECTION II - APPLICANT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*
Veteran	**Ann**	**M**	**666-66-6666**	**09-03-1946**

STREET ADDRESS	CITY	STATE	ZIP CODE
123 Tenbucktwo Ave	**Sioux Falls**	**SD**	**57107**

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
	(605)123-2345	☐ MALE ☑ FEMALE

☑ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*
		Spouse

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*

STREET ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
		☐ MALE ☐ FEMALE

☐ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*

STREET ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*	GENDER
		☐ MALE ☐ FEMALE

☐ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*

SECTION III - CERTIFICATION

I declare under penalty of perjury that the foregoing is true and accurate to the best of my knowledge. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to title 18, United States Code, Sections 287 and 1001. *(Sign and date below.)*

SIGNATURE:	DATE *(MM/DD/YYYY)*
Ann Veteran	**05-06-2024**

If certification is signed by a person other than an applicant, complete the following:

LAST NAME	FIRST NAME	MI	RELATIONSHIP TO APPLICANT(S)	
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**	**PHONE NUMBER *(Include Area Code)***

Non-Service-Connected Pension Quick Reference Sheet

Non-Service-Connected Pension based on service, income, and age or disability.

Eligibility

Veteran considered Permanently and Totally Disabled, or over age 65, who served at least 90 consecutive days (prior to September 8, 1980), one day of which was during a period of war. After September 7, 1980, enlisted veteran's must have served 24 months of continuous active duty, or the full period for which they were called to active duty with at least one day of which was during war time. Officers, entering active duty after October 16, 1981, must have 24 months of continuous active duty. Service must have been terminated by discharge or separation under conditions other than dishonorable.

Income Requirements

This is an income-based program intended to bring claimant up to the minimum standards of living level. VA counts the claimant's income and assets as well as any dependents living in the home. The table below shows the more common countable/non-countable income. See 38 CFR 3.272 for list of excluded income.

Income Counted	Income Not Counted
Social Security, Private Pension, Annuities	Welfare (SSI, SNAP, LIHEAP, etc)
Workers Comp or Unemployment Insurance	Income Tax Refunds
Gains from Gambling	Interest on IRAs
Income from Joint Accounts	VA Burial Benefits
Income from Earnings (interest)	Reverse Mortgage Payments
Life Insurance	Home Equity Line

Deductible Expenses

Expenses that can be deducted against countable income include: Medicare premiums, private medical insurance premiums, and out of pocket un-reimbursed medical expenses (UME). Be sure to include any payments for other recurring expenses such as nursing home costs.

Misc. Information

Click here to view what the VA counts for net worth when considering eligibility. There is a three-year look back period when tracing assets. Life estates do count as assets.

Forms to File

21-22	POA and SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
21P-527EZ	Fill in all blanks
21P-0969	Income and Asset Statement (if applicable)
DD214	Certified copy
21P-8416	Medical Expense Report
21-2680	Examination for housebound or permanent need for regular A&A Request for Nursing Home Information
21-0779	Care Expense Statement
CES	Copy of voided check or deposit slip

Non-Service Connected Pension

Basic Eligibility Requirements (38 CFR 3.2 and 3.3)

Veterans Pension is a 'needs based' benefit paid to wartime veterans who have limited or no income and net worth. Additionally, to qualify for pension, the veterans must be age 65 or older or, if under age 65, must be **permanently and totally** disabled.

There are four basic requirements a veteran must meet to be eligible for VA pension:

1. **Length of Service/Character of Discharge** Veteran must have been discharged under other-than-dishonorable conditions, and
   - Have at least 90 days of wartime service, or
   - Have at least 90 days of consecutive service, 1 day of which was during a period of war, or
   - Have served during a wartime period and was discharged for a service connected disability regardless of length of service.

2. **Wartime Service** For VA purposes, the wartime periods are as follows:

Era	From	To
WWII	December 7, 1941	December 31, 1946
Korea	June 27, 1950	January 31, 1955
Vietnam (In country service)	February 28, 1961	May 7, 1975
Gulf War	August 2, 1990	(a date to be determined)

Veterans Healthcare and Benefits Improvement Act of 2020 (Public Law 116-315) moved the beginning date of the Vietnam Era back to November 1, 1955, for veterans **who actually served in Vietnam** between November 1, 1955, to February 28, 1961. *The period of February 28, 1961, to May 7, 1975, covers all Vietnam Veterans who served in the theatre (Blue Water Navy, In-Country, and Thailand).

Enlisted personnel who first entered service **after** September 7, 1980, and officers who were commissioned **after** October 16, 1981, must meet the minimum active duty requirement which is commonly known as the '24-month rule' or the 'two-year rule'. This requires that the veteran must have completed at least:

- 24 months of active duty, or
- The full period for which called or ordered to active duty

Exceptions are made for veterans who were discharged prior to the end of their enlistment. As with other benefit programs, pension may be paid if the discharge was due to:

- Convenience of the government within three-months of the end of their enlistment (which is an early out under Title 10, Section 1171), or
- Hardship (under Title 10, Section 1173), or
- Service connected disability.

3. Permanent and total disability (38 CFR 3.23, 3.314, 3.342, and 3.351)

If under age 65, the veteran must be permanently and totally disabled (P&T). The disability(ies) can not be the result of willful misconduct but they can be non-service connected which means they are not related to military service. P&T ratings are based on factors such as age, degree of disability and unemployability.

Permanent and Total Disability is defined as

- Total disability as an impairment of mind or body which is sufficient to make it impossible for the average person to follow a substantially gainful occupation.
- Permanent and total disability exists when impairment is reasonably certain to continue throughout the life of the disabled person.

In the event that a disability rating is not total, but the veteran is deemed to be un-employable by reason of disability the veteran still must have at least an overall permanent disability rating of 60%. The percentage of disability needed is no longer directly related to the veteran's age. Only a determination that the veteran is unemployable by reason of his/her disability or disabilities is the governing factor.

Establishing a veteran's disabilities for pension purposes requires:

- Medical evidence
- A physician's statement if it includes clinical manifestations and substantiation of the diagnosis by findings of diagnostic techniques generally accepted by medical authorities such as pathological studies, x-rays or laboratory tests.

When the medical evidence and or statement from a private physician is fully adequate for rating the initial claim, it is not necessary for these cases to receive a Compensation and Pension medical exam.

4. Income/Net Worth Qualifications (38 CFR 3.274 and 3.275)

The purpose of the VA pension program is to bring the total income of qualified veteran to an established level. This includes income received by the veteran and his or her dependents, if any, from earnings, disability and retirement payments, interest and dividends, and net income from farming or business.

Net worth is the value of all assets including bank accounts, stocks, bonds, mutual funds and any property other than the veteran's residence and a reasonable lot area. There is no set limit on

how much net worth a veteran can have, but it cannot be excessive. The VA pension program is not intended to protect substantial assets or build up an estate for the benefit of heirs.

With a Life Estate the life tenant is the owner of the property during his/her life and is entitled to exclusive possession and control of the property, so the VA considers the claimant as the owner of the property and it counts the full value as an asset.

Click here to view the veteran pension rates and click here to view the survivors pension rates. The VA will take into consideration factors such as the veteran's age, amount of medical expenses, etc.

Veterans Pension Application Procedures

VA Form 21P-527EZ 'Veterans Application for Pension' is used by a veteran to apply for Pension benefits. Accompanying this form should be:

- VA Form 21-22 'Appointment of Veteran's Service Organization as Claimants Representative'
- Intent to File 21-0966 if applicable
- SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
- Certified copy of DD-214(s) or military discharge record
- Dependency documentation (if applicable)
- Medical evidence to support the claim for P&T disability (if the veteran is under age 65)
- VA Form 21P-8416 Medical expense report covering appropriate periods
- 21P-0969 - Income and Asset Statement (If applicable)
- Special Monthly Pension
    - 21-0779 and Care Expense Statement (CES) (Nursing Home)
    - 21-2680 and Care Expense Statement (CES) (A&A or Housebound)
    - Any Title XIX documentation

Medical Evidence

There are some notable differences between the medical evidence required for disability compensation and pension. They are as follows:

- For pension, it is not necessary that the veteran's disability be service related
- For pension, the disability must be P&T
- For pension, service medical records (SMR's) are not required

Developing for a Disability

For pension purposes, the VA will generally accept private hospital or physician records in lieu of a VA examination. This report must contain a full description and diagnosis of the disabling condition(s).

Under certain conditions it may not be necessary to submit medical evidence. In any of these situations it is important that the VSO informs the VA so that the veteran will not be requested to submit medical evidence in support of his or her claim. These special conditions are:

- The veteran has been receiving treatment at a VA Medical facility
- Medical evidence is already on record showing that the claimant is P&T
- The veteran is destitute and unable to defray the cost of a private medical examination

Dependency documentation (38CFR 3.204)

Evidence of dependent relationships must be as clear and complete as possible so as to avoid questions or unnecessary delays in the processing of the claim. **For example**: If the veteran or spouse had any prior marriages, the application should include copies of divorce decrees or death certificates verifying termination of the marriage. If incomplete information is provided, the VA may require copies of the documents terminating the prior marriages.

Determining a claimant's income for pension eligibility

This section is intended to assist you in starting a claim for pension and understanding the basic workings of a pension claim. The information here is very basic and deals with the most common type of pension claims you will see. These instructions are not all inclusive but we have given attention to the exceptions that are commonly seen.

The VA considers claimant's income (work, social security, retirement, interest income or other income and subtracts the amount of qualifying reported un-reimbursed medical expenses (UME), the amount left over is what the VA considers as 'income for VA purposes' (IVAP).

Example: On his application for pension, John Smith a single veteran reported $10,000 per year in social security as his only income and $5,000 in un-reimbursed medical expense (UME).

The 2018 maximum annual pension rate (MAPR) for a single veteran is $13,166. The UME offset is $659 ($13,166 X 5% = $659). For VA purposes, Mr. Smith's countable UME is $4,341.

Income Inclusions (38CFR 3.271) (M21-1MR, Part V, Subpart iii, Chapter 1, Section I 57,58)

The general rule for Improved Pension is that all income is countable unless specifically excluded. Examples of countable income include:

- Earnings
- Retirement income and Annuities
- Survivors'programs
- Interest
- Dividends
- Unemployment compensation
- Operation of a business

General Guidelines on Income Inclusions

When an individual retirement account (IRA) or similar instrument starts paying benefits, count the entire amount even though it represents a partial return of principal.

Count cash dividends from rural cooperatives and similar entities.

Gifts and inheritances of property or cash count as income. The value of a gift or inheritance of property is the fair market value of the property at the time it is received. For financial instruments such as a stock certificate or bond it is the amount it would bring if it were cashed on receipt, even though this might be less than its face value.

The net winnings from gambling count. Gambling losses during a particular Eligibility Verification Report (EVR) period may be deducted from the gross winnings during the same EVR reporting period to arrive at net gambling income.

Income from joint accounts or jointly owned property is counted in proportion to the claimant's ownership share.

Count social security lump-sum payments the same as any other social security income, including the $255 death benefit.

Count payments to land owners under the U.S. Department of Agriculture's Conservation Reserve Program (CRP) and similar programs for the purpose of keeping land out of production. If the operator of a business receives CRP payments, treat them as any other business income. A beneficiary who does not operate a business can still deduct taxes and other expenses of maintaining the land from the CRP income. This income should be treated like rental income since the beneficiary receives payment for relinquishing partial right to land.

Income Exclusions (38 CFR 3.272) (M21-1MR, Part V, Subpart iii, Chapter1, Section 1, 58)

IMPORTANT NOTE: This section on income exclusions is provided as a guideline and reference only. Always remember – **all income is reportable** to VA even though it may not be considered as 'countable'.

- Welfare, Supplemental Security Income (SSI), and Drug discounts
- Income from VA Work Restoration programs
- Income tax refunds
- Withheld Social Security
- Timber sales
- Mineral and oil royalties
- IRA interest
- Loans, including reverse mortgages
- VA pension and accrued benefits
- Insurance dividends
- Joint accounts
- Withdrawals from bank accounts and certificates of deposit
- Proceeds of cashed-in savings bonds
- Interest on certain Prepaid Burial plans

General Guidelines on Income Exclusions

In general, any type of benefit for which eligibility is based on the claimant's financial need is excluded as income. This would include Welfare, Supplemental Security Income (SSI) and savings from prescription drug discounts received under the Medicare Prescription Medication, Improvement and Modernization Act (MMA).

Income received from Work Restoration programs administered by the Veterans Health Administration (VHA), including Incentive Therapy (IT) and Compensated Work Therapy (CWT).

Income received from the occasional sale of timber or extraction of minerals or oil royalties is not counted as they are considered a conversion of assets.

Income from a reverse mortgage is not counted as it is a home equity loan.

Insurance dividends are not income as they are considered to be a return of excess premium payments. **Exception:** if insurance dividends are left on deposit, count any interest earned.

Proceeds from cashing in savings bonds, up to face value of the bond, are not counted as this is a conversion of assets.

Regular cash contributions, if the claimant uses them to pay for necessities such as food or housing, are not counted.

Income received from American Indian trust or restricted lands up to $2,000 per individual in receipt of these payments. The claimant may need a statement from the Tribal Land Office indicating the land is trust or restricted lands. The payments may be direct or indirect.

Interest earned on Irrevocable Burial plans generally is not available to the holder of the policy and is not counted as income. A copy of the burial plan should be provided to VA so they have a record of the plan.

Reporting Medical Expenses

When filing an **original pension claim** report ongoing medical expenses such as Medicare and private health insurance premiums, from the date the veteran signs the form forward for 12 months or, to the end of the calendar year. To determine the best rate of pay for the veteran, the VA may send a letter requesting other dates and the amount of medical expenses paid during those time frames. There are some cases where the VA may liberalize the veteran's pension and may request income and expense information from one year prior to the date of the original claim. These include (1) veteran who are **age 65, or older**, and (2) veteran who are **under age 65** and are in a nursing home or are in receipt of Social Security Disability benefits. In these cases, VA does not have to do a rating decision and can administratively grant the veteran's pension.

For example veteran is filing a pension on June 28, 2018. Report medical expenses paid during the previous year, June 28, 2017 – June 27, 2018. Then report projected medical expenses for the period June 28, 2018 – December 31, 2018.

Appealing a Veteran's Pension Claim

A veteran who was previously on pension and is requesting re-instatement to pension will need to submit the following documentation:

- VA Form 20-0995
- VA Form 21P-4138 Statement Form - explanation for appeal
- VA Form 21P-527EZ 'Application for Pension
- VA Form 21P-8416 'Medical Expense Report' (The expenses listed on this form must have been paid by the veteran and NOT reimbursed by insurance or other organization)
- Expenses listed can be for the veteran, his/her spouse and dependents
- VA Form 21-22 - Appointment of Veterans Service Organization as Claimant's Representative.
- SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142), if not already done
- 21P-0969 - Income and Asset Statement (if applicable)
- VA Form 21-0779 plus Care and Expense Statement (CES) if veteran is in a nursing home
- VA Form 21-2680 plus Care and Expense Statement (CES) if veteran is in need of Aid and Attendance.

When reporting any ongoing medical expenses, project them from the date of the claim forward one year. The VA will **NOT** consider the prior years' medical expenses on re-instatements of pension regardless of the veteran's age or residence in a nursing home **unless,** the claim is filed within the year of denial or termination, then the VA will go back and count medical expenses from the date of claim or termination.

Annual Retro Check for UME

Certain veterans and widows receive only one pension check per year based on the UME they paid during the previous twelve months. This generally happens because their annual income is over the pension limit and the amount they pay in medical expenses each year varies enough that they cannot safely be projected or considered as ongoing.

The veteran has countable income of $13,000 per year and the maximum pension rate is $11,830. The only predictable medical expense he has is his annual Medicare premium of $1156 which is not enough to make him eligible for a monthly pension check once the VA takes in to consideration the 5% UME offset. ($1156 - $591 = $565 countable UME).

During the year the veteran's pays additional medical expenses of $1,600 for travel, eye glasses and dental care for a total of $2,722 paid during the year. He is now eligible for a retro check of $961 for UME.

$2,722	Total medical expense	$13,000	Countable income
- 591	UME Offset	- 2,131	Countable UME
$2,131	Countable UME	$10,869	Income for VA purposes
$11,830	Maximum pension rate		
- 10,869	Income for VA purposes		
$ 961	Pension retro entitlement		

Special Monthly Pension

Special monthly pension may be payable to veterans or surviving spouses who are in receipt of, or eligible to receive, pension benefits. This special monthly allowance is in addition to the basic pension award.

Housebound (38 CFR 3.351)

Housebound benefits may be payable to a veteran or a surviving spouse who is substantially confined to his or her home and the immediate premises or, if institutionalized, to the ward or clinical areas and it is reasonably certain that the disability or disabilities and resultant confinement will continue throughout his or her lifetime.

Application documents

If the veteran's, spouse or surviving spouse is currently receiving pension benefits the following forms need to be submitted:

- VA Form 21-2680 - This form is completed by the veteran's physician and must be signed by a physician or the primary medical care provider
- VA Form 21P-8416 'Medical Expense Report'. Use if there are additional medical expenses that were not included in the veteran's or surviving spouse's pension award and/or EVR
- VA Form 21-4138 'Statement in Support of Claim'. Write a statement requesting the benefit and stating where the claimant is receiving medical care
- Care and Expense Statement
- Copies of private medical records or VA Form 21-4142 and 21-4142a 'Authorization for Release of Information' if the claimant is receiving their primary medical care outside of the VA

Aid and Attendance (38 CFR 3.351)

The meaning of Aid and Attendance is:

- Inability of claimant to dress or undress self; or
- To keep him/herself ordinarily clean and presentable; or
- Frequent need to adjustment of any special prosthetic or orthopedic appliances which by reason of the particular disability cannot be done without aid (this will not include the adjustment of appliances which normal persons would be unable to adjust without aid, such as supports, belts, lacing at the back, etc;) or
- Inability of claimant to feed him/herself through loss of coordination of upper extremities or through extreme weakness; or
- Inability to attend to the needs of nature; or
- Incapacity, physical or mental, which requires care or assistance on a regular basis to protect the claimant from hazards or dangers incident to his or her daily environment; or
- Bedridden (defined as that condition which, through its essential character, actually requires that the claimant remain in bed)

It is not required that all of the conditions listed above be found to exist. The personal functions which the claimant is unable to perform should be considered in connection with his or her condition as a whole. It is only necessary that the evidence establishes the claimant is so helpless as to need regular aid and attendance, not that there be a constant need.

The fact that the claimant has voluntarily taken to bed or that a physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure will **NOT** suffice. Further, favorable determinations are **NOT** based solely upon an opinion that the claimant's condition is such as would require him or her to be in bed. It must be based on the actual requirement of personal assistance from others.

Eligibility Requirements

Aid and Attendance benefits may be payable to a veteran's or a surviving spouse of a veteran if:

- Claimant is a patient in a nursing home because of mental or physical incapacity; or
- Claimant is blind or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less; or
- Claimant establishes a factual need for aid and attendance of another within the definition of aid and attendance as defined above

The claimant does not have to be living in a nursing home to be granted Aid and Attendance. In the event that the claimant is living at home there is no presumption and Aid an Attendance must be decided by rating decision by the VA Rating Activity.

Assisted Living (38 CFR 3.351)

Veteran or surviving spouse living in assisted living can be granted aid and attendance by rating decision. Assisted living facilities do not warrant presumption of Aid and Attendance. Assisted living expenses can be used if the veteran or surviving spouse is on Aid and Attendance. Claimants in Assisted living facilities are not subject to the $90 pension rate.

Application Documents

If the veteran or surviving spouse is currently receiving pension and have been moved to the assisted living, the following forms need to be submitted:

- Care Expense Statement
- VA Form 21-2680 'Examination for Housebound Status or Permanent Need for Regular Aid and Attendance'
- VA Form 21P-8416 'Request 'Medical Expense Report' for information
- Concerning Medical, Legal or other Expenses'. Use this form if there are additional medical expenses that were not included in the veteran's or surviving spouse's pension award and/or EVR.
- VA Form 21-4138 'Statement in Support of Claim' – Request A&A due to nursing home care.
- If claimant is receiving or has been recently awarded Title 19 benefits you will need to submit the award letter from Department of Social Services. (See the section on Title 19 and Pension.)

Title 19 (Medicaid) Benefits for Claimants Living in a Nursing Home

Once a claimant who is receiving pension benefits begins receiving assistance from Title 19 (Medicaid program) the VA must be notified immediately. Pension awards will be reduced for a single veteran or single surviving spouse to $90 a month once they have been awarded Title 19 benefits. This reduction is mandated by 38 USC 5503, even if claimant is in receipt of housebound or aid and attendance. The reduced amount of pension will not be used to defray costs to the

State Title 19 program. This money is strictly for the use of the veteran or surviving spouse for personal needs. In addition, the veteran or surviving widow will be allowed to also retain $60 of their social security by the Medicaid program. This money is also only for the personal needs of the claimant and can not be used by the state to defray Title 19 costs.

Please note that while Social Services does not count a claimant's Aid and Attendance allowance as income, the claimants pension award will still be reduced to the $90 rate.

A VA Form 21P-8416 and Due Process Waiver 21-4138 and a copy of the Title 19 award letter need to be submitted to the VA as notification by the claimant as soon as the award is made.

Eligibility Verification Report (EVR) (38 CFR 3.274 and 3.275)

Pension recipients need to report medical expenses each year if changes have been made. They must also notify the VA if their income has changed.

Also, on the EVR, claimants project what they anticipate paying out over the next year for medical expenses. Caution should be taken when projecting the medical expense due to the fact that the claimant will have to complete a medical expense report proving that they in fact paid that amount if not more during the year. Further, random selections of pension claims are made each year to provide proof of reported expenses.

Once on pension, individuals on fixed incomes such as Social Security would not submit an EVR each year. If the individual has unusual medical expenses during the year, the appropriate – Form along with a VA Form 21P-8416 should be submitted to recoup a portion of the medical expenses that were paid out of pocket by the claimant.

*****Please note: the VA can and does go into the Internal Revenue Service records to insure that a pension recipient has reported all income. If VA does an IRS match and finds income not reported, the claimant will get an overpayment and VA will take necessary action to collect any pension award that was overpaid. The VA can do a Social Security verification as well. If a claimant starts receiving Social Security benefits, and does not report it to the VA, they will have an overpayment from VA.**

In the event that a claimant does not in fact pay what they projected for medical expenses and the amount paid is less for the year, the VA will create an overpayment that the claimant will have to reimburse back to VA.

FDC Pension

21-22 & SDDVA policy statement & HIPPA Disclosure

DD 214 - Certified

21P-527EZ – All blanks/ boxes must be filled out & 0 or none is placed in any unfilled boxes for Income

21P-0969 – Income and Asset Statement (if applicable)

Copy of Voided Check or Deposit Slip

21P-8416 if more room needed for medical expenses

Medical Records if under 65

Vet must have served at least one day during war time, be over age 65 or have a disability preventing work, & meet income guidelines.

Special Monthly Pension

21-0779 (Nursing home)

21-2680 (Aid and Attendance or Housebound)

Any Title XIX documentation

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 7/31/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, Appointment of Individual as Claimant's Representative. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

SECTION I: VETERAN'S 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 of the form.

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

Joe P Veteran

2. SOCIAL SECURITY NUMBER *(SSN)*	3. VA FILE NUMBER *(If applicable)*	4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
123-23-3456	**123233456**	Month **09** - Day **08** - Year **1947**

5. VETERAN'S SERVICE NUMBER *(If applicable)*	6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

8. TELEPHONE NUMBER *(Include Area Code)*	9. EMAIL ADDRESS *(Optional)*
(605)123-2345	

SECTION II: CLAIMANT'S INFORMATION *(If other than veteran)*

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

11A. CLAIMANT'S DATE OF BIRTH	11B. RELATIONSHIP TO VETERAN
Month - Day - Year	

12. CURRENT 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 **US** ZIP Code/Postal Code

13. TELEPHONE NUMBER *(Include Area Code)*	14. EMAIL ADDRESS *(Optional)*

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

038 - South Dakota Department of Veterans Affairs

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*	16B. JOB TITLE OF PERSON NAMED IN ITEM 16A
Kevin Swanson	**Veterans Service Officer**
17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15	18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*
statevso.mailbox@va.gov	**03-28-2024**

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☑ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☑ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT (**Required**)	22B. DATE SIGNED *(MM/DD/YYYY)*
Jon P Vuckovich	**03-28-2024**
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (**Required**)	23B. DATE SIGNED *(MM/DD/YYYY)*
[signature]	**03-28-2024**

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

	COPY OF VA FORM 21-22 SENT TO:	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason and date (MM/DD/YYYY))*
VA USE ONLY	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

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 Control No. 2900-0002
Respondent Burden: 30 minutes
Expiration Date: 08/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME *(First, Middle Initial, Last)*
Joe P Veteran

1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*	1D. HAVE YOU EVER FILED A CLAIM WITH VA?
123-23-3456	**09-08-1947**	☑ YES ☐ NO *(If NO, skip question 1E)*

1E. VA FILE NUMBER *(If applicable)*
123233456

SECTION II: VETERAN'S CONTACT INFORMATION

2A. MAILING ADDRESS

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

2B. TELEPHONE NUMBER *(Include Area Code)*
(605)123-2345 Enter International Phone Number *(If applicable)* _____

2C. VETERAN'S E-MAIL ADDRESS *(Optional)*

SECTION III: VETERAN'S SERVICE INFORMATION *(MUST COMPLETE)*

3A. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER *(If None, leave blank)*

3B. DATE INITIALLY ENTERED ACTIVE DUTY *(MM/DD/YYYY)*	3C. FINAL RELEASE DATE FROM ACTIVE DUTY *(MM/DD/YYYY)*	3D. YOUR SERVICE NUMBER
01-01-1968	**09-30-1974**	

3E. BRANCH OF SERVICE
☑ ARMY ☐ NAVY ☐ AIR FORCE
☐ COAST GUARD ☐ MARINE CORPS
☐ SPACE FORCE ☐ USPHS ☐ NOAA

3F. PLACE OF YOUR LAST SEPARATION
Ft. Lewis, WA

3G. HAVE YOU EVER BEEN A PRISONER OF WAR?	3H. DATES CONFINEMENT STARTED *(MM/DD/YYYY)*	3I. DATES CONFINEMENT ENDED *(MM/DD/YYYY)*
☐ YES ☑ NO *(If "NO," skip to question 4A)*		

SECTION IV: PENSION INFORMATION

4A. ARE YOU OVER THE AGE OF 65 OR HAVE YOU BEEN DETERMINED TO BE DISABLED BY SOCIAL SECURITY ADMINISTRATION?
☑ YES ☐ NO *(If "YES," skip question 4B)*

4B. ARE YOU MEDICALLY INCAPABLE OF WORKING?
☑ YES ☐ NO *(If "YES," you must submit medical evidence with this application)*

4C. DO YOU LIVE IN A NURSING HOME?
☐ YES ☑ NO *(If "NO, skip question 4D)*

4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED FOR MEDICAID?
☐ YES ☐ NO *(If "YES," please have an official from your nursing home complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance)*

4E. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL IMPAIRMENT OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?
☐ YES ☑ NO *(If "YES," complete and attach with this application, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS))*

4F. HAVE YOU RECEIVED TREATMENT FROM A VA MEDICAL CENTER?
☑ YES ☐ NO Specify Facility: **VA Sioux Falls**

4G. HAVE YOU RECENTLY RECEIVED TREATMENT FROM ANY FEDERAL MEDICAL FACILITIES *(Military base, etc.)*?
☐ YES ☑ NO Specify Facility:

SECTION V: EMPLOYMENT HISTORY

5A. ARE YOU CURRENTLY EMPLOYED?
☐ YES ☑ NO *(If "NO," skip questions 5B and 5C)*

5B. WHAT KIND OF WORK ARE YOU CURRENTLY DOING?

5C. HOW MANY HOURS PER WEEK DO YOU AVERAGE?

5D. WHEN DID YOU LAST WORK? *(MM/DD/YYYY)*

5E. HOW MANY HOURS PER WEEK DID YOU AVERAGE?

5F. WHAT WAS YOUR JOB TITLE?

5G. WHAT KIND OF WORK DID YOU DO?

SECTION VI: MARITAL STATUS *(MUST COMPLETE)*

6A. WHAT IS YOUR MARITAL STATUS? *(Check one)*
☑ MARRIED ☐ SEPARATED ☐ NOT MARRIED *(Widowed or Never Married - Skip to Section VIII)*

6B. SPOUSE'S CURRENT LEGAL NAME *(First, Middle Initial, Last)*
Ann Marrie Veteran

6C. SPOUSE'S BIRTH DATE *(MM/DD/YYYY)*
09-03-1946

6D. SPOUSE'S SOCIAL SECURITY NUMBER
666-66-6666

6E. DATE AND PLACE OF MARRIAGE (MM/DD/YYYY)
10-15-1975

CITY AND STATE OR COUNTRY
Sioux Falls, SD

6F. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, etc.)*
☑ CEREMONIAL ☐ OTHER (Specify)

6G. IS YOUR SPOUSE ALSO A VETERAN?
☐ YES ☑ NO *(If "NO," skip question 6H)*

6H. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? *(If any)*

6I. IF YOU ARE SEPARATED, PLEASE TELL US THE REASON YOU ARE SEPARATED (Illness, work, etc.)
☐ MEDICAL REASON ☐ MARITAL DISCORD ☐ WORK ☐ OTHER *(Specify)* _____

6J. SPOUSE'S MAILING ADDRESS *(If separated)*
No. & Street

Apt./Unit Number City

State/Province Country **US** ZIP Code/Postal Code

6K. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? *(If separated)*
$

SECTION VII: PRIOR MARITAL HISTORY

Tell us about your and your spouse's previous marriages. If you have never been married or your current marriage is yours and your spouse's only marriage skip to Section VIII.

VETERAN'S PRIOR MARRIAGES *(If None, skip to question 7L)*

7A. WHO WERE YOU MARRIED TO? *(First, Middle Initial, Last)*

7B. HOW DID YOUR PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)*
_____

7C. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START:
END:

7D. PLACE OF MARRIAGE *(City and State or Country)*

7E. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

VETERAN'S PRIOR MARRIAGES - CONTINUED *(If None, skip to question 7L)*

7F. WHO WERE YOU MARRIED TO? *(First, Middle Initial, Last)*

7G. HOW DID YOUR PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*

☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)* _____

7H. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

START:
END:

7I. PLACE OF MARRIAGE *(City and State or Country)*

7J. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?

☐ YES ☐ NO *(If "YES," please submit a VA Form 21-686c, Declaration of Status of Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history)*

SPOUSE'S PRIOR MARRIAGES *(If "None," skip to Section VIII)*

7L. WHO WAS YOUR SPOUSE MARRIED TO? *(First, Middle Initial, Last)*

7M. HOW DID YOUR PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*

☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)* _____

7N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

START:
END:

7O. PLACE OF MARRIAGE *(City and State or Country)*

7P. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7Q. WHO WAS YOUR SPOUSE MARRIED TO? *(First, Middle Initial, Last)*

7R. HOW DID YOUR PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*

☐ DEATH ☐ DIVORCE ☐ OTHER *(Specify)* _____

7S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*

START:
END:

7T. PLACE OF MARRIAGE *(City and State or Country)*

7U. PLACE OF MARRIAGE TERMINATION (City and State or Country)

7V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?

☐ YES ☐ NO *(If "YES", please submit a VA Form 21-686c, Declaration of Status of Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history.)*

SECTION VIII: DEPENDENT CHILDREN

NOTE: Please refer to the Special Circumstances on the instructions page for information regarding dependents and the necessary forms if additional space is required to list all dependents. If None, skip to Section IX. **In most circumstances, children over the age of 23 are not considered dependent for VA purposes.**

8A. HOW MANY DEPENDENT CHILDREN LIVE WITH YOU? *(Please complete a VA Form 21-686c, Application Request to Add and/or Remove Dependents, if you need more space for additional dependents.)*

8B. CHILD'S NAME *(First, Middle Initial, Last)*

8C. CHILD'S BIRTH DATE *(MM/DD/YYYY)*

8D. CHILD'S SOCIAL SECURITY NUMBER

8E. PLACE OF BIRTH *(City and State or Country)*

8F. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*

☐ BIOLOGICAL ☐ STEPCHILD ☐ SERIOUSLY DISABLED ☐ 18-23 YEARS OLD *(in school)* ☐ PREVIOUSLY MARRIED ☐ ADOPTED ☐ DOES NOT LIVE WITH YOU BUT CONTRIBUTES **$**

8G. CHILD'S NAME *(First, Middle Initial, Last)*

8H. CHILD'S BIRTH DATE *(MM/DD/YYYY)*

8I. CHILD'S SOCIAL SECURITY NUMBER

8J. PLACE OF BIRTH *(City and State or Country)*

SECTION VIII: DEPENDENT CHILDREN *(CONTINUED)*

8K. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*

☐ BIOLOGICAL ☐ STEPCHILD ☐ SERIOUSLY DISABLED ☐ 18-23 YEARS OLD *(in school)* ☐ PREVIOUSLY MARRIED ☐ ADOPTED

☐ DOES NOT LIVE WITH YOU BUT CONTRIBUTES **$**

8L. CHILD'S NAME *(First, Middle Initial, Last)*

8M. CHILD'S BIRTH DATE *(MM/DD/YYYY)*	8N. CHILD'S SOCIAL SECURITY NUMBER

8O. PLACE OF BIRTH *(City and State or Country)*

8P. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*

☐ BIOLOGICAL ☐ STEPCHILD ☐ SERIOUSLY DISABLED ☐ 18-23 YEARS OLD *(in school)* ☐ PREVIOUSLY MARRIED ☐ ADOPTED

☐ DOES NOT LIVE WITH YOU BUT CONTRIBUTES **$**

8Q. DO ALL OF YOUR CHILDREN THAT ARE NOT LIVING WITH YOU AS ANSWERED ABOVE RESIDE AT THE SAME ADDRESS?

☐ YES ☐ NO *(If "NO," Please submit a VA Form 21-4138, Statement in Support of Claim, with the following information: Who the child is currently living with, and the full address of where the child resides.)*

8R. PLEASE PROVIDE THE NAME OF THE CUSTODIAN AND THE ADDRESS OF CHILDREN NOT LIVING WITH YOU *(First, Middle Initial, Last)*

NAME OF CUSTODIAN *(First, Middle Initial, Last)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS

NOTE: Assets are all the money and property you or your dependents own. Assets do not include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

9A. DO YOU AND YOUR DEPENDENTS HAVE OVER $25,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?

☐ YES ☑ NO *(If "YES", please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.))*

$ .00 *(If "NO," please estimate the total value of your assets)*

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? *(Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)*

☐ YES ☑ NO *(If "YES," please submit VA Form 21P-0969)*

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?	9D. IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?
☑ YES ☐ NO *(If "NO," skip to Item 9G)*	☐ YES ☑ NO *(If "NO," skip to Item 9G)*
9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES? *(Do not include the value of the residence or the first 2 acres.)* **$ .00**	**9F. IS THE LAND OVER 2 ACRES (87, 120 SQ FT) REPORTED IN QUESTION 9E MARKETABLE?** ☐ YES ☐ NO *(If "YES," please submit VA Form 21P-0969)*

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

☐ YES ☑ NO *(If "YES," please submit VA Form 21P-0969 and ONLY report your Social Security Income below)*

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C., by questions 9A through 9G, we only require Social Security income reported below. All other income should be reported on VA Form 21P-0969. Income will be counted as reported, do not duplicate.

NOTE: If reporting income in 9H through 9K, any items skipped or left blank will be considered as an unspecified income and could require a request for further information, potentially delaying your claim. If you leave the entire question blank, we will assume you have no income to report.

9H(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9H(2) PLEASE SPECIFY THE TYPE OF INCOME *(Specify name of institution)*	9H(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☑ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	☑ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	**Social Security** 9H(4) CURRENT GROSS MONTHLY $ **1,523.90**

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS *(Continued)*

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9I(2) PLEASE SPECIFY THE TYPE OF INCOME *(Specify name of institution)*	9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☑ SPOUSE ☐ CHILD *(Specify)*	☑ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	**Social Security** 9I(4) CURRENT GROSS MONTHLY $ **982.90**
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9J(2) PLEASE SPECIFY THE TYPE OF INCOME *(Specify name of institution)*	9J(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9J(4) CURRENT GROSS MONTHLY $
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9K(2) PLEASE SPECIFY THE TYPE OF INCOME *(Specify name of institution)*	9K(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9K(4) CURRENT GROSS MONTHLY $

SECTION X: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses that you expect to pay indefinitely (including the Medicare deduction) for yourself, any claimed dependents who are under your obligation for support, or any relatives who are members of your household. In some circumstances we can consider medical expenses up to one year prior to your initial date of entitlement. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you or your dependents were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If more space is needed, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?
☑ YES ☐ NO *(If "NO," skip to Section XI)*

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed in questions 10B through 10J. Do not include expenses paid by other family members, insurance, etc.

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or residential care, adult daycare, or similar care facility, you must complete the applicable worksheet(s) on **pages 16 and 17** for each provider.

10B(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10B(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10B(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	☐ CARE FACILITY ☐ IN-HOME CARE ATTENDANT	$ PER HOUR HOURS WORKED PER WEEK

10B(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10B(5). PAYMENT FREQUENCY	10B(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	$

10C(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10C(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10C(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	☐ CARE FACILITY ☐ IN-HOME CARE ATTENDANT	$ PER HOUR HOURS WORKED PER WEEK

10C(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10C(5). PAYMENT FREQUENCY	10C(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	$

IN-HOME CARE OR CARE FACILITY *(Continued)*

10D(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10D(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10D(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	☐ CARE FACILITY ☐ IN-HOME CARE ATTENDANT	$ PER HOUR HOURS WORKED PER WEEK

10D(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10D(5). PAYMENT FREQUENCY	10D(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	$

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES

10E(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10E(2) PAID TO (Name of Provider, Insurance Company, etc.)	10E(4) DATE COSTS PAID *(MM/DD/YYYY)*
☑ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	**Social Security** 10E(3) PURPOSE (Insurance premium, medical supplies, etc.) **Part B**	10E(5) PAYMENT FREQUENCY ☑ MONTHLY ☐ ANNUALLY ☐ ONE-TIME 10E(6) AMOUNT YOU PAY *(Based on Frequency selected)* $ **174.70**

10F(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10F(2) PAID TO (Name of Provider, Insurance Company, etc.)	10F(4) DATE COSTS PAID *(MM/DD/YYYY)*
☐ VETERAN ☑ SPOUSE ☐ CHILD *(Specify)*	**Social Seurity** 10F(3) PURPOSE (Insurance premium, medical supplies, etc.) **Part B**	10F(5) PAYMENT FREQUENCY ☑ MONTHLY ☐ ANNUALLY ☐ ONE-TIME 10F(6) AMOUNT YOU PAY *(Based on Frequency selected)* $ **174.70**

10G(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10G(2) PAID TO (Name of Provider, Insurance Company, etc.)	10G(4) DATE COSTS PAID *(MM/DD/YYYY)*
☑ VETERAN ☑ SPOUSE ☐ CHILD *(Specify)*	**Blue Cross Blue Shield** 10G(3) PURPOSE (Insurance premium, medical supplies, etc.) **Insurance Premium**	10G(5) PAYMENT FREQUENCY ☑ MONTHLY ☐ ANNUALLY ☐ ONE-TIME 10G(6) AMOUNT YOU PAY *(Based on Frequency selected)* $ **245.00**

10H(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10H(2) PAID TO (Name of Provider, Insurance Company, etc.)	10H(4) DATE COSTS PAID *(MM/DD/YYYY)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	10H(3) PURPOSE (Insurance premium, medical supplies, etc.)	10H(5) PAYMENT FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME 10H(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

10I(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10I(2) PAID TO (Name of Provider, Insurance Company, etc.)	10I(4) DATE COSTS PAID *(MM/DD/YYYY)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)*	10I(3) PURPOSE (Insurance premium, medical supplies, etc.)	10I(5) PAYMENT FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME 10I(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES *(Continued)*

10J(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10J(2) PAID TO (Name of Provider, Insurance Company, etc.)	10J(4) DATE COSTS PAID *(MM/DD/YYYY)*
☐ VETERAN ☐ SPOUSE ☐ CHILD *(Specify)* _____	10J(3) PURPOSE (Insurance premium, medical supplies, etc.)	10J(5) PAYMENT FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ ONE-TIME 10J(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

SECTION XI: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and attach either a voided personal check or a deposit slip**. If you **do not** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP) and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit sent)*
Bank of the West

11B. TYPE OF ACCOUNT *(Check the appropriate box and provide the account number or simply write "Established," if you have a direct deposit with VA.)*
☑ CHECKING ☐ SAVINGS ☐ I CERTIFY I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

11C. ROUTING NUMBER	11D. ACCOUNT NO.
987654321	**12548**

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

I CERTIFY THAT AND AUTHORIZE the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency to give the Department of Veterans Affairs any information about me and waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Pension Benefits.

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA Medical Center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in item 12A indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

12A. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

12B. SIGNATURE OR MARK	12C. DATE SIGNED *(MM/DD/YYYY)*
	05-06-2024

SECTION XIII: WITNESSES TO SIGNATURE

(TWO (2) WITNESS SIGNATURES ARE REQUIRED IF THE CLAIMANT SIGNED ITEM 12B WITH AN "X")

13A. SIGNATURE OF THE FIRST WITNESS *(If claimant signed above using an "X")*	13B. PRINTED NAME AND ADDRESS OF FIRST WITNESS Name: Address:
13C. SIGNATURE OF THE SECOND WITNESS *(If claimant signed above using an "X")*	13D. PRINTED NAME AND ADDRESS OF SECOND WITNESS Name: Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE *(NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)*

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; OR, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; OR, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; OR, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; AND, that the claimant is under the age of 18; OR, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; OR, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED *(MM/DD/YYYY)*
	05-06-2024

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.

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the federal register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA Benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 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.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestion about this form.

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/Postal Code

7. WHAT IS THE FACILITY'S WEBSITE 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, PLEASE CHECK THE BOX IF THE 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 dangerous incidents 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)*

05-06-2024

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/Postal Code

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES 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 dangerous incidents 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)*

05-06-2024

OMB Control No. 2900-0829
Respondent Burden: 30 minutes
Expiration Date: 11/30/2026

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME (First, Middle Initial (M.I.), Last)

First: **Joe** MI: **P** Last: **Veteran**

1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VETERAN'S FILE NUMBER (If known)
123-23-3456	**123233456**

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION (If you are the Veteran, skip questions 2A and 2B)

2A. CLAIMANT'S NAME (First, Middle Initial (M.I.), Last)

First: MI: Last:

2B. CLAIMANT'S SOCIAL SECURITY NUMBER	2C. CLAIMANT'S TELEPHONE NUMBER (If known)

2D. TYPE OF CLAIMANT (Check only one box)

☑ VETERAN ☐ SURVIVING SPOUSE ☐ SURVIVING CHILD ☐ PARENT ☐ CUSTODIAN OF CHILD BENEFICIARY

This form is designed to provide VA with your income and net worth during a specific date range to determine your eligibility or adjust your benefits. If you are submitting an initial application, report current information. Your effective date is typically the earliest of the following dates:

- Date VA receives your application
- Date VA receives your intent to file
- Date of Veteran's death (Survivor's Benefits only)

If you are submitting this form as a response to VA correspondence, report your income and net worth information during the date range specified in that correspondence. If you are reporting an income change, report changes from the date the change took effect.

NOTE: Submit a separate VA Form 21P-0969 if reporting income and net worth information for additional date ranges.

2E. THE INFORMATION ON THIS FORM REPRESENTS INCOME AND NET WORTH FOR THE FOLLOWING PERIOD:

01-01-2021 THROUGH **01-01-2024** -OR- ☐ DATE RECEIVED BY VA (For initial claims only.)

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (See instructions on Page 2)

3A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS FROM SOURCES NOT RELATED TO AN ACCOUNT OR YOUR ASSETS?

☐ YES ☐ NO (If NO, skip to Section IV)

3B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME

☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT ☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME

☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT ☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (Continued)
(See instructions on Page 2)

3D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3E.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3F.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS
(See instructions on Page 2)

4A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS THAT IS RELATED TO FINANCIAL ACCOUNTS?

☐ YES ☐ NO (If NO, skip to Section V)

4B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$

4C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$

4D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS (Continued)
(See instructions on Page 2)

4E.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED

☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME

$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT

$

4F.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED

☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME

$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT

$

SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS
(See instructions on Page 2)

5A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS GENERATED BY OWNED PROPERTY OR OTHER PHYSICAL ASSETS?

☐ YES ☐ NO (If NO, skip to Section VI)

5B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED

☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

5C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED

☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

5D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED

☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES
(See instructions on Page 2)

6A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES?

☐ YES ☐ NO (If NO, skip to Section VII)

6B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET

☐ BENEFITS FROM INTELLECTUAL PROPERTY ☐ EXTRACTION OF MINERALS/LUMBER ☐ USE OF LAND
☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME	(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET	(6). CAN THE ASSET BE SOLD?
$	$	☐ YES ☐ NO

(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET

6C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET

☐ BENEFITS FROM INTELLECTUAL PROPERTY ☐ EXTRACTION OF MINERALS/LUMBER ☐ USE OF LAND
☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME	(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET	(6). CAN THE ASSET BE SOLD?
$	$	☐ YES ☐ NO

(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET

SECTION VII: ASSET TRANSFERS
(See instructions on Page 2)

7A. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ANY ASSETS?

☐ YES ☐ NO (If NO, skip to Section VIII)

7B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED

☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?

☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?

$

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)

$

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?

☐ YES ☐ NO

$

SECTION VII: ASSET TRANSFERS (Continued)
(See instructions on Page 2)

7C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED
☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?
☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?
$

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)
$

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)
$

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?
☐ YES ☐ NO

7D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED
☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?
☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?
$

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)
$

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)
$

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?
☐ YES ☐ NO

SECTION VIII: TRUSTS
(See instructions on Page 2)

8A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED A TRUST OR DO YOU OR YOUR DEPENDENTS HAVE ACCESS TO A TRUST? (If you have more than one trust to report, submit the information on a separate VA Form 21P-0969 or provide the information on VA Form 21-4138 for each trust established.)
☐ YES ☐ NO (If NO, skip to Section IX)

8B.DATE TRUST ESTABLISHED (MM/DD/YYYY)

8C.SPECIFY MARKET VALUE OF ALL ASSETS WITHIN THE TRUST AT TIME OF ESTABLISHEMENT
$

8D.SPECIFY TYPE OF TRUST ESTABLISHED
☐ REVOCABLE ☐ IRREVOCABLE
☐ BURIAL TRUST

8E.HAVE YOU ADDED FUNDS TO THE TRUST AFTER IT WAS ESTABLISHED?
☐ YES ☐ NO

8F.WHEN DID YOU ADD FUNDS? (MM/DD/YYYY) (If more than one date, submit a VA Form 21-4138 with all dates and amounts)

8G.HOW MUCH DID YOU ADD?
$

8H.ARE YOU RECEIVING INCOME FROM THE TRUST?
☐ YES ☐ NO

8I.HOW MUCH DO YOU RECEIVE ANNUALLY?
$

8J.IS THE TRUST BEING USED TO PAY FOR OR TO REIMBURSE SOMEONE ELSE FOR YOUR MEDICAL EXPENSES? (Such as a guardian, family member or other service provider)
☐ YES ☐ NO

8K.HOW MUCH IS BEING REIMBURSED MONTHLY?
$

8L.WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?
☐ YES ☐ NO

8M.DO YOU HAVE ANY ADDITIONAL AUTHORITY OR CONTROL OF THE TRUST?
☐ YES ☐ NO

SECTION IX: ANNUITIES
(See instructions on Page 2)

9A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED AN ANNUITY? (If you have more than one annuity to report, submit the information below on a separate VA Form 21P-0969, or provide the below information on VA Form 21-4138 for each annuity established.)

☑ YES ☐ NO (If NO, skip to Section X)

9B.SPECIFY DATE ANNUITY WAS ESTABLISHED (MM/DD/YYYY)	9C.SPECIFY MARKET VALUE OF ASSET AT TIME OF ANNUITY PURCHASE	9D.HAVE YOU ADDED FUNDS TO THE ANNUITY IN THE CURRENT OR PRIOR THREE YEARS?
09-22-2001	$ **5000.00**	☐ YES ☑ NO
9E.WHEN DID YOU ADD FUNDS? (MM/DD/YYYY)	9F.HOW MUCH DID YOU ADD?	9G.IS THE ANNUITY REVOCABLE OR IRREVOCABLE?
	$	☐ REVOCABLE ☑ IRREVOCABLE
9H.DO YOU RECEIVE INCOME FROM THE ANNUITY?	9I.IF YES IN 9H, PROVIDE ANNUAL AMOUNT RECEIVED (If NO, skip to 9J)	
☐ YES ☑ NO	$	
9J.CAN THE ANNUITY BE LIQUIDATED?	9K.IF YES IN 9J, PROVIDE THE SURRENDER VALUE (If NO, skip to Section X)	
☐ YES ☑ NO	$	

SECTION X: ASSETS PREVIOUSLY NOT REPORTED
(See instructions on Page 2)

10A.DO YOU OR YOUR DEPENDENTS HAVE ASSETS NOT ALREADY REPORTED?

☐ YES ☐ NO (If NO, skip to Section XI)

10B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4).SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10C.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4).SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10D.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4).SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10E.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4).SPECIFY ASSET LOCATION (Financial institution, property address, etc.)

SECTION XI: DISCONTINUED OR IRREGULAR INCOME
(See instructions on Page 2)

11A. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME THAT HAS STOPPED OR IS NO LONGER BEING RECEIVED WITHIN: THE REPORTING PERIOD (From question 2E)? - **OR** - LAST FULL CALENDAR YEAR (For initial claim)?

☐ YES ☐ NO (If NO, skip to Section XII)

11B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD

☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)

(5). SPECIFY FREQUENCY OF INCOME RECEIVED

☐ RECURRING ☐ IRREGULAR

☐ ONE TIME PAYMENT

(6). DATE INCOME LAST RECEIVED (MM/DD/YYYY)

(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?

$

11C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD

☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)

(5). SPECIFY FREQUENCY OF INCOME RECEIVED

☐ RECURRING ☐ IRREGULAR

☐ ONE TIME PAYMENT

(6). DATE INCOME LAST RECEIVED (MM/DD/YYYY)

(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?

$

SECTION XII: WAIVER OF RECEIPT OF INCOME
(See instructions on Page 2)

12A. DID YOU OR YOUR DEPENDENTS WAIVE OR EXPECT TO WAIVE ANY RECEIPT OF INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ (If NO, skip to Section XIII Certification and Signature)

12B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD

☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE?

$

(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY)

☐ This income will not resume

(6). WAIVED GROSS MONTHLY INCOME

$

12C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD

☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE?

$

(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY)

☐ This income will not resume

(6). WAIVED GROSS MONTHLY INCOME

$

SECTION XIII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on the form are true and correct to the best of my knowledge and belief. **I UNDERSTAND THAT** without consent, the Department of Veterans Affairs (VA) may disclose information that I provide to entities under a published "routine use." Under such a routine use, the VA may disclose information to third party entities that participate in VA claims processing and are authorized to assist the VA in administering benefits; to other federal agencies under computer matching programs, such as those with the Internal Revenue Service, Social Security Administration, Selective Service System, Department of Homeland Security, Department of Justice; and to members of Congress if they are assisting to help with Veteran's benefit questions.

13A. SIGNATURE

13B. DATE SIGNED (MM/DD/YYYY)
04-16-2024

SECTION XIV: WITNESS TO SIGNATURE
(Two witness signatures are required if the claimant signed item 13A with an "X")

14A. SIGNATURE OF FIRST WITNESS (If claimant signed above using an "X")

14B. PRINTED NAME OF FIRST WITNESS

First: MI: Last:

14C. ADDRESS OF FIRST WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code

14D. SIGNATURE OF SECOND WITNESS (If claimant signed above using an "X")

14E. PRINTED NAME OF SECOND WITNESS

First: MI: Last:

14F. ADDRESS OF SECOND WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code

Where to Send Correspondence - After completing the form, mail to:
Department of Veterans Affairs
Pension Intake Center
P.O. Box 5365
Janesville, WI 53547-5365

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.

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 09/30/2026

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 on page 2. VA uses this form to determine eligibility for pension and aid and attendance benefits based on nursing home status. For more information you can contact us online through **Ask VA**: https://ask.va.gov, or call us toll-free at 1-800-827-1000 (TTY: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 checkbox to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. DATE OF BIRTH (MM/DD/YYYY)
123-23-3456	**123233456**	**09-08-1947**

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
Good Samaritan Society - Luther Manor

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

No. & Street **1500 W 38th St**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57105**

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?
11-15-2023	☑ YES ☐ NO

13. HAS THE PATIENT APPLIED FOR MEDICAID?	14A. IS THE PATIENT COVERED BY MEDICAID?	14B. DATE MEDICAID PLAN BEGAN (MM/DD/YYYY)
☑ YES ☐ NO	☑ YES ☐ NO (If "YES," complete Item 14B)	**01-23-2024**

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)
	04-16-2024

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.

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 Veteran Readiness 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: VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. 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.

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 02/28/2026

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

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 4. Use this form to determine eligibility for aid and attendance or housebound benefits. For more information, you can contact us online through Ask VA: https://ask.va.gov/. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms.

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 check box to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)
123-23-3456	**123233456**
4. VETERAN'S SERVICE NUMBER (If applicable)	5. DATE OF BIRTH (MM/DD/YYYY)
	09-08-1947

SECTION II: CLAIMAINT'S IDENTIFICATION INFORMATION

6. CLAIMANT'S NAME (First, Middle Initial, Last)
Joe P Veteran

7. CLAIMANT'S SOCIAL SECURITY NUMBER	8. RELATIONSHIP OF CLAIMANT TO VETERAN	9. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)
123-23-3456	☑ SELF ☐ PARENT ☐ SPOUSE ☐ CHILD	**09-08-1947**

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number

City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

11. TELEPHONE NUMBER (Optional) (Include Area Code)
(605)123-2345 Enter International Phone Number (If applicable)

12. EMAIL ADDRESS (Optional) ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III: CLAIM INFORMATION

13. SELECT ONE OF THE FOLLOWING BENEFITS (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 or Dependency Indemnity Compensation (DIC). 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 them from the hazards of their daily environment, or are housebound (substantially confined to their 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.

VETERAN'S SOCIAL SECURITY NUMBER **123-23-3456**

SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

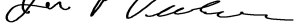
14A. IS THE CLAIMANT HOSPITALIZED?	14B. DATE ADMITTED (MM/DD/YYYY)
☐ YES (If "YES," complete Items 14B, 14C & 14D) ☑ NO (If "NO," skip to Section V)	

14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

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.

15A. VETERAN/CLAIMANT'S SIGNATURE (Required)	15B. DATE SIGNED (MM/DD/YYYY)
	**04-16-2024**

SECTION VI: EXAMINATION INFORMATION
(IMPORTANT: Remainder of form MUST be filled out by Examiner)

NOTE: Examiner **must be** a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.

16. DATE OF EXAMINATION (MM/DD/YYYY)

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veteran/claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. Please provide as much description as needed for each question as this will assist VA to determine if the disease(s) or injury(ies) listed may lead to physical or mental impairment, loss of coordination or enfeeblement that require assistance with daily living. 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 they ambulate, where they go, and what they are able to do during a typical day.

17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR EACH CONDITION (Diagnosis needs to equate to the level of assistance described in Items 26 through 37) (Describe below)

18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)

A.		**D.**	
B.		**E.**	
C.		**F.**	

19A. AGE	19B. WEIGHT	19C. HEIGHT
	ACTUAL: LBS. ESTIMATED: LBS.	FEET: INCHES:

20. NUTRITION	21. GAIT

22. BLOOD PRESSURE	23. PULSE RATE	24. RESPIRATORY RATE	25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

26. IF THE PATIENT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

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

27. DOES THE PATIENT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply)

- ☐ BATHING/SHOWERING
- ☐ TENDING TO HYGIENE NEEDS
- ☐ ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below)
- ☐ EATING OR SELF-FEEDING
- ☐ TRANSFERRING IN OR OUT OF BED/CHAIR
- ☐ DRESSING
- ☐ TOILETING
- ☐ AMBULATING WITHIN THE HOME OR LIVING AREA
- ☐ MEDICATION MANAGEMENT

28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)

- ☐ YES
- ☐ NO

29B. CORRECTED VISION

LEFT EYE	RIGHT EYE

29. DOES THE PATIENT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

- ☐ YES
- ☐ NO

30. IN YOUR JUDGMENT, DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYMENTS, OR ARE THEY ABLE TO DIRECT SOMEONE TO DO SO?

- ☐ YES
- ☐ NO

(If "NO," provide the disability(ies) that prevent them from performing this function and any rationale to support your conclusion in the space provided)

31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE

33. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. (**NOTE**: If indicated, comment specifically on weight bearing, balance and propulsion of each lower extremity)

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

35. DESCRIBE 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 PATIENT'S ABILITY TO PERFORM SELF-CARE, OR IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA

36. HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES (to include the level of assistance required) IS THE PATIENT ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES (Describe)

37. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION?

☐ YES (If "YES," check the applicable box or specify distance) ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER (Specify distance) _____

☐ NO

SECTION VII: EXAMINER'S SIGNATURE

38. PRINTED NAME OF EXAMINER	39. TITLE OF EXAMINER
40. SIGNATURE OF EXAMINER (REQUIRED)	41. DATE SIGNED (MM/DD/YYYY) **04-16-2024**

42. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER OF EXAMINER

43. NAME OF MEDICAL FACILITY

44. ADDRESS OF MEDICAL FACILITY (Number and street or rural route, city, state, ZIP Code and Country)

45. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)
Enter International Phone Number (If applicable)

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.

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 website 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.

OMB Control No. 2900-0161
Respondent Burden: 30 minutes
Expiration Date: 10/31/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

MEDICAL EXPENSE REPORT

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1A. NAME OF VETERAN (First, Middle Initial, Last)

FIRST: MI: LAST:

1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VA FILE NUMBER (If applicable)

SECTION II: CLAIMANT'S CONTACT INFORMATION

2A. NAME OF CLAIMANT (First, Middle Initial, Last - if different from veteran)

FIRST: MI: LAST:

2B. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code, and Country)

No. and Street Apt./Unit Number

City State/Province Country Zip Code/Postal Code

2C. PRIMARY TELEPHONE NUMBER (Include Area Code)

International Telephone Number (If applicable) _____

2D. CLAIMANT'S EMAIL ADDRESS (Optional)

SECTION III: REPORTING PERIOD

This form is designed to provide VA with your medical expenses paid during a specific date range to determine or adjust your benefits. If you are submitting an initial application, please only report medical expenses paid on or after your effective date. Your effective date is typically the earliest of the following dates:

- Date VA receives your initial application
- Date VA receives your VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*
- Date of the veteran's death (for Survivors Pension, if within one year of the veteran's death)

If you are already in receipt of pension benefits, report medical expenses you paid on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX). If you are responding to a letter that identifies a specific date range, please report medical expenses you paid during the requested period(s).
NOTE: Submit separate VA Form 21P-8416's if reporting information for additional date ranges beyond a 1-year period.

3. THE INFORMATION SHOWN BELOW REPRESENTS MEDICAL EXPENSES PAID DURING THE FOLLOWING DATE RANGE:

Report amounts paid between the dates _____ and _____ - OR- ☐ DATE RECEIVED BY VA (For initial applications only)

SECTION IV: IN-HOME CARE AND CARE FACILITY EXPENSES

IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on **pages 9 and 10**, in addition to completion of this section. If you are reporting a nursing home found under the "Nursing homes including rehab services" section of the https://www.medicare.gov/care-compare" website, you must submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*, instead of a worksheet.

4A (1). WHOSE EXPENSES WERE PAID?	4A. (3) PROVIDER START AND END DATE (MM/DD/YYYY)
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	START: **NOTE**: If care is ongoing leave end date blank.
4A (2). NAME OF PROVIDER	END:

4A (4). AMOUNT PAID MONTHLY	4A (5). IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
$	Payment Rate (Per Hour) $ .00 Average Hours Worked (Per Week)

4B (1). WHOSE EXPENSES WERE PAID?	4B. (3) PROVIDER START AND END DATE (MM/DD/YYYY)
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	START: **NOTE**: If care is ongoing leave end date blank.
4B (2). NAME OF PROVIDER	END:

4B (4). AMOUNT PAID MONTHLY	4B (5). IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
$	Payment Rate (Per Hour) $ .00 Average Hours Worked (Per Week)

NOTE: If you have additional in-home care or care facility expenses, complete Addendum A: In-Home Care or Care Facility Expenses on page 6.

SECTION V: OTHER MEDICAL EXPENSES

DO NOT report your monthly recurring expenses on multiple lines; rather, report recurring expenses on one line. For recurring expenses include the specific dates the recurring expense started and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. If a recurring expense has already terminated, please treat the expense as non-recurring.
Non-recurring expenses must be reported individually on separate lines. Prescription medications are generally not considered recurring.

NOTE: A new VA Form 21P-8416 submitted without reporting a previously counted continuing medical expense may result in removal of the medical expense from the date of receipt of the form.

5A (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5A (2). DATE COSTS PAID (MM/DD/YYYY)	5A. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5A. (4). PAYMENT AMOUNT $
5A. (5). PAID TO (Name of provider, insurance company, etc.)	5A. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5B (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5B (2). DATE COSTS PAID (MM/DD/YYYY)	5B. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5B. (4). PAYMENT AMOUNT $
5B. (5). PAID TO (Name of provider, insurance company, etc.)	5B. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5C (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5C (2). DATE COSTS PAID (MM/DD/YYYY)	5C. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5C. (4). PAYMENT AMOUNT $
5C. (5). PAID TO (Name of provider, insurance company, etc.)	5C. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5D (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5D (2). DATE COSTS PAID (MM/DD/YYYY)	5D. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5D. (4). PAYMENT AMOUNT $
5D. (5). PAID TO (Name of provider, insurance company, etc.)	5D. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5E (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5E (2). DATE COSTS PAID (MM/DD/YYYY)	5E. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5E. (4). PAYMENT AMOUNT $
5E. (5). PAID TO (Name of provider, insurance company, etc.)	5E. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5F (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5F (2). DATE COSTS PAID (MM/DD/YYYY)	5F. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5F. (4). PAYMENT AMOUNT $
5F. (5). PAID TO (Name of provider, insurance company, etc.)	5F. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5G (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5G (2). DATE COSTS PAID (MM/DD/YYYY)	5G. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5G. (4). PAYMENT AMOUNT $
5G. (5). PAID TO (Name of provider, insurance company, etc.)	5G. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

NOTE: If you have additional medical expenses to report, complete Addendum B: Other Medical Expenses on page 7.

SECTION VI: MILEAGE

Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in Section III of this form.

6A. (1). WHO NEEDED TO TRAVEL? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6A. (3). TOTAL MILES TRAVELED	6A. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year
6A. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6A. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
6B. (1). WHO NEEDED TO TRAVEL? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6B. (3). TOTAL MILES TRAVELED	6B. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year
6B. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6B. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
6C. (1). WHO NEEDED TO TRAVEL? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6C. (3). TOTAL MILES TRAVELED	6C. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year
6C. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6C. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
6D. (1). WHO NEEDED TO TRAVEL? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6D. (3). TOTAL MILES TRAVELED	6D. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year
6D. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6D. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $

NOTE: If you have additional mileage reimbursement to report, complete Addendum C: Mileage for Privately Owned Vehicle Travel for Medical Purposes on page 8.

SECTION VII: CERTIFICATION AND SIGNATURE

CERTIFICATION: I **have not** and **will not** receive reimbursement for these expenses. I certify the information contained on this form and the attached addendums is a true representation of expenses I have paid.

7A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE	7B. DATE SIGNED (MM/DD/YYYY)

SECTION VIII: WITNESS TO SIGNATURE
(Two witness signatures are required if claimant signed 7A with an "X")

8A. PRINTED NAME OF FIRST WITNESS (**NOTE**: Only to be used if claimant signed in 7A using an "X")	8B. SIGNATURE OF FIRST WITNESS (**NOTE**: Only to be used if claimant signed in 7A using an "X")

8C. MAILING ADDRESS OF FIRST WITNESS

No. and Street — Apt./Unit Number

City — State/Province — Country — Zip Code/Postal Code

8D. PRINTED NAME OF SECOND WITNESS (**NOTE**: Only to be used if claimant signed in 7A using an "X")	8E. SIGNATURE OF SECOND WITNESS (**NOTE**: Only to be used if claimant signed in 7A using an "X")

8F. MAILING ADDRESS OF SECOND WITNESS

No. and Street — Apt./Unit Number

City — State/Province — Country — Zip Code/Postal Code

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 payment to which you are not entitled.

ADDENDUM A: IN-HOME CARE OR CARE FACILITY EXPENSES

If you are not claiming expenses related to a care facility or from an in-home care provider, completion of Addendum A is not required.

IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on pages **9 and 10**, in addition to completion of this section. If you are reporting a nursing home, you must submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*.

1A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

1B. NAME OF PROVIDER

1C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

1D. AMOUNT PAID MONTHLY
$

1E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

2A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

2B. NAME OF PROVIDER

2C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

2D. AMOUNT PAID MONTHLY
$

2E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

3A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

3B. NAME OF PROVIDER

3C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

3D. AMOUNT PAID MONTHLY
$

3E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

4A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

4B. NAME OF PROVIDER

4C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

4D. AMOUNT PAID MONTHLY
$

4E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

5A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

5B. NAME OF PROVIDER

5C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

5D. AMOUNT PAID MONTHLY
$

5E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

6A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

6B. NAME OF PROVIDER

6C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

6D. AMOUNT PAID MONTHLY
$

6E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

ADDENDUM B: OTHER MEDICAL EXPENSES

If you are not claiming additional expenses, completion of Addendum B is not required.

Please report your monthly recurring expenses that are not reported in other sections on one line, including the specific dates the recurring expense started, and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. Prescription medications are generally not considered recurring. If a recurring expense has already stopped, please treat the expense as non-recurring and report a total amount paid during the designated time period

NOTE: A new VA Form 21P-8416 submitted without reporting a previously counted continuing medical expense may result in removal of the medical expense from the date of receipt of the form.

1A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
1B. DATE COSTS PAID (MM/DD/YYYY)	1C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	1D. PAYMENT AMOUNT $
1E. PAID TO (Name of provider, insurance company, etc.)	1F. PURPOSE (Insurance premium, medical supplies, etc.)	
2A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
2B. DATE COSTS PAID (MM/DD/YYYY)	2C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	2D. PAYMENT AMOUNT $
2E. PAID TO (Name of provider, insurance company, etc.)	2F. PURPOSE (Insurance premium, medical supplies, etc.)	
3A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
3B. DATE COSTS PAID (MM/DD/YYYY)	3C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	3D. PAYMENT AMOUNT $
3E. PAID TO (Name of provider, insurance company, etc.)	3F. PURPOSE (Insurance premium, medical supplies, etc.)	
4A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
4B. DATE COSTS PAID (MM/DD/YYYY)	4C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	4D. PAYMENT AMOUNT $
4E. PAID TO (Name of provider, insurance company, etc.)	4F. PURPOSE (Insurance premium, medical supplies, etc.)	
5A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
5B. DATE COSTS PAID (MM/DD/YYYY)	5C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	5D. PAYMENT AMOUNT $
5E. PAID TO (Name of provider, insurance company, etc.)	5F. PURPOSE (Insurance premium, medical supplies, etc.)	
6A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
6B. DATE COSTS PAID (MM/DD/YYYY)	6C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	6D. PAYMENT AMOUNT $
6E. PAID TO (Name of provider, insurance company, etc.)	6F. PURPOSE (Insurance premium, medical supplies, etc.)	
7A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
7B. DATE COSTS PAID (MM/DD/YYYY)	7C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	7D. PAYMENT AMOUNT $
7E. PAID TO (Name of provider, insurance company, etc.)	7F. PURPOSE (Insurance premium, medical supplies, etc.)	

ADDENDUM C: MILEAGE FOR PRIVATELY OWNED VEHICLE TRAVEL FOR MEDICAL PURPOSES

Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in Section III of VA Form 21P-8416, *Medical Expense Report* submitted with this addendum.

1A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	1C. TOTAL MILES TRAVELED	1D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
1B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		1E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
2A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	2C. TOTAL MILES TRAVELED	2D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
2B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		2E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
3A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	3C. TOTAL MILES TRAVELED	3D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
3B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		3E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
4A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	4C. TOTAL MILES TRAVELED	4D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
4B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		4E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
5A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	5C. TOTAL MILES TRAVELED	5D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
5B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		5E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
6A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6C. TOTAL MILES TRAVELED	6D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
6B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
7A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	7C. TOTAL MILES TRAVELED	7D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
7B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		7E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
8A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	8C. TOTAL MILES TRAVELED	8D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
8B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		8E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $

NOTE: If needed, you can complete and submit additional copies of Addendum C.

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 WEBSITE 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)

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)

Death/Survivor's Pension Quick Reference Sheet

Pension based on deceased veteran's service and survivor's income.

Eligibility

Veteran must have served at least 90 consecutive days (prior to September 7, 1980), one day of which was during a period of war. After September 7, 1980, enlisted veteran's must have served 24 months of continuous active duty or the full period for which they were called to active duty. All veterans, including officers, entering active duty after October 16, 1981 must have 24 months of continuous active duty. Service must have been terminated by discharge or separation under conditions other than dishonorable. Surviving spouse must have been married to veteran at time of his death and not have remarried.

Filing Deadline - N/A

Income Requirements

This is an income based payment intended to bring surviving spouse/children up to a minimum standard of living. VA counts the claimant's income and assets as well as any dependents living in the home. The table below shows the more common countable/non-countable income. See 38 CFR 3.272 for list of excluded income.

Income Counted	Income Not Counted
Social Security, Private Pension, Annuities	Welfare (SSI, SNAP, LIHEAP, etc)
Workers Comp or Unemployment Insurance	Income Tax Refunds
Gains from Gambling	Interest on IRAs
Income from Joint Accounts	VA Burial Benefits
Income from Earnings (interest)	Reverse Mortgage Payments
Life Insurance	Home Equity Line

Deductible Expenses

Expenses that can be deducted against countable income include: Medicare premiums, private medical insurance premiums, and out of pocket un-reimbursed medical expenses (UME). Be sure to include any payments for other recurring expenses such as nursing home costs as well as the final expenses of veteran, to include funeral.

Misc. Information - Works the same as if a veteran applied for a pension although there is no disability/age requirement. However, the annual/monthly payout is less than a single veteran.

Forms to File:

21-22	POA and SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
21P-534EZ	Fill in all blanks
DD 214	Certified copy
21-4138	Statement if necessary
21P-8416	Medical Expense Report
21-2680	Examination for housebound or permanent need for regular A&A
21-0779	Request for Nursing Home Information
21P-0969	Income and Asset Statement (if applicable)

Survivors Pension for Spouse and Dependent Children Basic Eligibility Requirements (38 CFR 3.2 and 3.3)

Basic Eligibility Requirements
The eligibility requirements for survivors pension are very similar to those for veteran's pension. Their common requirements are:

- Period(s) of service (see first page of NSC pension section)
- Character of discharge (see first page of NSC pension section)
- Income/net worth criteria (see second page of NSC pension section)

NOTE: The one major difference between veteran's pension and survivors pension is that the widow or child applicant **does not have to be permanently and totally disabled.**

Application Documents

The claimant may apply by submitting the following forms:

- VA Form 21-22 'Appointment of Veterans Service Organization as Claimant's Representative'. This must be completed regardless of the fact that veteran had appointed an organization prior to his/her death. The appointment of an accredited representative is no long recognized once the claimant is deceased
- VA Form "Intent to File 21-0966" if applicable
- VA Form 21P-534EZ 'Application for DIC, Survivors Pension, and/or Accrued Benefits'
- VA Form 21P-0969 - Income and Asset Statement (if applicable)
- VA Form 21P-8416 'Request for information Concerning Medical, Legal or other Expenses' (The expenses listed on this form must have been paid by the widow for herself, for the veteran's last medical expenses and/or expenses of dependent children. These expenses must **NOT** have been reimbursed by insurance or other organization.
- Veteran's DD214 unless it is already a matter of record with the VA. If in doubt send at least a copy to start with. If the veteran had never established a claims file with VA it will be necessary to provide a certified copy of one with the application
- Marriage certificate, if not already a matter of record in the veteran's' C-file
- Death certificate for the veteran
- South Dakota Department of Veteran's Affairs Policy Statement
- Birth certificates for children under age 18 or under age 23 if still in school

Reporting Medical Expenses

If a surviving spouse files a claim within one year of the death, list the veteran's medical, legal or other expenses on VA Form 21P-8416 from the date the veteran died and projected out one year. **Example:** The veteran died on June 28, 2018. The surviving spouse should report all medical expenses paid from June 28, 2018, to December 31, 2018 and Jan 1, 2019 - ongoing.) The VA will not retroactively date a widow's pension award back one year because the widow would not have been a widow and therefore would not have been entitled to a death pension benefit.

Be sure to report any burial expenses, including the cost of a headstone or marker that the widow has paid. If the funeral is paid off in full at the time of the application submit a copy of a paid receipt from the funeral home. The receipt must state who paid the amount and the date of payment.

In the event that the veteran's funeral was paid by a pre-paid burial trust that the veteran and spouse paid into, the widow can still report the funeral expenses as the money they paid for the burial was pre-paid by the veteran and his/her spouse.

If the claim is filed more than one year after the death of the veteran, the surviving spouse can only claim expenses from the date of claim and forward one year.

Supplemental Survivors Pension Claim

To request re-instatement of the pension benefit the claimant may apply by filling out the following forms:

- VA Form 20-0995
- VA Form 21P-534 EZ 'Application for DIC, Death Pension, and/or Accrued Benefits'
- Enclosed voided check or deposit slip
- VA Form 21P-8416 'Medical Expense Report'. (The expenses listed on this form must have been paid by the widow for herself and expense of dependent children. These expenses must **NOT** be reimbursed by insurance or other organization
- VA Form 21-22 'Appointment of Veterans Service Organization as Claimant's Representative'. (If one is not already on file with the surviving spouses' signature for the organization the claimant is requesting representation from)
- South Dakota Department of Veterans Affairs Policy Statement, if not done already
- VA Form 21-0779 (Nursing Home)
- VA Form 21-2680 (Aid and Attendance and Housebound)
- VA Form 21P-0969 - Income and Asset Statement (if applicable)

Special Monthly Pension

Special monthly pension may be payable to veterans or surviving spouses who are in receipt of, or eligible to receive, pension benefits. This special monthly allowance is in addition to the basic pension award.

Housebound (38 CFR 3.351)

Housebound benefits may be payable to a veteran or a surviving spouse who is substantially confined to his or her home and the immediate premises or, if institutionalized, to the ward or clinical areas and it is reasonably certain that the disability or disabilities and resultant confinement will continue throughout his or her lifetime.

Application documents

If the veteran's, spouse or surviving spouse is currently receiving pension benefits the following forms need to be submitted:

- VA Form 21-2680 - This form is completed by the veteran's physician and must be signed by a physician or the primary medical care provider
- VA Form 21P-8416 'Medical Expense Report'. Use if there are additional medical expenses that were not included in the veteran's or surviving spouse's pension award and/or EVR
- VA Form 21-4138 'Statement in Support of Claim'. Write a statement requesting the benefit and stating where the claimant is receiving medical care
- Care and Expense Statement (last two pages of the 534EZ)
- Copies of private medical records or VA Form 21-4142 and 21-4142a 'Authorization for Release of Information' if the claimant is receiving their primary medical care outside of the VA

Aid and Attendance (38 CFR 3.351)

The meaning of Aid and Attendance is:

- Inability of claimant to dress or undress self; or
- To keep him/herself ordinarily clean and presentable; or
- Frequent need to adjustment of any special prosthetic or orthopedic appliances which by reason of the particular disability cannot be done without aid (this will not include the adjustment of appliances which normal persons would be unable to adjust without aid, such as supports, belts, lacing at the back, etc;) or
- Inability of claimant to feed him/herself through loss of coordination of upper extremities or through extreme weakness; or
- Inability to attend to the needs of nature; or
- Incapacity, physical or mental, which requires care or assistance on a regular basis to protect the claimant from hazards or dangers incident to his or her daily environment; or
- Bedridden (defined as that condition which, through its essential character, actually requires that the claimant remain in bed)

It is not required that all of the conditions listed above be found to exist. The personal functions which the claimant is unable to perform should be considered in connection with his or her condition as a whole. It is only necessary that the evidence establishes the claimant is so helpless as to need regular aid and attendance, not that there be a constant need.

The fact that the claimant has voluntarily taken to bed or that a physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure will **NOT** suffice. Further, favorable determinations are **NOT** based solely upon an opinion that the claimant's condition is such as would require him or her to be in bed. It must be based on the actual requirement of personal assistance from others.

Eligibility Requirements

Aid and Attendance benefits may be payable to a veteran's or a surviving spouse of a veteran if:

- Claimant is a patient in a nursing home because of mental or physical incapacity; or
- Claimant is blind or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less; or
- Claimant establishes a factual need for aid and attendance of another within the definition of aid and attendance as defined above

The claimant does not have to be living in a nursing home to be granted Aid and Attendance. In the event that the claimant is living at home there is no presumption and Aid an Attendance must be decided by rating decision by the VA Rating Activity.

Assisted Living (38 CFR 3.351)

Veteran or surviving spouse in an assisted living facility can be granted aid and attendance by rating decision. Assisted living facilities do not warrant presumption of Aid and Attendance. Assisted living expenses can be used if the veteran or surviving spouse is on Aid and Attendance. Claimants in Assisted living facilities are not subject to the $90 pension rate.

Application Documents

If the veteran or surviving spouse is currently receiving pension and have been moved to the assisted living, the following forms need to be submitted:

- Care Expense Statement
- VA Form 21-2680 'Examination for Housebound Status or Permanent Need for Regular Aid and Attendance'
- VA Form 21P-8416 'Request 'Medical Expense Report' for information
- Concerning Medical, Legal or other Expenses'. Use this form if there are additional medical expenses that were not included in the veteran's or surviving spouse's pension award and/or EVR.
- VA Form 21-4138 'Statement in Support of Claim' – Request A&A due to nursing home care.
- If claimant is receiving or has been recently awarded Title 19 benefits you will need to submit the award letter from Department of Social Services. (See the section on Title 19 and Pension.)

Title 19 (Medicaid) Benefits for Claimants Living in a Nursing Home

Once a claimant who is receiving pension benefits begins receiving assistance from Title 19 (Medicaid program) the VA must be notified immediately. Pension awards will be reduced for a single veteran or single surviving spouse to $90 a month once they have been awarded Title 19 benefits. This reduction is mandated by 38 USC 5503, even if claimant is in receipt of housebound or aid and attendance. The reduced amount of pension will not be used to defray costs to the State Title 19 program. This money is strictly for the use of the veteran or surviving spouse for personal needs. In addition, the veteran or spouse will be allowed to also retain $60 of their social security by the Medicaid program. This money is also only for the personal needs of the claimant and can not be used by the state to defray Title 19 costs.

Please note that while Social Services does not count a claimant's Aid and Attendance allowance as income, the claimants pension award will still be reduced to the $90 rate.

A VA Form 21-4138, VA Form21P-8416, and a copy of the Title 19 award letter need to be submitted to the VA as notification by the claimant as soon as the award is made.

Eligibility Verification Report (EVR) (38 CFR 3.274 and 3.275)

Pension recipients need to report medical expenses each year if changes have been made. They must also notify the VA if their income has changed.

Also, on the EVR, claimants project what they anticipate paying out over the next year for medical expenses. Caution should be taken when projecting the medical expense due to the fact that the claimant will have to complete a medical expense report proving that they in fact paid that amount if not more during the year. Further, random selections of pension claims are made each year to provide proof of reported expenses.

Once on pension, individuals on fixed incomes such as Social Security would not submit an EVR each year. If the individual has unusual medical expenses during the year, the appropriate – Form along with a VA Form 21P-8416 should be submitted to recoup a portion of the medical expenses that were paid out of pocket by the claimant.

*****Please note: the VA can and does go into the Internal Revenue Service records to insure that a pension recipient has reported all income. If VA does an IRS match and finds income not reported, the claimant will get an overpayment and VA will take necessary action to collect any pension award that was overpaid. The VA can do a Social Security verification as well. If a claimant starts receiving Social Security benefits, and does not report it to the VA, they will have an overpayment from VA.**

In the event that a claimant does not in fact pay what they projected for medical expenses and the amount paid is less for the year, the VA will create an overpayment that the claimant will have to reimburse back to VA.

FDC Death Pension
21-22 & SDDVA Policy Statement and HIPAA Disclosure (VA Form 21-4142)
DD 214 - Certified
21P-534EZ – All blanks/ boxes must be filled out & 0 or none is placed in any unfilled boxes for Income
21P-0969 - Income and Asset Statement (if applicable)
Medical Records if Under 65
21P-8416 if more room needed for medical expenses
Death Certificate
Marriage/Divorce/Birth certificates

Copy of Voided Check or Deposit Slip
Medical Records if under 65

Special Monthly Pension
21-0779 (Nursing Home)
21-2680 (Aid and Attendance and Housebound, Assisted Living)
Any title XIX documentation

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 7/31/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

INSTRUCTIONS: Before completing the form, read the Privacy Act and Respondent Burden on Page 3. The VA Office of General Counsel maintains a list of all attorneys, claims agents, and Veterans Service Organization (VSO) representatives accredited by VA to assist in preparing, presenting, and prosecuting claims for VA benefits at: https://www.va.gov/ogc/apps/accreditation/index.asp. You can search this list by name, state, or zip code. We recommend you use the list to confirm and validate VA accreditation before signing any contract or appointing someone to represent you on your VA benefits claim. If you prefer to have an individual assist you with your claim instead of a VSO, complete VA Form 21-22a, Appointment of Individual as Claimant's Representative. For more information, you can contact us through Ask VA: https://ask.va.gov/, or call us toll-free at 1-800-827-1000 (TTY:711). VA forms are available at www.va.gov/vaforms. After completing the form, use the mailing addresses provided on Page 4.

SECTION I: VETERAN'S 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 of the form.

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

Joe P Veteran

2. SOCIAL SECURITY NUMBER *(SSN)*	3. VA FILE NUMBER *(If applicable)*	4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
123-23-3456	**123233456**	Month **09** - Day **08** - Year **1947**

5. VETERAN'S SERVICE NUMBER *(If applicable)*	6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

8. TELEPHONE NUMBER *(Include Area Code)*	9. EMAIL ADDRESS *(Optional)*
(605)123-2345	

SECTION II: CLAIMANT'S INFORMATION *(If other than veteran)*

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

11A. CLAIMANT'S DATE OF BIRTH	11B. RELATIONSHIP TO VETERAN
Month - Day - Year	

12. CURRENT 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 **US** ZIP Code/Postal Code

13. TELEPHONE NUMBER *(Include Area Code)*	14. EMAIL ADDRESS *(Optional)*

SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

038 - South Dakota Department of Veterans Affairs

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*	16B. JOB TITLE OF PERSON NAMED IN ITEM 16A
Kevin Swanson	**Veterans Service Officer**
17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15	18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*
statevso.mailbox@va.gov	**03-28-2024**

SECTION IV: AUTHORIZATION INFORMATION

19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C. - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☑ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

20. LIMITATION OF CONSENT- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☑ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 19 and 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

SECTION V: SIGNATURES

NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

22A. SIGNATURE OF VETERAN OR CLAIMANT (**Required**)	22B. DATE SIGNED *(MM/DD/YYYY)*
Jon P Vuckovich	**03-28-2024**
23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (**Required**)	23B. DATE SIGNED *(MM/DD/YYYY)*
[signature]	**03-28-2024**

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

	COPY OF VA FORM 21-22 SENT TO:	DATE SENT *(MM/DD/YYYY)*	ACKNOWLEDGED *(Date) (MM/DD/YYYY)*	REVOKED *(Reason and date (MM/DD/YYYY))*
VA USE ONLY	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

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.

South Dakota Division of Veteran Affairs
Policy Statement for Representation

Thank you for choosing the South Dakota Department of Veterans Affairs (SDDVA) to assist you with your claim for benefits from the United States Department of Veterans Affairs (VA). The SDDVA serves as the accredited representative for the following organizations.

American Legion	SD Department of Veteran Affairs
Veterans of Foreign Wars of the United States	The Retired Enlisted Association

We can best serve your interest if you work directly with our Service Officers and/or your local County/Tribal Veterans Service Officer. The purpose of having a representative is to have an advocate skilled in veterans' benefits, working for you, and involved in every step of the claims process. Please do not take any action directly with the VA, and do not try to work the claim yourself. You must understand that the SDDVA and your local Veterans Service Officer is not responsible for any actions taken by the claimant directly with the VA. Let us help you.

What You Need to Do to Assist SDDVA

- Be truthful with your VSO and the VA at all times.
- Provide adequate information in a timely manner whenever requested by the VSO or the VA.
- Be alert for time-sensitive deadlines.
- Provide any and all legal documentation or evidence required for the processing of your claim directly to our office.
- Report to all examinations requested by the VA.
- Reply to any VA requests for information through our office.
- Notify us immediately of any change in your address and/or telephone number.

What SDDVA Will Do For You

As your advocate, we will review the facts and circumstances of your claim and develop it for presentation to the VA. We will ensure that your claim is properly filed and will monitor it as it proceeds through the VA claims process. We will advise you of significant developments with respect to your claim and do all we ethically can to see that your claim is decided in your favor. If the VA decides against you, we will, at your request, advise you about the appellate process and, based on controlling laws and regulations, the probable outcome of your particular case. The decision to appeal is your decision and right, but it is vital that you fully understand the process. We will capture your electronic signature and with your permission respond to VA development on your behalf.

We are pleased to serve as your representative; however, we will withdraw representation if you:

- Threaten abuse, mistreat, or harass any employee of the SDDVA or affiliated VSO
- Knowingly present a fraudulent claim or provide false information
- Initiate any action that would result in a conflict of interest in pursuing benefits with the VA
- Fail to cooperate with SDDVA or affiliated VSO in the prosecution of your claim
- Create or become involved in any situation that makes it inappropriate for SDDVA to continue as your representative.

Your understanding and cooperation with the SDDVA's policy for representation is appreciated. Be assured that our Service Officers want to assist you and that we will work hard for you. We appreciate the confidence you have placed in the SDDVA.

	**123233456**	Name: **Kevin Swanson** Title: **Veterans Service Officer**	**04-16-2024**
Applicant	Claim #	Veterans Service Officer	Date

Revised 2022

OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: 07/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 18. Use this form to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. For additional information or questions contact us online at https://www.va.gov/contact-us or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms. If submitting by mail, send completed form to: **Department of Veterans Affairs, Pension Intake Center, P.O. Box 5365, Janesville, WI 53547-5365**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

NOTE: You may *either* complete the form by typing the information in on the computer or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1A. VETERAN'S NAME (First, Middle Initial, Last)
Joe P Veteran

1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VETERAN'S DATE OF BIRTH (MM/DD/YYYY)	1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?
123-23-3456	**09-08-1947**	☑ YES ☐ NO (If "YES," provide the file number in Item 1E)

1E. VA FILE NUMBER (If known)	1F. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?	1G. VETERAN'S SERVICE NUMBER
123233456	☐ YES ☑ NO	

1H. VETERAN'S DATE OF DEATH? (MM/DD/YYYY)
04-17-2024

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

2A. YOUR NAME (First, Middle Initial, Last)
Ann M Veteran

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)

☑ SURVIVING SPOUSE ☐ CHILD 18-23 IN SCHOOL ☐ CUSTODIAN FILING FOR CHILD UNDER 18 ☐ HELPLESS ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER	2D. YOUR DATE OF BIRTH (MM/DD/YYYY)	2E. ARE YOU A VETERAN?
666-66-6666	**09-03-1946**	☐ YES ☐ NO

2F. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

2G. YOUR TELEPHONE NUMBER (Include Area Code)
(605)123-2345 Enter International Phone Number (If applicable)

2H. E-MAIL ADDRESS (Optional)

2I. WHAT ARE YOU CLAIMING? (Check all that apply)

☑ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☐ SURVIVORS PENSION ☐ ACCRUED BENEFITS

SECTION III: VETERAN'S SERVICE INFORMATION

(Skip to Section IV if the veteran was receiving VA compensation or pension benefits at the time of their death)

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME?

☐ YES ☑ NO (If "YES," list other names the veteran served under below)

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)

3B. DATE VETERAN ENTERED ACTIVE DUTY (MM/DD/YYYY)
01-01-1968

3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY)
09-30-1974

3D. BRANCH OF SERVICE
☑ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS
☐ COAST GUARD ☐ SPACE FORCE ☐ NOAA ☐ USPHS

3E. PLACE OF LAST SEPARATION
Ft. Lewis, WA

3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard)
☐ YES ☑ NO (If "NO," skip to Item 3J)

3G. DATE OF ACTIVATION (MM/DD/YYYY)

3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

3J. WAS THE VETERAN EVER A PRISONER OF WAR?
☐ YES ☑ NO (If "NO," skip to Section IV)

3K. DATES OF CONFINEMENT (MM/DD/YYYY)
START:
END:

SECTION IV: MARITAL INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?
☐ YES ☑ NO (If "YES," provide explanation below)

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF THE VETERAN'S DEATH?
☑ YES ☐ NO (If "NO," complete Item 4C)

4C. HOW DID YOUR MARRIAGE TO THE VETERAN END?
☑ DEATH ☐ DIVORCE ☐ OTHER (Explain)

4D. DATES OF YOUR MARRIAGE TO THE VETERAN (MM/DD/YYYY)
START: **10-15-1975**
END: **04-17-2024**

4E. PLACE OF MARRIAGE (City/State or Country)
Sioux Falls, SD

4F. PLACE OF MARRIAGE TERMINATION (City/State or Country)
Sioux Falls SD

4G. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.)
☑ CEREMONIAL ☐ OTHER (Explain):

4H. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?
☐ YES ☑ NO

4I. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?
☐ YES ☑ NO

4J. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF THE VETERAN'S DEATH?
☑ YES ☐ NO (If "YES," skip to Item 4L)

4K. WAS THE SEPARATION DUE TO MARITAL DISCORD, MEDICAL, OR FINANCIAL REASONS?
☐ YES ☐ NO (If "YES," provide explanation in space provided)
NOTE: Give, the reason, date(s), and duration of the separation
(If the separation was by court order, attach a copy of the order)

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4L. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?
☐ YES ☑ NO (If "NO," skip to Item 5A)

4M. WHAT ARE THE DATES OF YOUR REMARRIAGE? (MM/DD/YYYY)
START:
END:

4N. HOW DID YOUR REMARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ DID NOT END ☐ OTHER (Explain)

4O. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH?
☐ YES ☐ NO (If "YES," please submit a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for each marriage)

SECTION V: MARITAL HISTORY

TELL US ABOUT ANY OTHER MARRIAGES YOU AND/OR THE VETERAN HAD. IF YOU AND THE VETERAN DID NOT HAVE ANY ADDITIONAL MARRIAGES SKIP TO SECTION VI.

VETERAN'S PRIOR MARRIAGES (If none skip to Item 5L)

5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START:
END:

5D. PLACE OF MARRIAGE (City/State or Country)

5E. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START:
END:

5I. PLACE OF MARRIAGE (City/State or Country)

5J. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
☐ YES ☐ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN (If none skip to Section VI)

5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5M. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE?(MM/DD/YYYY)
START:
END:

5O. PLACE OF MARRIAGE (City/State or Country)

5P. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5R. HOW DID YOUR PREVIOUS MARRIAGE END?
☐ DEATH ☐ DIVORCE ☐ OTHER (Explain below)

5S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE?(MM/DD/YYYY)
START:
END:

5T. PLACE OF MARRIAGE (City/State or Country)

5U. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
☐ YES ☐ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

SECTION VI: CHILD OF THE VETERAN INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)
(Skip to Section VII if you are NOT claiming benefits for a child(ren) of the veteran)

NOTE: Please refer to instructions page 2, under "*Special Circumstances*" for what is considered a dependent child. In most circumstances, children over the age of 23 are not considered dependent for VA purposes.

6A. HOW MANY DEPENDENT CHILDREN DO YOU HAVE?
0 (**NOTE**: Please complete a VA Form 21-686c, *Application Request to Add and/or Remove Dependents*, if you need more space for additional dependents)

6B. CHILD'S NAME (First, Middle Initial, Last)

6C. CHILD'S DATE OF BIRTH (MM/DD/YYYY)	6D. CHILD'S SOCIAL SECURITY NUMBER

6E. PLACE OF BIRTH (City/State or Country)

6F. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT **$ .00**

6G. CHILD'S NAME (First, Middle Initial, Last)

6H. CHILD'S DATE OF BIRTH (MM/DD/YYYY)	6I. CHILD'S SOCIAL SECURITY NUMBER

6J. PLACE OF BIRTH (City/State or Country)

6K. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT **$ .00**

6L. CHILD'S NAME (First, Middle Initial, Last)

6M. CHILD'S DATE OF BIRTH (MM/DD/YYYY)	6N. CHILD'S SOCIAL SECURITY NUMBER

6O. PLACE OF BIRTH (City/State or Country)

6P. WHAT IS THE CHILD'S STATUS? (Check all that apply)

☐ BIOLOGICAL ☐ ADOPTED ☐ STEPCHILD ☐ 18-23 YEARS OLD (in school) ☐ SERIOUSLY DISABLED ☐ CHILD PREVIOUSLY MARRIED

☐ DOES NOT LIVE WITH YOU AND MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT **$ .00**

6Q. DO YOUR CHILDREN WHO DO NOT LIVE WITH YOU (If listed above) RESIDE AT THE SAME ADDRESS?

☐ YES ☐ NO (If "YES," please complete Item 6R) (If "NO," please complete a VA Form 21-4138, Statement in Support of Claim, with the following information. Name of person the child is currently living with, and the full address where the child resides)

6R. PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHILD(RENS) CUSTODIAN BELOW:
Custodian's Name (First, Middle Initial, Last)

Custodian's 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 VII: DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Skip to Section VIII if you are NOT claiming DIC)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

☐ DIC ☐ DIC under 38 U.S.C. 1151 (Note: DIC under 38 U.S.C. 1151 is a rare benefit. Please refer to Instructions page 5 for guidance on 38 U.S.C 1151) ☐ DIC due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 (PACT Act) (Note: Please refer to Instructions page 6 for guidance on PACT Act)

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES:

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
	START: END:
	START: END:
	START: END:

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

☐ YES ☑ NO *(If "YES," please complete a VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP/CRNP), or Clinical Nurse Specialist (CNS))*

8B. ARE YOU NOW IN A NURSING HOME?

☐ YES ☑ NO *(If "YES," complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance. For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC")* (If "NO," skip to Item 9A)

SECTION IX: INCOME AND ASSETS
(Skip to Section X if you are NOT claiming survivors pension benefits)

NOTE: **Assets** are all the money and property you or your dependents own. Assets ***do not*** include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

IMPORTANT:

- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER $25,000.00 IN ASSETS? (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)

☐ YES ☑ NO If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC))*

(If "No," provide an estimate of the total value of your assets below)

$

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)

☐ YES ☑ NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC))*

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

☐ YES ☑ NO (If "NO," skip to Item 9G)

9D. IS THE VALUE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

☐ YES ☐ NO (If "NO," skip to Item 9G)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF THE LAND OVER 2 ACRES?
(Do **NOT** include the value of the residence or the first 2 acres)

$

9F. IS THE LAND OVER 2 ACRES (87,120 SQ FT) MARKETABLE?

☐ YES ☐ NO (If "YES," please submit a VA Form 21P-0969)

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

☐ YES ☑ NO (If "YES," please submit a VA Form 21P-0969, and ONLY report your Social Security income in Item 9I)

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

☐ YES ☑ NO (If "YES," please submit a VA Form 21P-0969)

SECTION IX: INCOME AND ASSETS
(Skip to Section X if you are NOT claiming survivors pension benefits)

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9I(2) SPECIFY THE TYPE OF INCOME	9I(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☑ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☑ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9I(4) CURRENT GROSS MONTHLY INCOME **$ 884.00**
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9J(2) SPECIFY THE TYPE OF INCOME	9J(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9J(4) CURRENT GROSS MONTHLY INCOME **$**
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9K(2) SPECIFY THE TYPE OF INCOME	9K(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9K(4) CURRENT GROSS MONTHLY INCOME **$**
9L(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9L(2) SPECIFY THE TYPE OF INCOME	9L(3) SPECIFY INCOME PAYER *(Name of business, financial institution, etc.)*
☐ SURVIVING SPOUSE ☐ CHILD *(Specify)*	☐ SOCIAL SECURITY ☐ INTEREST/DIVIDENDS ☐ CIVIL SERVICE ☐ PENSION/RETIREMENT ☐ OTHER *(Specify type of income)*	9L(4) CURRENT GROSS MONTHLY INCOME **$**

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid.

Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child, educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES OR OTHER EXPENSES?

☑ YES ☐ NO (If "NO," skip to Section XI)

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10B (1). WHOSE EXPENSES WERE PAID?	10B (2). NAME OF PROVIDER AND TYPE OF CARE	10B (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) **$ .00** Hours Worked (Per Week)

10B (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10B (5). PAYMENT FREQUENCY	10B (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10B (5))
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	**$**

IN-HOME CARE OR CARE FACILITY (Continued)

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10C (1). WHOSE EXPENSES WERE PAID?	10C (2). NAME OF PROVIDER AND TYPE OF CARE	10C (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) **$ .00** Hours Worked (Per Week)

10C (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10C (5). PAYMENT FREQUENCY	10C (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10C (5))
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	**$**

10D (1). WHOSE EXPENSES WERE PAID?	10D (2). NAME OF PROVIDER AND TYPE OF CARE	10D (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
☐ SURVIVING SPOUSE ☐ OTHER (Specify below)	CHECK ONE: ☐ CARE FACILITY ☐ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) **$** .00 Hours Worked (Per Week)

10D (4). PROVIDER START AND END DATE (MM/DD/YYYY)	10D (5). PAYMENT FREQUENCY	10D (6). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10D (5))
START: END: ☐ NO END DATE	☐ MONTHLY ☐ ANNUALLY	**$**

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E (1). WHOSE EXPENSES WERE PAID? (Check one)	10E (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☑ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: **Cross Funeral Home** Purpose: **Burial**

10E (3). DATE COSTS PAID (MM/DD/YYYY)	10E (4). PAYMENT FREQUENCY	10E (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10E (4))
04-30-2024	☐ MONTHLY ☐ ANNUALLY ☑ ONE-TIME	**$ 10,538.00**

10F (1). WHOSE EXPENSES WERE PAID? (Check one)	10F (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☑ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: **Medicare Part B** Purpose:

10F (3). DATE COSTS PAID (MM/DD/YYYY)	10F (4). PAYMENT FREQUENCY	10F (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10F (4))
	☑ MONTHLY ☐ ANNUALLY ☐ ONE-TIME	**$ 174.70**

10G (1). WHOSE EXPENSES WERE PAID? (Check one)	10G (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
☑ SURVIVING SPOUSE ☐ VETERAN (LAST EXPENSE/BURIAL) ☐ CHILD *(Specify)*	Provider: **Blue Cross Blue Sheild** Purpose: **Insurance Premium**

10G (3). DATE COSTS PAID (MM/DD/YYYY)	10G (4). PAYMENT FREQUENCY	10G (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10G (4))
	☑ MONTHLY ☐ ANNUALLY ☐ ONE-TIME	**$ 154.82**

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES (Continued)

10H (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10H (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10H (3). DATE COSTS PAID (MM/DD/YYYY)

10H (4). PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY
☐ ONE-TIME

10H (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10H (4))
$

10I (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10I (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10I (3). DATE COSTS PAID (MM/DD/YYYY)

10I (4). PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY
☐ ONE-TIME

10I (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10I (4))
$

10J (1). WHOSE EXPENSES WERE PAID? (Check one)
- ☐ SURVIVING SPOUSE
- ☐ VETERAN (LAST EXPENSE/BURIAL)
- ☐ CHILD *(Specify)*

10J (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
Provider:
Purpose:

10J (3). DATE COSTS PAID (MM/DD/YYYY)

10J (4). PAYMENT FREQUENCY
☐ MONTHLY ☐ ANNUALLY
☐ ONE-TIME

10J (5). AMOUNT YOU PAY OR PAID (Based on frequency selected in Item 10J (4))
$

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and** attach either a voided personal check or a deposit slip. If you do not have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)
First Dakota National Bank

11B. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)
091400486

11C. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

☑ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.: **10102235698**

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

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

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 12A, indicating that I **DO NOT** want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

12A. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

☐ **I DO NOT want my claim considered for paid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE) (Continued)	
12B. CLAIMANT'S SIGNATURE OR MARK WITH AN "X" IF UNABLE TO SIGN **(REQUIRED)**	12C. DATE SIGNED (MM/DD/YYYY) **04-19-2024**

SECTION XIII: WITNESSES TO SIGNATURE (TWO (2) WITNESS SIGNATURES ARE REQUIRED ONLY IF ITEM 12B IS SIGNED WITH AN "X")	
13A. SIGNATURE OF WITNESS (Sign in INK) (NOTE: Only sign if claimant signed in Item 12B using an "X")	13B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:
13C. SIGNATURE OF WITNESS (Sign in INK) (NOTE: Only sign if claimant signed in Item 12B using an "X")	13D. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED (MM/DD/YYYY) **04-19-2024**

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your response is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above. 13A. SIGNATURE OF WITNESS (Sign in INK) (NOTE: Only sign if claimant signed in Item 12B using an "X")

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 40 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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/Postal Code

7. WHAT IS THE FACILITY'S WEBSITE 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)
04-19-2024

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/Postal 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)
04-19-2024

OMB Control No. 2900-0829
Respondent Burden: 30 minutes
Expiration Date: 11/30/2026

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME (First, Middle Initial (M.I.), Last)

First: **Joe** MI: **P** Last: **Veteran**

1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VETERAN'S FILE NUMBER (If known)
123-23-3456	**123233456**

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION (If you are the Veteran, skip questions 2A and 2B)

2A. CLAIMANT'S NAME (First, Middle Initial (M.I.), Last)

First: MI: Last:

2B. CLAIMANT'S SOCIAL SECURITY NUMBER	2C. CLAIMANT'S TELEPHONE NUMBER (If known)

2D. TYPE OF CLAIMANT (Check only one box)

☑ VETERAN ☐ SURVIVING SPOUSE ☐ SURVIVING CHILD ☐ PARENT ☐ CUSTODIAN OF CHILD BENEFICIARY

This form is designed to provide VA with your income and net worth during a specific date range to determine your eligibility or adjust your benefits. If you are submitting an initial application, report current information. Your effective date is typically the earliest of the following dates:

- Date VA receives your application
- Date VA receives your intent to file
- Date of Veteran's death (Survivor's Benefits only)

If you are submitting this form as a response to VA correspondence, report your income and net worth information during the date range specified in that correspondence. If you are reporting an income change, report changes from the date the change took effect.

NOTE: Submit a separate VA Form 21P-0969 if reporting income and net worth information for additional date ranges.

2E. THE INFORMATION ON THIS FORM REPRESENTS INCOME AND NET WORTH FOR THE FOLLOWING PERIOD:

01-01-2021 THROUGH **01-01-2024** -OR- ☐ DATE RECEIVED BY VA (For initial claims only.)

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (See instructions on Page 2)

3A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS FROM SOURCES NOT RELATED TO AN ACCOUNT OR YOUR ASSETS?

☐ YES ☐ NO (If NO, skip to Section IV)

3B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME

☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT ☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME

☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT ☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (Continued)
(See instructions on Page 2)

3D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3E.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3F.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME
☐ SOCIAL SECURITY ☐ RETIREMENT/PENSION ☐ WAGES ☐ UNEMPLOYMENT
☐ CIVIL SERVICE ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME
$

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS
(See instructions on Page 2)

4A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS THAT IS RELATED TO FINANCIAL ACCOUNTS?

☐ YES ☐ NO (If NO, skip to Section V)

4B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$

4C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$

4D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED
☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME
$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT
$

SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS (Continued)
(See instructions on Page 2)

4E.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED

☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME

$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT

$

4F.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). SPECIFY THE TYPE OF INCOME EARNED

☐ INTEREST ☐ DIVIDENDS
☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). GROSS MONTHLY INCOME

$

(3). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

(6). VALUE OF ACCOUNT

$

SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS
(See instructions on Page 2)

5A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS GENERATED BY OWNED PROPERTY OR OTHER PHYSICAL ASSETS?

☐ YES ☐ NO (If NO, skip to Section VI)

5B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED

☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

5C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED

☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

5D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

$

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY

$

(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED

☐ FARM - VA FORM 21P-4165 ☐ BUSINESS - VA FORM 21P-4185 ☐ RENTAL PROPERTY - VA FORM 21P-4185

SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES
(See instructions on Page 2)

6A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES?

☐ YES ☐ NO (If NO, skip to Section VII)

6B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET

☐ BENEFITS FROM INTELLECTUAL PROPERTY ☐ EXTRACTION OF MINERALS/LUMBER ☐ USE OF LAND
☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME	(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET	(6). CAN THE ASSET BE SOLD?
$	$	☐ YES ☐ NO

(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET

6C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET

☐ BENEFITS FROM INTELLECTUAL PROPERTY ☐ EXTRACTION OF MINERALS/LUMBER ☐ USE OF LAND
☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME	(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET	(6). CAN THE ASSET BE SOLD?
$	$	☐ YES ☐ NO

(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET

SECTION VII: ASSET TRANSFERS
(See instructions on Page 2)

7A. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ANY ASSETS?

☐ YES ☐ NO (If NO, skip to Section VIII)

7B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED

☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?

☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?

$

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)

$

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?

☐ YES ☐ NO

$

SECTION VII: ASSET TRANSFERS (Continued)
(See instructions on Page 2)

7C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED
☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?
☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?
$

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)
$

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)
$

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?
☐ YES ☐ NO

7D.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN
☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD
☐ PARENT ☐ OTHER (Specify):

(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)

(2). SPECIFY HOW THE ASSET WAS TRANSFERRED
☐ SOLD ☐ GAVE AWAY ☐ CONVEYED ☐ TRADED
☐ OTHER (Specify):

(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?
☐ YES ☐ NO

(3). WHAT ASSET WAS TRANSFERRED?

(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?
$

(4). WHO RECEIVED THE ASSET?

(10). WHAT WAS THE SALE PRICE? (If applicable)
$

(5). RELATIONSHIP TO NEW OWNER

(11). WHAT WAS THE GAIN? (Capital gain, etc.)
$

(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?
☐ YES ☐ NO

SECTION VIII: TRUSTS
(See instructions on Page 2)

8A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED A TRUST OR DO YOU OR YOUR DEPENDENTS HAVE ACCESS TO A TRUST? (If you have more than one trust to report, submit the information on a separate VA Form 21P-0969 or provide the information on VA Form 21-4138 for each trust established.)
☐ YES ☐ NO (If NO, skip to Section IX)

8B.DATE TRUST ESTABLISHED (MM/DD/YYYY)

8C.SPECIFY MARKET VALUE OF ALL ASSETS WITHIN THE TRUST AT TIME OF ESTABLISHEMENT
$

8D.SPECIFY TYPE OF TRUST ESTABLISHED
☐ REVOCABLE ☐ IRREVOCABLE
☐ BURIAL TRUST

8E.HAVE YOU ADDED FUNDS TO THE TRUST AFTER IT WAS ESTABLISHED?
☐ YES ☐ NO

8F.WHEN DID YOU ADD FUNDS? (MM/DD/YYYY) (If more than one date, submit a VA Form 21-4138 with all dates and amounts)

8G.HOW MUCH DID YOU ADD?
$

8H.ARE YOU RECEIVING INCOME FROM THE TRUST?
☐ YES ☐ NO

8I.HOW MUCH DO YOU RECEIVE ANNUALLY?
$

8J.IS THE TRUST BEING USED TO PAY FOR OR TO REIMBURSE SOMEONE ELSE FOR YOUR MEDICAL EXPENSES? (Such as a guardian, family member or other service provider)
☐ YES ☐ NO

8K.HOW MUCH IS BEING REIMBURSED MONTHLY?
$

8L.WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?
☐ YES ☐ NO

8M.DO YOU HAVE ANY ADDITIONAL AUTHORITY OR CONTROL OF THE TRUST?
☐ YES ☐ NO

SECTION IX: ANNUITIES
(See instructions on Page 2)

9A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED AN ANNUITY? (If you have more than one annuity to report, submit the information below on a separate VA Form 21P-0969, or provide the below information on VA Form 21-4138 for each annuity established.)

☑ YES ☐ NO (If NO, skip to Section X)

9B.SPECIFY DATE ANNUITY WAS ESTABLISHED (MM/DD/YYYY)	9C.SPECIFY MARKET VALUE OF ASSET AT TIME OF ANNUITY PURCHASE	9D.HAVE YOU ADDED FUNDS TO THE ANNUITY IN THE CURRENT OR PRIOR THREE YEARS?
09-22-2001	$ **5000.00**	☐ YES ☑ NO
9E.WHEN DID YOU ADD FUNDS? (MM/DD/YYYY)	9F.HOW MUCH DID YOU ADD?	9G.IS THE ANNUITY REVOCABLE OR IRREVOCABLE?
	$	☐ REVOCABLE ☑ IRREVOCABLE
9H.DO YOU RECEIVE INCOME FROM THE ANNUITY?	9I.IF YES IN 9H, PROVIDE ANNUAL AMOUNT RECEIVED (If NO, skip to 9J)	
☐ YES ☑ NO	$	
9J.CAN THE ANNUITY BE LIQUIDATED?	9K.IF YES IN 9J, PROVIDE THE SURRENDER VALUE (If NO, skip to Section X)	
☐ YES ☑ NO	$	

SECTION X: ASSETS PREVIOUSLY NOT REPORTED
(See instructions on Page 2)

10A.DO YOU OR YOUR DEPENDENTS HAVE ASSETS NOT ALREADY REPORTED?

☐ YES ☐ NO (If NO, skip to Section XI)

10B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4).SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10C.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4).SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10D.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4).SPECIFY ASSET LOCATION (Financial institution, property address, etc.)
10E.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN ☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD ☐ PARENT ☐ OTHER (Specify):	(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY $
	(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)	(4).SPECIFY ASSET LOCATION (Financial institution, property address, etc.)

SECTION XI: DISCONTINUED OR IRREGULAR INCOME
(See instructions on Page 2)

11A. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME THAT HAS STOPPED OR IS NO LONGER BEING RECEIVED WITHIN: THE REPORTING PERIOD (From question 2E)? - **OR** - LAST FULL CALENDAR YEAR (For initial claim)?

☐ YES ☐ NO (If NO, skip to Section XII)

11B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD

☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)

(5). SPECIFY FREQUENCY OF INCOME RECEIVED

☐ RECURRING ☐ IRREGULAR

☐ ONE TIME PAYMENT

(6). DATE INCOME LAST RECEIVED (MM/DD/YYYY)

(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?

$

11C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD

☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)

(5). SPECIFY FREQUENCY OF INCOME RECEIVED

☐ RECURRING ☐ IRREGULAR

☐ ONE TIME PAYMENT

(6). DATE INCOME LAST RECEIVED (MM/DD/YYYY)

(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?

$

SECTION XII: WAIVER OF RECEIPT OF INCOME
(See instructions on Page 2)

12A. DID YOU OR YOUR DEPENDENTS WAIVE OR EXPECT TO WAIVE ANY RECEIPT OF INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ (If NO, skip to Section XIII Certification and Signature)

12B.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD

☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE?

$

(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY)

☐ This income will not resume

(6). WAIVED GROSS MONTHLY INCOME

$

12C.

(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN ☐ SPOUSE ☐ CUSTODIAN OF CHILD ☐ CHILD

☐ PARENT ☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)

(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE?

$

(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY)

☐ This income will not resume

(6). WAIVED GROSS MONTHLY INCOME

$

SECTION XIII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the statements on the form are true and correct to the best of my knowledge and belief. **I UNDERSTAND THAT** without consent, the Department of Veterans Affairs (VA) may disclose information that I provide to entities under a published "routine use." Under such a routine use, the VA may disclose information to third party entities that participate in VA claims processing and are authorized to assist the VA in administering benefits; to other federal agencies under computer matching programs, such as those with the Internal Revenue Service, Social Security Administration, Selective Service System, Department of Homeland Security, Department of Justice; and to members of Congress if they are assisting to help with Veteran's benefit questions.

13A. SIGNATURE

13B. DATE SIGNED (MM/DD/YYYY)
04-16-2024

SECTION XIV: WITNESS TO SIGNATURE
(Two witness signatures are required if the claimant signed item 13A with an "X")

14A. SIGNATURE OF FIRST WITNESS (If claimant signed above using an "X")

14B. PRINTED NAME OF FIRST WITNESS

First: MI: Last:

14C. ADDRESS OF FIRST WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code

14D. SIGNATURE OF SECOND WITNESS (If claimant signed above using an "X")

14E. PRINTED NAME OF SECOND WITNESS

First: MI: Last:

14F. ADDRESS OF SECOND WITNESS

No. & Street Apt./Unit Number

City

State/Province Country ZIP Code/Postal Code

Where to Send Correspondence - After completing the form, mail to:
Department of Veterans Affairs
Pension Intake Center
P.O. Box 5365
Janesville, WI 53547-5365

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.

OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 09/30/2026

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 on page 2. VA uses this form to determine eligibility for pension and aid and attendance benefits based on nursing home status. For more information you can contact us online through **Ask VA**: https://ask.va.gov, or call us toll-free at 1-800-827-1000 (TTY: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 checkbox to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. DATE OF BIRTH (MM/DD/YYYY)
123-23-3456	**123233456**	**09-08-1947**

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
Good Samaritan Society - Luther Manor

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

No. & Street **1500 W 38th St**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57105**

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?
11-15-2023	☑ YES ☐ NO

13. HAS THE PATIENT APPLIED FOR MEDICAID?	14A. IS THE PATIENT COVERED BY MEDICAID?	14B. DATE MEDICAID PLAN BEGAN (MM/DD/YYYY)
☑ YES ☐ NO	☑ YES ☐ NO (If "YES," complete Item 14B)	**01-23-2024**

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)
	04-16-2024

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.

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 Veteran Readiness 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: VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. 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.

South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF ECONOMIC ASSISTANCE
221 Mall Drive Suite 101
PO Box 6221
Rapid City, SD 57701-6221
PHONE: (605) 394-2525
TOLL FREE: (800) 644-2914
FAX: (605) 394-6887

April 26, 2024

Case Number:

Notice of Decision - Change of Circumstances

Based on a change reported from you or another trusted source, we have updated eligibility for the people listed below. Be sure to read both sides of each page.

Name	Medicaid ID	Eligibility	Cost Share	Start Date	Expiration Date
		Long Term Care Coverage			

How We Made Our Eligibility Decisions

We counted household size, income, and resources (if applicable) for each person shown in the grid above to determine eligibility, as follows:

has been found eligible for Long Term Care Coverage effective 05/01/2024. His/her provider may start billing for his/her stay beginning 05/01/2024.

The cost share he/she is required to pay is the total income minus any deductions. Based on the information provided, the cost share to will be $ effective 05/01/2024.
ARSD 67:46:06

Using your Health Coverage

You should continue to use your existing Medicaid card. If you have lost your card, please contact us to order a replacement. Until you get your new card, you can get health services using your Medicaid ID number as listed in the grid above.

You can view a copy of the South Dakota Medicaid Recipient Handbook at https://tinyurl.com/MedHndbk

If you have any questions about covered services or co-payments for different health services, please contact the Division of Medical Services at (800) 597-1603.

You Must Report Changes

You must report any changes in household income, resources, insurance premiums, employment status, tax filing status, living arrangements, etc. If you are receiving long-term care or HCBS waiver services, are married, and part of your income is used for your spouse, you must inform DSS of any changes in your spouse's income and shelter costs. These changes must be reported promptly to your local office at the number listed above or online at https://dss.sd.gov/economicassistance/portal. The amount of resources you are allowed to keep is based upon the program you are eligible for. Your resources must be less than the limit on any day of the month to be eligible for that month. If you have questions about your resource limit, contact your local office.

Children, Family, Adult Medicaid - No resource limit
Long-term Care or HCBS Waiver Services - $2,000
QMB, SLMB, QI-1 - $8,400 if single; $12,600 if married
Chronic Renal Disease or QDWI - $4,000 if single; $6,000 if married
MAWD - $8,000

What if I have Questions

If you have questions or need assistance, please contact your local office. Contact information is at the top of this document.

How To Request a Hearing

If you believe we've made a mistake or you do not agree with the action the Department has taken, you may appeal our decision. You can have a conference with your Benefits Specialist and receive a full explanation of the proposed action as long as you request the conference **within 15 days** of when the notice was sent to you.

If you still do not agree with the proposed action or wish to proceed directly to a hearing, you may begin the process by filing a signed, written request for a hearing to the Office of Administrative Hearings, 700 Governors Drive, Pierre, SD 57501-2291, Fax (605) 773-6873. You may also request a hearing via telephone by calling (866) 357-2544 or by e-mail at ADMHRNGS@STATE.SD.US. The request must state the action that is being appealed. At both the conference and the fair hearing, you can present your case by yourself or with assistance of others including legal counsel. The cost of legal counsel will not, however, be the responsibility of the Department. You may request a hearing up to thirty (30) days after notice of the proposed action, or thirty (30) days after action should have been taken as provided by law or rule.

If you want to ensure that your payments remain the same pending the hearing decision, you must request within ten (10) days after the notice of the proposed change. If the action of the Department is upheld, you may have to repay the amount of money you received during the hearing process. If you have any questions about hearings or time limits, contact our office. You may request assistance from our office in your request for a hearing.

Rights and Responsibilities - Medical Programs

Nondiscrimination

As a recipient of Federal financial assistance and a State or local governmental agency, the Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission or access to, or treatment or employment in, its programs, activities, or services, whether carried out by the Department of Social Services directly or through a contractor or any other entity with which the Department of Social Services arranges to carry out its programs and activities; or on the basis of actual or perceived race, color, religion, national origin, sex, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in, its programs, activities, or services when carried out by the Department of Social Services directly or when carried out by sub-recipients of grants issued by the United States Department of Justice, Office on Violence Against Women. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre SD 57501, 605-773-3305.

Confidence

The information provided will be held in confidence and used solely for purposes of administration of the program.

Cooperating Requirements

By applying for Medical Assistance, you have agreed to cooperate with the Department of Social Services in identifying and providing information to help pursue any third party who may be responsible for paying for care and services for each person for whom medical coverage was requested. You may also be required to cooperate with the Division of Child Support.

Social Security Number

The Division of Economic Assistance will use the SSN to verify your income and eligibility for Medical Assistance. It is possible the SSN will be used to determine another person's right to Medical Assistance or to comply with Federal law requiring release of information from medical records. The information may be matched with the records in other agencies, such as the Social Security Administration or Internal Revenue Service. The matches may be done by computer or on an individual basis. This is required by section 1137(a)(I) of the Social Security Act and Medical Assistance regulations at 42CFR 435.910.

Fraud

There are state and federal penalties for fraud and false reporting in connection with your application for Medical Assistance. You may be required to repay any benefits that are paid to you as a result of incorrect or false information or failing to report changes. Willfully giving false statements, (misrepresentations, impersonations or other fraudulent means), can result in conviction for one or more felony criminal offenses which are punishable by fines and/or confinement in the South Dakota State Penitentiary.

Fair Credit Reporting Act

This action may have been based in part on a report from Accuity, Inc. Accuity was not involved in the decision-making process, and cannot give reasons for it. However, you have the right to receive a free copy of the report upon request to Consumer Center, Attn: Accuity, PO Box 105108, Atlanta, GA

30348 within **sixty (60) days** and may dispute the accuracy or completeness of any information contained therein.

Language Assistance

Español (Spanish)- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-999-5612. (TTY:711)

Deutsch (German)-ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 877-999-5612 (TTY:711)

Notice of Privacy Practices

You can view a copy of the Department of Social Services Notice of Privacy Practices at https:// dss.sd.gov/formsandpubs/docs/GEN/NoticeofPrivacy.pdf or request a copy be mailed to you at any time.

Client Portal Sign Up

South Dakota BEES Customer Portal keeps all important information about your application and health coverage. You can choose to get letters like this online and view or make changes to your information at anytime. To create an account, go to https://dss.sd.gov/economicassistance/portal and register.

OMB Control No. 2900-0161
Respondent Burden: 30 minutes
Expiration Date: 10/31/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

MEDICAL EXPENSE REPORT

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

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

1A. NAME OF VETERAN (First, Middle Initial, Last)

FIRST: MI: LAST:

1B. VETERAN'S SOCIAL SECURITY NUMBER	1C. VA FILE NUMBER (If applicable)

SECTION II: CLAIMANT'S CONTACT INFORMATION

2A. NAME OF CLAIMANT (First, Middle Initial, Last - if different from veteran)

FIRST: MI: LAST:

2B. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code, and Country)

No. and Street Apt./Unit Number

City State/Province Country Zip Code/Postal Code

2C. PRIMARY TELEPHONE NUMBER (Include Area Code)

International Telephone Number (If applicable) _____

2D. CLAIMANT'S EMAIL ADDRESS (Optional)

SECTION III: REPORTING PERIOD

This form is designed to provide VA with your medical expenses paid during a specific date range to determine or adjust your benefits. If you are submitting an initial application, please only report medical expenses paid on or after your effective date. Your effective date is typically the earliest of the following dates:

- Date VA receives your initial application
- Date VA receives your VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*
- Date of the veteran's death (for Survivors Pension, if within one year of the veteran's death)

If you are already in receipt of pension benefits, report medical expenses you paid on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX). If you are responding to a letter that identifies a specific date range, please report medical expenses you paid during the requested period(s).
NOTE: Submit separate VA Form 21P-8416's if reporting information for additional date ranges beyond a 1-year period.

3. THE INFORMATION SHOWN BELOW REPRESENTS MEDICAL EXPENSES PAID DURING THE FOLLOWING DATE RANGE:

Report amounts paid between the dates _____ and _____ - OR- ☐ DATE RECEIVED BY VA (For initial applications only)

SECTION IV: IN-HOME CARE AND CARE FACILITY EXPENSES

IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on **pages 9 and 10**, in addition to completion of this section. If you are reporting a nursing home found under the "Nursing homes including rehab services" section of the https://www.medicare.gov/care-compare" website, you must submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*, instead of a worksheet.

4A (1). WHOSE EXPENSES WERE PAID?	4A. (3) PROVIDER START AND END DATE (MM/DD/YYYY)
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	START: **NOTE**: If care is ongoing leave end date blank.
4A (2). NAME OF PROVIDER	END:

4A (4). AMOUNT PAID MONTHLY	4A (5). IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
$	Payment Rate (Per Hour) $ .00 Average Hours Worked (Per Week)

4B (1). WHOSE EXPENSES WERE PAID?	4B. (3) PROVIDER START AND END DATE (MM/DD/YYYY)
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	START: **NOTE**: If care is ongoing leave end date blank.
4B (2). NAME OF PROVIDER	END:

4B (4). AMOUNT PAID MONTHLY	4B (5). IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
$	Payment Rate (Per Hour) $ .00 Average Hours Worked (Per Week)

NOTE: If you have additional in-home care or care facility expenses, complete Addendum A: In-Home Care or Care Facility Expenses on page 6.

SECTION V: OTHER MEDICAL EXPENSES

DO NOT report your monthly recurring expenses on multiple lines; rather, report recurring expenses on one line. For recurring expenses include the specific dates the recurring expense started and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. If a recurring expense has already terminated, please treat the expense as non-recurring.
Non-recurring expenses must be reported individually on separate lines. Prescription medications are generally not considered recurring.

NOTE: A new VA Form 21P-8416 submitted without reporting a previously counted continuing medical expense may result in removal of the medical expense from the date of receipt of the form.

5A (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5A (2). DATE COSTS PAID (MM/DD/YYYY)	5A. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5A. (4). PAYMENT AMOUNT $
5A. (5). PAID TO (Name of provider, insurance company, etc.)	5A. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5B (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5B (2). DATE COSTS PAID (MM/DD/YYYY)	5B. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5B. (4). PAYMENT AMOUNT $
5B. (5). PAID TO (Name of provider, insurance company, etc.)	5B. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5C (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5C (2). DATE COSTS PAID (MM/DD/YYYY)	5C. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5C. (4). PAYMENT AMOUNT $
5C. (5). PAID TO (Name of provider, insurance company, etc.)	5C. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5D (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5D (2). DATE COSTS PAID (MM/DD/YYYY)	5D. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5D. (4). PAYMENT AMOUNT $
5D. (5). PAID TO (Name of provider, insurance company, etc.)	5D. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5E (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5E (2). DATE COSTS PAID (MM/DD/YYYY)	5E. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5E. (4). PAYMENT AMOUNT $
5E. (5). PAID TO (Name of provider, insurance company, etc.)	5E. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5F (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5F (2). DATE COSTS PAID (MM/DD/YYYY)	5F. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5F. (4). PAYMENT AMOUNT $
5F. (5). PAID TO (Name of provider, insurance company, etc.)	5F. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

5G (1). WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____

5G (2). DATE COSTS PAID (MM/DD/YYYY)	5G. (3). FREQUENCY ☐ MONTHLY ☐ ANNUALLY	5G. (4). PAYMENT AMOUNT $
5G. (5). PAID TO (Name of provider, insurance company, etc.)	5G. (6). PURPOSE (Insurance premium, medical supplies, etc.)	

NOTE: If you have additional medical expenses to report, complete Addendum B: Other Medical Expenses on page 7.

SECTION VI: MILEAGE

Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in Section III of this form.

6A. (1). WHO NEEDED TO TRAVEL? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6A. (3). TOTAL MILES TRAVELED	6A. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year
6A. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6A. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
6B. (1). WHO NEEDED TO TRAVEL? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6B. (3). TOTAL MILES TRAVELED	6B. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year
6B. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6B. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
6C. (1). WHO NEEDED TO TRAVEL? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6C. (3). TOTAL MILES TRAVELED	6C. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year
6C. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6C. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
6D. (1). WHO NEEDED TO TRAVEL? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6D. (3). TOTAL MILES TRAVELED	6D. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year
6D. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6D. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $

NOTE: If you have additional mileage reimbursement to report, complete Addendum C: Mileage for Privately Owned Vehicle Travel for Medical Purposes on page 8.

SECTION VII: CERTIFICATION AND SIGNATURE

CERTIFICATION: I **have not** and **will not** receive reimbursement for these expenses. I certify the information contained on this form and the attached addendums is a true representation of expenses I have paid.

7A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE	7B. DATE SIGNED (MM/DD/YYYY)

SECTION VIII: WITNESS TO SIGNATURE
(Two witness signatures are required if claimant signed 7A with an "X")

8A. PRINTED NAME OF FIRST WITNESS (**NOTE**: Only to be used if claimant signed in 7A using an "X")	8B. SIGNATURE OF FIRST WITNESS (**NOTE**: Only to be used if claimant signed in 7A using an "X")

8C. MAILING ADDRESS OF FIRST WITNESS

No. and Street — Apt./Unit Number

City — State/Province — Country — Zip Code/Postal Code

8D. PRINTED NAME OF SECOND WITNESS (**NOTE**: Only to be used if claimant signed in 7A using an "X")	8E. SIGNATURE OF SECOND WITNESS (**NOTE**: Only to be used if claimant signed in 7A using an "X")

8F. MAILING ADDRESS OF SECOND WITNESS

No. and Street — Apt./Unit Number

City — State/Province — Country — Zip Code/Postal Code

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 payment to which you are not entitled.

ADDENDUM A: IN-HOME CARE OR CARE FACILITY EXPENSES

If you are not claiming expenses related to a care facility or from an in-home care provider, completion of Addendum A is not required.

IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on pages **9 and 10**, in addition to completion of this section. If you are reporting a nursing home, you must submit VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*.

1A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

1B. NAME OF PROVIDER

1C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

1D. AMOUNT PAID MONTHLY
$

1E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

2A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

2B. NAME OF PROVIDER

2C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

2D. AMOUNT PAID MONTHLY
$

2E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

3A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

3B. NAME OF PROVIDER

3C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

3D. AMOUNT PAID MONTHLY
$

3E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

4A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

4B. NAME OF PROVIDER

4C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

4D. AMOUNT PAID MONTHLY
$

4E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

5A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

5B. NAME OF PROVIDER

5C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

5D. AMOUNT PAID MONTHLY
$

5E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

6A. WHOSE EXPENSES WERE PAID?
☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)
Specify Name of Child or Other: _____

6B. NAME OF PROVIDER

6C. PROVIDER START AND END DATE (MM/DD/YYYY)
START:
NOTE: If care is ongoing leave end date blank.
END:

6D. AMOUNT PAID MONTHLY
$

6E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE RATE AND HOURS BELOW
Payment Rate (Per Hour) **$ .00** Average Hours Worked (Per Week)

ADDENDUM B: OTHER MEDICAL EXPENSES

If you are not claiming additional expenses, completion of Addendum B is not required.

Please report your monthly recurring expenses that are not reported in other sections on one line, including the specific dates the recurring expense started, and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. Prescription medications are generally not considered recurring. If a recurring expense has already stopped, please treat the expense as non-recurring and report a total amount paid during the designated time period

NOTE: A new VA Form 21P-8416 submitted without reporting a previously counted continuing medical expense may result in removal of the medical expense from the date of receipt of the form.

1A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
1B. DATE COSTS PAID (MM/DD/YYYY)	1C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	1D. PAYMENT AMOUNT $
1E. PAID TO (Name of provider, insurance company, etc.)	1F. PURPOSE (Insurance premium, medical supplies, etc.)	
2A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
2B. DATE COSTS PAID (MM/DD/YYYY)	2C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	2D. PAYMENT AMOUNT $
2E. PAID TO (Name of provider, insurance company, etc.)	2F. PURPOSE (Insurance premium, medical supplies, etc.)	
3A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
3B. DATE COSTS PAID (MM/DD/YYYY)	3C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	3D. PAYMENT AMOUNT $
3E. PAID TO (Name of provider, insurance company, etc.)	3F. PURPOSE (Insurance premium, medical supplies, etc.)	
4A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
4B. DATE COSTS PAID (MM/DD/YYYY)	4C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	4D. PAYMENT AMOUNT $
4E. PAID TO (Name of provider, insurance company, etc.)	4F. PURPOSE (Insurance premium, medical supplies, etc.)	
5A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
5B. DATE COSTS PAID (MM/DD/YYYY)	5C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	5D. PAYMENT AMOUNT $
5E. PAID TO (Name of provider, insurance company, etc.)	5F. PURPOSE (Insurance premium, medical supplies, etc.)	
6A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
6B. DATE COSTS PAID (MM/DD/YYYY)	6C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	6D. PAYMENT AMOUNT $
6E. PAID TO (Name of provider, insurance company, etc.)	6F. PURPOSE (Insurance premium, medical supplies, etc.)	
7A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify)	Specify Name of Child or Other: _____	
7B. DATE COSTS PAID (MM/DD/YYYY)	7C. FREQUENCY ☐ MONTHLY ☐ ANNUALLY ☐ NOT RECURRING	7D. PAYMENT AMOUNT $
7E. PAID TO (Name of provider, insurance company, etc.)	7F. PURPOSE (Insurance premium, medical supplies, etc.)	

ADDENDUM C: MILEAGE FOR PRIVATELY OWNED VEHICLE TRAVEL FOR MEDICAL PURPOSES

Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in Section III of VA Form 21P-8416, *Medical Expense Report* submitted with this addendum.

1A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	1C. TOTAL MILES TRAVELED	1D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
1B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		1E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
2A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	2C. TOTAL MILES TRAVELED	2D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
2B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		2E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
3A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	3C. TOTAL MILES TRAVELED	3D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
3B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		3E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
4A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	4C. TOTAL MILES TRAVELED	4D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
4B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		4E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
5A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	5C. TOTAL MILES TRAVELED	5D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
5B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		5E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
6A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	6C. TOTAL MILES TRAVELED	6D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
6B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
7A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	7C. TOTAL MILES TRAVELED	7D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
7B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		7E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $
8A. WHOSE EXPENSES WERE PAID? ☐ VETERAN ☐ SPOUSE ☐ CHILD (Specify) ☐ OTHER (Specify) Specify Name of Child or Other: _____	8C. TOTAL MILES TRAVELED	8D. DATE TRAVELED (MM/DD/YYYY) Month Day Year
8B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		8E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) $

NOTE: If needed, you can complete and submit additional copies of Addendum C.

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 WEBSITE 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)

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)

Appeal Process

Under the new Appeals Modernization Act there are now three new lanes to have your disagreement reviewed: as a supplemental claim, through a higher-level review, or by appealing directly to the Board of Veteran's Appeals. Under the appeal to the Board of Veterans Appeals there are three additional lanes: direct review, evidence submission, and docket hearing.

Supplemental Claims:

- Replaces "reconsiderations" and "reopening" claims with "new and material" evidence
- VA will readjudicate a claim if "new and relevant" evidence is presented or identified with a supplemental claim using the new VA Form 20-0995
- VA will assist in gathering new and relevant evidence (duty to assist).
- Effective date for benefits is always protected when submitted within 1 year of prior decision.
- Tracked and controlled under EP 040 series
- Decision makers are Veterans Service Representatives (VSRs) and Rating VSRs (RVSRs)

Higher Level Review:

- Requested using the new VA Form 20-0996
- More experienced VA employee takes a second look at the same evidence (closed record and no duty to assist)
- Option for a one-time telephonic informal conference with the higher-level reviewer to discuss the error in the prior decision
- De novo review with full difference of opinion authority
- Duty to assist errors will be returned to lower-level for correction
- Tracked and controlled under EP 030 series
- Decision makers are Decision Review Officers (DROs) and Senior VSRs

**If you disagree with a decision from the Supplemental Claim Lane, you ay choose to resubmit the claim as another supplemental claim with new evidence, as a higher-level review or as an appeal to the Board of Veterans' Appeals.

Board of Veterans Appeals:

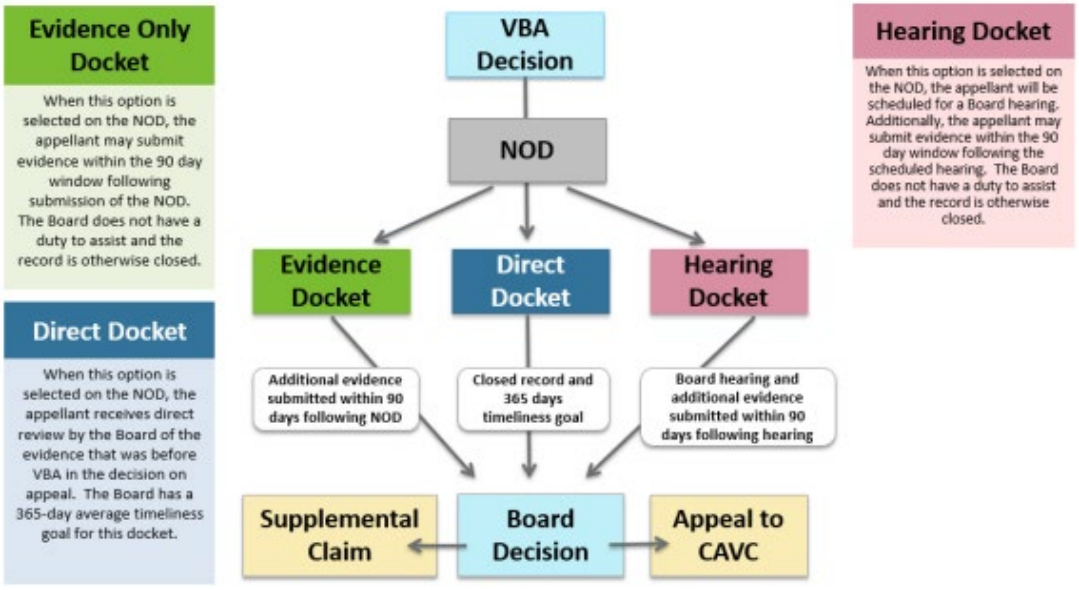
The Notice of Disagreement, (VA FORM 10182) is filed with the BVA and one of the following lanes must be chosen:

- Evidence only docket: The appellant may submit evidence within the 90 day window following submission of the NOD. The Board does not have a duty to assist and the record is otherwise closed.
- Direct docket: The appellant receives direct review by the Board of the evidence that was before VBA in the decision on appeal. The Board has a 365-day timeliness goal for this docket. Quality feedback loop for VBA.
- Hearing docket: The appellant will be scheduled for a Board hearing. Additionally, the appellant may submit evidence within the 90-day window following the scheduled hearing. The Board does not have a duty to assist and the record is otherwise closed.

There are 3 hearing docket options:

- Central office – The SDDVA does not recommend ever choosing this option. This requires the veteran to travel to Washington DC at their own expense.
- Videoconference – Choose this option if the veteran or county cannot host their own hearing. They will travel at their own expense to the closest VA facility to conduct a hearing.
- Virtual – the preferred option requires an email address be provided to send a virtual hearing link to. This is a video and audio interaction with a law judge, like the video conference hearing.

Appeals Framework



**If you disagree with a Board decision you may either resubmit as a supplemental claim or through an appeal to the U.S. Court of Appeals for Veterans Claims. **

NOD
20-0995 Decision Review Request: Supplemental Claim
20-0996 Decision Review Request: Higher-Level Review
10182 Decision Review Request: Board Appeal (Notice of Disagreement)

OMB Control No. 2900-0886
Respondent Burden: 15 minutes
Expiration Date: 04/30/2024

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

DECISION REVIEW REQUEST: SUPPLEMENTAL CLAIM

INSTRUCTIONS: PLEASE READ THE PRIVACY ACT NOTICE AND RESPONDENT BURDEN INFORMATION ON PAGE 2 BEFORE COMPLETING THIS FORM.

PART I - CLAIMANT'S IDENTIFYING 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'S NAME *(First, Middle Initial, Last)*

Joe P Veteran

2. VETERAN'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER *(If applicable)*	4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
123-23-3456	**123233456**	**09-08-1947**

5. VETERAN'S SERVICE NUMBER *(If applicable)*	6. INSURANCE POLICY NUMBER *(If applicable)*

7. CLAIMANT'S NAME *(First, Middle Initial, Last) (If other than veteran)*

8. CLAIMANT TYPE:

☑ VETERAN ☐ VETERAN'S SPOUSE ☐ VETERAN'S CHILD ☐ VETERAN'S PARENT ☐ OTHER *(Specify)*

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **USA** ZIP Code/Postal Code **57107**

10. TELEPHONE NUMBER *(Include Area Code)*

(605)123-2345 Enter International Phone Number *(If applicable)*

11. E-MAIL ADDRESS *(Optional)*

12. BENEFIT TYPE: **PLEASE CHECK ONLY ONE** (If you would like to file for multiple benefit types, you must complete a separate request form for each benefit type.)

☑ COMPENSATION ☐ PENSION/DIC/SURVIVORS BENEFITS ☐ FIDUCIARY ☐ LIFE INSURANCE ☐ VETERANS HEALTH ADMINISTRATION

☐ VETERAN READINESS AND EMPLOYMENT AND EMPLOYMENT ☐ EDUCATION ☐ LOAN GUARANTY ☐ NATIONAL CEMETERY ADMINISTRATION

PART II - ISSUE(S) FOR SUPPLEMENTAL CLAIM

13. YOU MUST LIST EACH ISSUE DECIDED BY VA THAT YOU WOULD LIKE VA TO REVIEW AS PART OF YOUR **SUPPLEMENTAL CLAIM**. *Please refer to your decision notice(s) for a list of adjudicated issues. For each issue, please identify the date of VA's decision. (You may attach additional sheets of paper, if necessary. Include your name and file number on each additional sheet.*

If you are responding to a Statement of the Case (SOC) or a Supplemental Statement of the Case (SSOC): By submitting this form, I agree to participate in the modernized review system for the following issues decided in a SOC or SSOC. I am withdrawing the eligible appeal issues listed in 13A in their entirety, and any associated hearing requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn.

13A. SPECIFIC ISSUE(S)	13B. DATE OF VA DECISION NOTICE (MM/DD/YYYY)
Left Knee Condition Denied	**02/24/2011**

PART III - NEW AND RELEVANT EVIDENCE

14. To complete your application, you must submit new and relevant evidence to VA or tell us about new and relevant evidence that VA can assist you in gathering in support of your supplemental claim. If you have records in your possession, please attach the records to this form. Please list your name and file number on each page. If you would like VA to obtain **non-federal records**, please review your decision notification letter for the appropriate authorization forms to complete and submit those forms to VA with this request form.

15. DO YOU WANT VA TO GET FEDERAL RECORDS?

LIST BELOW ANY **VA MEDICAL CENTER(S) (VAMC)**, **VA TREATMENT FACILITIES**, **OR FEDERAL DEPARTMENTS OR AGENCIES** THAT HAVE NEW AND RELEVANT EVIDENCE THAT YOU ARE AUTHORIZING VA TO OBTAIN IN SUPPORT OF YOUR SUPPLEMENTAL CLAIM: *You may attach additional sheets of paper, if necessary. Please list your name and file number on each additional sheet.*

15A. NAME AND LOCATION	15B. DATE(S) OF RECORDS (MM/DD/YYYY)
Black Hills VA Health Care	**February 2019 to April 2024**

PART IV - 5103 NOTICE ACKNOWLEDGMENT
(This section applies to Compensation, Pension, DIC, and Accrued benefit claims only)

NOTE: If we issued your decision within the past year, you can skip this section.

16. Find out what evidence you'll need to provide by visiting one these pages on VA.gov:

• Evidence to support a claim for Veterans Disability Compensation and related Compensation benefits: https://www.va.gov/disability/how-to-file-claim/evidence-needed/

• Evidence to support a claim for VA pension, DIC, or accrued benefits: https://www.va.gov/resources/evidence-to-support-va-pension-dic-or-accrued-benefits-claims/

CERTIFY THAT I have reviewed the notice of evidence that relates to my claim.

☑ YES ☐ NO (If you check "NO," VA will send the 5103 notice to you via mail)

PART V - CERTIFICATION AND SIGNATURE

NOTE: This section is **MANDATORY** and completion is required to process your claim, any omission may delay claim processing time.

VA AUTHORIZED REPRESENTATIVES ONLY: I certify that the claimant has authorized the undersigned representative to file this supplemental claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature *will not* be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual As Claimant's Representative*, indicating the appropriate POA is of record with VA.

17A. SIGNATURE OF VETERAN OR CLAIMANT OR VA AUTHORIZED REPRESENTATIVE *(Sign in ink)*	17B. DATE SIGNED *(MM/DD/YYYY)*
Jon P Vuke	**07/17/2024**

17C. NAME OF VA AUTHORIZED REPRESENTATIVE *(Please Print)*

ALTERNATE SIGNER CERTIFICATION AND SIGNATURE

18. **I CERTIFY THAT** by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

18A. SIGNATURE OF ALTERNATE SIGNER *(Sign in ink)*	18B. DATE SIGNED *(MM/DD/YYYY)*
	07-17-2024

18C. NAME OF ALTERNATE SIGNER *(Please Print)*

PENALTY: The law provides severe penalties which include a fine, imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

OMB Control No. 2900-0862
Respondent Burden: 15 minutes
Expiration Date: 4/30/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

DECISION REVIEW REQUEST: HIGHER-LEVEL REVIEW

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 5. Use this form to request a Higher-Level Review of a decision you received. A Higher-Level Review is a new review of an issue(s) previously decided by VA based on the evidence of record at the time of the prior decision. For more information 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 https://www.va.gov/find-forms/.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)	4. DATE OF BIRTH (MM/DD/YYYY)
123-23-3456	**123233456**	**09-08-1947**

5. VA INSURANCE POLICY NUMBER (If applicable)

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

☐ I AM HOMELESS OR AT RISK OF HOMELESSNESS

7. TELEPHONE NUMBER (Include Area Code)
(605)123-2345 Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS (Optional)

SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION (If other than veteran)

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

10. SOCIAL SECURITY NUMBER (If applicable)	11. DATE OF BIRTH (MM/DD/YYYY) (If applicable)

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

No. & Street

Apt./Unit Number City

State/Province Country **US** ZIP Code/Postal Code

13. TELEPHONE NUMBER (Include Area Code)
Enter International Phone Number (If applicable)

14. E-MAIL ADDRESS (Optional)

SECTION III - BENEFIT TYPE

15. **PLEASE CHECK ONLY ONE** (If you would like to file for multiple benefit types, you must complete a separate request form for each benefit type.)

☑ COMPENSATION ☐ PENSION/DIC/SURVIVORS BENEFITS ☐ FIDUCIARY ☐ EDUCATION ☐ VETERANS HEALTH ADMINISTRATION
☐ VETERAN READINESS AND EMPLOYMENT ☐ LOAN GUARANTY ☐ LIFE INSURANCE ☐ NATIONAL CEMETERY ADMINISTRATION

SECTION IV - OPTIONAL INFORMAL CONFERENCE

16. YOU OR YOUR AUTHORIZED REPRESENTATIVE MAY REQUEST AN INFORMAL CONFERENCE WITH THE HIGHER-LEVEL REVIEWER FOR THE SOLE PURPOSE OF POINTING OUT ERRORS OF FACT OR LAW IN THE PRIOR DECISION. (VA will only conduct one informal conference by telephonic communication associated with this request for Higher-Level Review.)

☑ 16A. I WOULD LIKE AN INFORMAL CONFERENCE. I understand electing an informal conference is optional and may delay a decision.

16B. IF YOU SELECTED THE BOX ABOVE, VA will make two attempts to contact you OR your representative to schedule the informal conference. Contact attempts will be between the hours of 8:00 a.m. and 4:30 p.m. Eastern Time. INDICATE ONE PREFERENCE:

☑ Call me between 8:00 a.m. - 12:00 p.m. ET
☐ Call me between 12:00 p.m. - 4:30 p.m. ET
☐ Call my representative between 8:00 a.m. - 12:00 p.m. ET
☐ Call my representative between 12:00 p.m. - 4:30 p.m. ET

17. IF YOU WOULD LIKE VA TO CONTACT YOUR REPRESENTATIVE, YOU MUST PROVIDE YOUR REPRESENTATIVE'S CONTACT INFORMATION BELOW:

17A. REPRESENTATIVE'S NAME (First, Last)

17B. REPRESENTATIVE'S TELEPHONE NUMBER (Include Area Code)

17C. REPRESENTATIVE'S E-MAIL ADDRESS

SECTION V - ISSUES FOR HIGHER-LEVEL-REVIEW

18. If you are responding to a Statement of the Case (SOC) or a Supplemental Statement of the Case (SSOC): By submitting this form, I agree to participate in the modernized review system for the following issues decided in a SOC or SSOC. I am withdrawing the eligible appeal issues listed in 18A in their entirety, and any associated hearing requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn.

INDICATE EACH ISSUE DECIDED BY VA FOR WHICH YOU ARE REQUESTING A HIGHER-LEVEL REVIEW. Refer to your decision notice(s) for a list of adjudicated issues. For each issue, identify the date of VA's most recent decision on the issue. You may attach additional sheets, if necessary - include your name and file number on each additional sheet. IMPORTANT: You may only list issues for the benefit type selected in Section III. A separate form is required for each benefit type.

18A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	18B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)
Example 1: Service connection for left knee Example	MM/DD/YYYY
Example 2: Earlier effective date for hearing loss Example	MM/DD/YYYY
Example 3: Reimbursement for non-VA emergency care Example	MM/DD/YYYY
Example 4: Denial of entitlement to VR&E benefits and services Example	MM/DD/YYYY
Example 5: Entitlement to Service-Disabled Veterans Insurance	MM/DD/YYYY
Left Knee Condition Denied	**08-16-2022**

SECTION VI - ISSUES FOR HIGHER-LEVEL REVIEW (Continued)	
18A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	18B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)

SECTION VI - CERTIFICATION AND SIGNATURE	
NOTE: This section is **MANDATORY** and completion is required to process your claim unless accompanied by VA Form 21-0972, Alternate Signer Certification or Section VII is completed.	
I CERTIFY the statements on this form are true and correct to the best of my knowledge and belief.	
19A. SIGNATURE OF VETERAN OR CLAIMANT (Sign in ink) 	19B. DATE SIGNED (MM/DD/YYYY) **04-16-2024**

SECTION VII - AUTHORIZED REPRESENTATIVE SIGNATURE	
I CERTIFY the statements on this form are true and correct to the best of my knowledge and belief.	
NOTE: A representative's signature will not be accepted unless at the time of submission of this request a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual as Claimant's Representative*, indicating the appropriate representative is of record with VA or included with this application.	
20A. NAME OF VA AUTHORIZED REPRESENTATIVE (First, Last)	
20B. SIGNATURE OF VA AUTHORIZED REPRESENTATIVE (Sign in ink)	20C. DATE SIGNED (MM/DD/YYYY) **04-16-2024**

PENALTY: The law provides severe penalties which include a fine, imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

PRIVACY ACT NOTICE: 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 voluntary.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the 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.

OMB Approved No. 2900-0674
Respondent Burden: 30 Minutes
Expiration Date: Mar. 31, 2025

VA U.S. Department of Veterans Affairs

DECISION REVIEW REQUEST: BOARD APPEAL (NOTICE OF DISAGREEMENT)

PART I - PERSONAL INFORMATION

1. VETERAN'S NAME *(First, middle initial, last)*	2. VETERAN'S FILE NUMBER	3. VETERAN'S DATE OF BIRTH
Joe P Veteran	**123233456**	**09-08-1947**

4. IF I AM NOT THE VETERAN, MY NAME IS *(First, middle initial, last)*	5. MY DATE OF BIRTH *(If I am not the Veteran)*

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

☐ I AM EXPERIENCING HOMELESSNESS

123 Tenbucktwo Ave
Sioux Falls SD 57107

7. MY PREFERRED TELEPHONE NUMBER *(Include Area Code)*	8. MY PREFERRED E-MAIL ADDRESS	9. MY REPRESENTATIVE'S NAME
(605)123-2345		

PART II - BOARD REVIEW OPTION *(Check only one)*

10. A Veterans Law Judge will consider your appeal in the order in which it is received, depending on which of the following review options you select. *(For additional explanation of your options, please see the attached information and instructions.)*

☐ 10A. Direct Review by a Veterans Law Judge: I do not want a Board hearing, and will not submit any additional evidence in support of my appeal. *(Choosing this option often results in the Board issuing its decision most quickly.)*

☐ 10B. Evidence Submission Reviewed by a Veterans Law Judge: I have additional evidence in support of my appeal that I will submit to the Board with my VA Form 10182 or within the 90 days of the Board's receipt of my VA Form 10182. *(Choosing this option will extend the time it takes for the Board to decide your appeal.)*

☑ 10C. Hearing with a Veterans Law Judge: I want a Board hearing and the opportunity to submit additional evidence in support of my appeal that I will provide within 90 days after my hearing. I want the hearing type below *(Choosing this option will extend the time it takes for the Board to decide your appeal.)*

- ☐ Central Office Hearing *(I will attend in person in Washington, DC)*
- ☐ Videoconference hearing *(I will go to a Regional Office)*
- ☑ Virtual Telehearing *(I will attend using an internet-connected device) (Important: Provide your e-mail address and Representative in Part I)*

PART III - SPECIFIC ISSUE(S) TO BE APPEALED TO A VETERANS LAW JUDGE AT THE BOARD

11. Please list each issue decided by VA that you would like to appeal. Please refer to your decision notice(s) for a list of adjudicated issues. For each issue, please identify the date of VA's decision and the area of disagreement *(e.g., service connection, disability evaluation, or effective date of award)*.

☐ Check here if you are including a request for an extension of time to file the VA Form 10182 due to good cause and then attach additional sheets explaining why you believe there is good cause for the extension.

☐ Check here if you are appealing a denial of benefits by the Veterans Health Administration (VHA)

A. Specific Issue(s)	B. Date of Decision
Left Knee Condition Denied	**08-16-2022**

C. Additional Issue(s)

☐ Check here if you attached additional sheets. Include the Veteran's last name and the file number.

PART IV - CERTIFICATION AND SIGNATURE

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

12. SIGNATURE *(Appellant or appointed representative) (Ink signature)*	13. DATE SIGNED
Joe P Veteran	**04-16-2024**

PENALTY: THE LAW PROVIDES SEVERE PENALTIES WHICH INCLUDE A FINE, IMPRISONMENT, OR BOTH, FOR THE WILLFUL SUBMISSION OF ANY STATEMENT OR EVIDENCE OF A MATERIAL FACT, KNOWING IT TO BE FALSE.

Burial Benefits Quick Reference Sheet

VA burial benefits are intended to assist the survivors of deceased eligible veterans in meeting the funeral and burial costs associated with the veteran's funeral.

Eligibility for Service-Connected Disability Burial Allowance

Veteran with a service-connected disability that was the direct or contributory cause of death is eligible for a $2,000 payment. There is no time limit to file this claim.

Eligibility for Non-Service Connected Disability Burial Allowance

Veteran must be receiving VA comp or pension; or receiving military retired pay at time of death. Click here to view burial allowances and plot allowances.
Claims for burial allowance must be filed within two years after burial.

Eligibility for Burial in VA National Cemetery

Veteran discharged or separated from active duty under conditions other than dishonorable, Service members who died on active duty, and persons who are entitled to retired pay as a result of 20 years of service with a reserve component. Also, members of a Reserve component/National Guard/ ROTC whose death occurs under honorable conditions, and a spouse, surviving spouse, minor child, or unmarried adult child of any above listed eligible individuals.

Eligibility for Headstone or Marker

Any veteran eligible for a burial in a VA National Cemetery. Only the following individuals may apply for a headstone, marker, or medallion: Decedent's NOK, authorized representative on behalf of decedent, or authorized representative on behalf of NOK.

If burial is in private cemetery, VA form 40-1330 'Claim for Standard Government Headstone or Marker' must be submitted with a copy of veteran's discharge document.

Burial Flags

One flag may be provided for each veteran (other than those dishonorably discharged), including those who served at least one term in the National Guard. Flags are available at most US post offices, VARO, and National Cemeteries.

Commemorative Urn or Plaque

VA may provide a commemorative urn or plaque for a deceased veteran. If an urn or plaque is received they cannot inter their loved one at a VA National Cemetery or receive a government furnished headstone, marker, niche or medallion. They would not be eligible for burial at the South Dakota Veterans Cemetery either, as the National eligibility rules are followed.

Forms to File

21-22 POA and SDDVA Policy Statement (if applicable)
21P-530 Application for Burial Benefits
DD-214 Certified copy
Death Certificate
Funeral Expense Statements

Headstone Requests (Processes at Memorial Affairs in Quantico, VA)

40-1330 Claim for Government headstone or Marker
DD-214
Death Certificate

Burial Flag

27-2008 Application for United States Flag for Burial Purposes
DD 214

Commemorative Urn or Plaque

40-1330UP Claim for Commemorative Urn or Plaque for Veterans' Cremains Not Interred
DD 214

BURIAL AND MEMORIAL BENEFITS

Burial Allowance (38 CFR 3.1600)

The VA burial allowance is a partial reimbursement of an eligible veteran's burial and funeral costs. To be eligible, the veteran's must have been discharged under conditions other than dishonorable. The amount of payment depends upon whether the veteran's cause of death is service-connected or nonservice-connected.

Service-Related Death

VA will pay up to $2,000 toward burial expenses for deaths on or after September 11, 2001, or up to $1,500 for deaths prior to September 11, 2001. If veteran is buried in a VA national cemetery, some or all of the cost of transporting the deceased may be reimbursed.

Non-Service-Related Death

Click here to view what VA will pay up toward burial and funeral expenses

Death While Hospitalized

Click here to view what VA will pay if veteran dies from nonservice-connected causes while hospitalized by the VA. The term 'hospitalized by the VA' includes hospital, nursing home or domiciliary care or, while on approved travel for VA medical care.

To be eligible for payment of non-service connected burial benefits, ONE of the following requirements must be met. The veteran must have

- Been in receipt of VA disability compensation or pension at the time of death; or was in receipt of military retirement pay in lieu of VA compensation; or
- Had a claim pending for disability compensation or pension benefits and was later determined to be eligible for the benefit from a date prior to the date of his or her death; or
- Been indigent. An indigent veteran must have been a veteran of a war, or discharged from active duty for a disability incurred or aggravated in the line of duty

Transportation Expenses (38 CFR 3.1600 (g))

In addition to the burial allowance, the VA may pay the cost of transporting the body of certain deceased veterans to the National Cemetery, State or Tribal Veterans Cemeteries, or Private Cemetery for burial. To be eligible, the veteran must:

- Have died of a service-connected condition, or
- Have had a service-connected condition at time of death for which he/she was receiving disability compensation, or
- Have been receiving military retirement pay or VA pension in lieu of disability compensation

The amount of payment is based on the cost of transporting the body from the veteran's place of death to the cemetery nearest the veteran's last place of residence.

If a veteran dies from nonservice-connected causes while hospitalized by the VA (includes hospital, nursing home or domiciliary care or, while on approved travel for VA medical care) the VA may pay the cost of transportation from the place of the veteran's death to the place of burial. This payment is in addition to the burial allowance.

Application Procedures

VA Form 21P-530 'Application for Burial Benefits' is used to apply for the burial, plot and/or transportation allowance. The following documentation should be submitted with the completed application:

- Certified copy of the DD-214 or discharge (if not already a matter of record with VA)
- Copy of the veteran's death certificate
- The funeral director's statement. A statement of account on the letterhead of the funeral director or cemetery is needed. <u>It must show</u>:
    - Name of the veteran
    - Itemized costs
    - Balance paid in full. If there is no unpaid balance, the statement should show whose funds were used.

Who completes the application depends on whether or not funeral or burial expenses for the deceased veteran have been paid. For example:

- If all funeral expenses have been paid, the application should be completed by the person(s) or agency that paid the bill
- If the expenses were paid from the veteran's estate, the executor or administrator for the estate should complete the application
- If the expenses have not been paid, the creditors (such as the funeral home) should complete the application.

Veterans Medallions

VA offers a medallion that can be provided in lieu of the traditional government headstone or marker for veteran whose death occurred on or after April 6, 1917. Under federal law, eligible veterans buried in a private cemetery are entitled to either the traditional grave markers or the medallion, but not both.

The medallions are available only for veterans buried in a private cemetery and whose grave is NOT marked with a government headstone or marker. The free medallion will be sent, along with a kit that will allow the family or private cemetery staff to affix the medallion to an existing privately purchased headstone or marker.

VA Form 40-1330M 'Claim for Government Medallion for Placement in a Private Cemetery is used for applying for a medallion.

The veteran's medallion DOES NOT qualify for the South Dakota Headstone Setting Fee.

Application Procedures

VA Form 40-1330 'Claim for Standard Government Headstone or Marker' is used and must be accompanied by a copy of the veteran's DD-214 or separation papers. Claim can be made by family members, C/TVSOs, and any other individual who is responsible for the deceased veteran.

Headstones and Markers

The United States Department of Veterans Affairs (VA) furnishes upon request, a government headstone or marker for the grave of any deceased eligible veteran in any cemetery around the world. Eligible veterans include:

- Any deceased veteran discharged under conditions other than dishonorable
- Members of the National Guard or Reserves who die while on training
- Members of the National Guard or Reserves who are eligible for retirement (although doesn't have to be receiving it – under age 60)
- Members of the National Guard or Reserves who have been activated, and
- Who served for the period for which called to active duty

Tips on Filling out VA Form 40-1330M

The bolded items are optional. All other items must be filled in correctly. If the applicant checks a war service in block 16, they must also have the discharge for that period of service or Memorial services will not put it on the stone (for example: if a veteran served in Korea and Vietnam but only has the discharge for Vietnam Service, Memorial Services will only put Vietnam for war service.) The person who puts their name/address in block 19A and signs in block 23 is responsible for the information that is entered on the form regardless of who fills the form out.

The person/address in block 25 is where the applicant wants the stone delivered. This is usually the business that will place the stone, either the funeral home or a monument service. However, it can be the C/TVSO's office or the applicants' house. Memorial Services prefers that it is a place of business, and not a private residence. If there is no cemetery official to sign in block 30 then Memorial Services wants the person who is responsible for the property listed in block 25 to sign the form.

ALWAYS KEEP A COPY OF THE APPLICATION YOU SUBMITTED FOR A HEADSTONE OR MARKER!!!!!

Send the completed application along with supporting documents to:

SD Department of Veterans Affairs
2501 W. 22nd Street
Sioux Falls, SD 57117-5046

OR

Memorial Programs Service (41B)
NCA FP Evidence Intake Center
PO Box 5237
Janesville, WI 53547
FAX # 1-800-455-7143

Commemorative Urn or Plaque

Commemorative Urn: a container that signifies the deceased individual's status as a veteran, in which the individual's cremated remains may be placed at private expense.

Commemorative Plaque: a commemorative plaque means a tablet that signifies the deceased individual's status as a veteran.

Who Can Be Commemorated by an Urn or Plaque - A deceased veteran who has been cremated with no portion of the remains interred* at any location at the time of application, and who was discharged under conditions other than dishonorable on or after April 6, 1917, or any Servicemember of the Armed Forces of the United States who dies on active duty whose remains have been cremated and is NOT interred at any location. Service after September 7, 1980 for enlisted personnel, and October 16, 1981 for officer personnel, must be for a minimum of 24 months continuous active duty or be completed under special circumstances, e.g., death on active duty. Persons who have only limited active duty service for training while in the National Guard or Reserves are not eligible unless there are special circumstances, e.g., death while on active duty, or as a result of training. Reservists and National Guard members who, at time of death, were entitled to retired pay, or would have been entitled, but for being under the age of 60, are eligible; please submit a copy of the Reserve Retirement Eligibility Benefits Letter with the claim. Reservists called to active duty other than training and National Guard members who are Federalized and who serve for the period called are eligible. * Interment means the burial or entombment of casketed or cremated remains, including the placement of cremated remains in a columbarium niche.

BENEFITS FORFEITED IN-LIEU OF A COMMEMORATIVE URN OR PLAQUE

A commemorative urn or plaque may only be provided in-lieu of other benefits that will be forfeited. If VA provides an urn or plaque for a veteran or service member, VA is prohibited from interring the veteran or service member in a VA national cemetery or providing a headstone or marker or medallion that would mark the veterans grave. If VA provides an applicant a commemorative urn or plaque to commemorate a veteran it may also negatively impact interment in other cemeteries including, but not limited to, cemeteries operated by the Department of Defense, including Arlington National Cemetery. VA encourages potential applicants for a commemorative urn or plaque who might seek interment in the future to check directly with other cemeteries regarding its effect on potential interment at those cemeteries. VA encourages careful consideration of the consequences before applying to VA for a commemorative urn or plaque. Many veterans and family members consider the benefits which will be forfeited to be of greater monetary and symbolic value than an urn or plaque. Consideration should also be given to the future disposition of the remains of a veteran or service member for whom an urn or plaque has been provided. Because options for future interment are more limited, there is greater risk for remains to become lost or unclaimed throughout time. For these reasons, it is critical that the family member consider the final disposition of the veteran's remains and be certain of their decision before completing this application for an urn or plaque.

Replacement Markers

The VA will replace a headstone or marker if:

- The headstone the family receives was not the one specified by the applicant, or
- The inscription was incorrect, or
- The material or workmanship is not in accordance with specifications, or
- The stone is deteriorated, illegible, stolen or vandalized

Memorial Services will replace headstones/markers, at no cost, if they made the error. All other errors, such as misspelled name or wrong date of birth or death are the responsibility of the person who signed block 19A on the VA Form 40-1330 ‘Claim for Standard Government Headstone or Marker’.

For guidance on obtaining a replacement headstone or marker, you may call the Memorial Programs Service Applicant Assistance Unit between the hours of 8:00 A.M. and 5:00 P.M. (ET), Monday through Friday at the toll-free number 1- 800-697-6947. Be sure you have a copy of the application with you when you call.

If the headstone or marker has deteriorated, is illegible, or has been vandalized you will need to reapply on a new VA Form 40-1330. Send the application and two pictures of the damaged headstone to Memorial Programs Service at the address found on the previous page.

Presidential Memorial Certificate

The VA administers the Presidential Memorial Certificate (PMC) program by preparing certificates which bear the current President’s signature expressing our countries grateful recognition of the Veteran’s service in the Armed Forces. Eligible recipients include the deceased veteran’s next of kin and loved ones. The VA will issue as many certificates as the family requests.

VA requests that you submit copies only of the separation papers and death certificate as they do not return original documents. Eligible recipients, or someone acting on their behalf, may apply for the PMC by mailing or faxing VA Form 40-0247. Could also apply by completing a 40-1330 or 40-1330M along with a copy of the veteran’s discharge and death certificate to verify eligibility to:
NCA FP Evidence Intake Center
PO Box 5237
Janesville, WI 53547
Or fax to: 1-800-455-7143

Burial Flags

A flag of the United States will be furnished by the VA to drape the casket of a deceased veteran who was:

- Discharged with an other than dishonorable discharge and served during a period of war or served at any time after January 31, 1955, or
- Entitled to retired pay for service in the Reserves or National Guard or would have been entitled to such pay upon reaching the age of 60, or
- A member or former member of the Selected Reserves or National Guard and served at least one enlistment, or in the case of an officer, the period of initial obligation, or was discharged for disability occurred in or aggravated in the line of duty, or died while a member of the Reserves or National Guard

Federal law prohibits persons convicted of, or, found to have committed a federal or state capital crime, from being furnished a burial flag, a headstone or marker, or a presidential memorial certificate.

The law allows one flag for a veteran's funeral. When death occurs in service, the issuance of a flag to the parents of the deceased service-member is authorized. This is in addition to the flag presented to the surviving spouse. These flags cannot be replaced by the VA if lost, destroyed or stolen.

In any case where a flag has not been issued at the time of interment, the nearest relative of the deceased may be issued a U.S. Flag for memorial purposes. A memorial flag will be issued to the next-of-kin in the same order of preference as a flag issued at the time of burial to drape the casket.

VA Form 21-2008 'Application for U.S. Flag for Burial Purposes' is used to apply for the flag. Flags may be obtained from VA Regional Offices, VA National Cemeteries and First-Class Post Offices.

Burial in a National Cemetery

Burial in a national cemetery is open to current and former members of the Armed Forces. Eligibility includes:

- Any member of the Armed Forces who died while on active duty
- Any veteran who was discharged under conditions other than dishonorable (Undesirable, bad conduct, or any other type of discharge other than honorable may be referred to a VA Regional Office for a determination of eligibility.)

Enlisted personnel who first entered active duty after September 7, 1980, or officers who began service after October 16, 1981, must meet the minimum active duty requirement of:

- Served 24 months of active duty, or
- Served the full period for which 'called' or 'ordered' to active duty (for example: members of the National Guard or Reserves who are activated for short periods of time such as the Gulf War)

Exceptions can be made for veterans who were discharged prior to their end of enlistment. As with other VA programs, benefits may be available if the discharge was for:

- Convenience of the government within three months of the end of their enlistment (which is an early out under Title 10, Section 1171), or
- Hardship (under Title 10, Section 1173), or
- Service connected disability

National Guard or Reserve members must meet ONE of the following criteria:

- Was entitled to military retirement pay based on service in the Guard or Reserves
- Was disabled or died from a disease or injury incurred or aggravated in the line of duty while on either active OR inactive duty for training
- Died while hospitalized or undergoing treatment at VA expense for an injury or disease contracted or incurred while performing either active or inactive duty for training
- Was a member of the Reserve Officers' Training Corps and died while attending a training camp or, while on authorized travel for training or, while hospitalized or undergoing treatment at VA expense for injury or disease contracted or incurred while in training.

Members of Reserve components who, during a period of active duty for training, were disabled or died from a disease or injury incurred or aggravated in the line of duty or, during a period of inactive duty training, were disabled or died from an injury or certain cardiovascular disorders incurred or aggravated in the line of duty.

Dependents

A veteran's spouse and certain dependent children may also be eligible for burial in a national cemetery. Some important facts to know are:

- It is not required that the veteran predecease the spouse
- It is not required that the veteran also be buried in the same national cemetery
- The veteran and spouse are buried in the same gravesite, if possible, but exceptions can be granted
- Remarried spouses may be eligible if their subsequent marriage was terminated by death or divorce

Children eligible for burial include those who at the time of death were:

- Under the age of 21
- Under the age of 23 and attending school
- Unmarried and physically or mentally disabled, and incapable of self-support, before reaching 21

Some additional individuals who may be eligible for interment in a national cemetery are:

- WWII Merchant Mariners with ocean going service between Dec. 7, 1941, to Dec. 31, 1946,
- Commissioned Officers of the National Oceanic and Atmospheric Administration
- Public Health Service members
- US citizens provided they had honorable wartime service with allied governments

Application Procedures

Gravesites cannot be reserved. Funeral directors, or others making burial arrangements, apply at the time of the veteran's or eligible dependent's death by contacting the Director or staff members of the National Cemetery where burial will take place. A copy of the veteran's DD-214, or other proof of qualifying service such as a casualty report, will be required to verify eligibility. Fax all discharge documentation to the National Cemetery Scheduling Office at 1-866- 900-6417 and follow-up with a phone call to 1-800-535-1117.

Burial at Sea Program

Burial at Sea is a means of final disposition of remains that is performed on United States Navy vessels. The committal ceremony is performed while the ship is deployed. Therefore, family members are not allowed to be present. The commanding officer of the ship assigned to perform the ceremony will notify the family of the logistics once the committal service has been completed.

Eligibility

Individuals eligible for this program are:

- Active duty members of the uniformed services
- Retirees and veterans who were honorably discharged
- U.S. civilian marine personnel of the Military Sealift Command and
- Dependent family members of active duty personnel, retirees, and veterans of the uniformed services

How to Get Started

After the death of the individual for whom the request for Burial at Sea is being made, the Person Authorized to Direct Disposition (PADD) should print out and complete a request form.
Navy – https://www.mynavyhr.navy.mil/Support-Services/Casualty/Mortuary-Services/Burial-at-Sea/
Coast Guard - https://www.dcms.uscg.mil/Portals/10/DOL/Base%20LALB/Documents/BurialAtSeaRequest.pdf?ver=2017-03-29-142210-710

Supporting documents which must accompany this request are:

1. Photocopy of the death certificate
2. Burial transit permit or the cremation certificate and
3. Copy of the DD Form 214, discharge certificate, or retirement order

The Burial at Sea Request Form and the three supporting documents make up the Burial at Sea Request package.

Burial Flag

A Burial Flag is required for all committal services performed aboard United States Naval vessels, except family members, who are not authorized a burial flag. Following the services at sea, the flag that accompanied the cremains/remains will be returned to the PADD. If the PADD does not wish to send a burial flag for the service, a flag will be provided by the Navy for the committal service, but will not be sent to the PADD.

Cremated Remains (Cremains)

Cremains must be in an urn or plastic/metal container to prevent spillage in shipping. The cremains, along with the completed Burial at Sea Request package, and the burial flag will be forwarded to the Burial at Sea Coordinator at the desired port of embarkation (listed below). Prior to shipment, it is recommended that a phone call be made informing the coordinator of the pending request. It is also recommended that the cremains package be sent via certified mail, return receipt requested.

Intact Remains (Casketed)

Specific guidelines are required for the preparation of casketed remains. All expenses incurred in this process are the responsibility of the PADD, who will select a funeral home in the area of the port of embarkation.

After this selection has been made and notification has been provided to the coordinator, the casketed remains, the request form, supporting documents, and the burial flag are to be forwarded to the receiving funeral home. The coordinator will make the inspection and complete the checklist for the preparation of casketed remains. It is recommended that funeral homes responsible for preparing and shipping intact remains contact Mortuary Service Office at Navy Casualty in Millington, TN.

Ports of Embarkation/Coordinators

Norfolk, VA
Commander, Naval Medical Center
ATTN: Code 0210C
620 John Paul Jones Cir.
Portsmouth, VA 23708-5100
Phone: (757) 953-2617\2618

Jacksonville, FL
Officer in Charge
Naval Hospital Branch Clinic
P. O. Box 280148
Naval Station
Mayport, FL 32228-0148
Phone: (904) 270-4285

San Diego, Calif.
Commanding Officer
Naval Medical Center
Decedent Affairs Code: 09O4
34800 Bob Wilson Drive
San Diego, CA 92134-5000
Phone: (800) 290-7410

Bremerton, Wash.
Commanding Officer
Naval Hospital Bremerton
Code: 015-BAS/HP01 Boone Road
Bremerton, WA 98312-1898
Phone: (360) 475-4313

Honolulu, Hi.
Navy Liaison Unit
Tripler Army Medical Center
Tripler AMC, HI 96859-5000
Phone: (808) 433-4709
(808) 577-7590

For More Assistance

If you have any questions about the Burial at Sea program, please contact the United States Navy Mortuary Affairs office toll-free at 1-866-787-0081.

Burial Benefits (Processed at PMC in St. Paul, MN)
21P-530
DD 214 – Certified
Death Certificate
Funeral Expense Statements

Burial Flag
27-2008
DD 214

OMB Approved No. 2900-0003
Respondent Burden: 30 Minutes
Expiration Date: 08/31/2025

Department of Veterans Affairs

APPLICATION FOR BURIAL BENEFITS
(Under 38 U.S.C. Chapter 23)

IMPORTANT - Please read the Privacy Act and Respondent Burden on page 8 before completing the form. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS IN SECTION VII, PAGE 7 OF THE FORM. *(Check the appropriate box) (See Instructions page 3)*

NOTE: You can *either* complete the form online or by hand. If you complete the form online, you may submit it at https://www.va.gov/ to expedite processing. If you complete the form by hand, please print the information requested in ink, neatly, and legibly to help process the form.

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

SECTION I - VETERAN'S INFORMATION

1. NAME OF THE DECEASED VETERAN *(First, Middle Initial, Last)*
Joe P Veteran

2. VETERAN'S SOCIAL SECURITY NUMBER
123-23-3456

3. VA FILE NUMBER
123233456

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
09-08-1947

5. VETERAN'S DATE OF DEATH *(MM/DD/YYYY)*
03-24-2024

6. VETERAN'S DATE OF BURIAL *(MM/DD/YYYY)*
04-02-2024

SECTION II - CLAIMANT'S INFORMATION

7. CLAIMANT'S NAME *(First, middle initial, last)*
Ann Veteran

8. CLAIMANT'S SOCIAL SECURITY NUMBER
666-66-6666

9. CLAIMANT'S DATE OF BIRTH *(MM/DD/YYYY) (See instructions for exceptions.)*
Month Day Year
09-03-1946

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

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number

City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

11. PREFERRED TELEPHONE NUMBER *(Include Area Code)*
(605)123-2345

12. E-MAIL ADDRESS

13. RELATIONSHIP OF CLAIMANT TO DECEASED VETERAN *(Check one)*

- [x] SPOUSE OR SURVIVOR OF LEGAL UNION
- [ ] CHILD
- [ ] PARENT
- [ ] EXECUTOR/ADMINISTRATOR OF ESTATE OR PERSON ACTING FOR THE ESTATE
- [ ] FUNERAL HOME OR OTHER THIRD PARTY
- [ ] OTHER RELATIVE OR FRIEND OF THE DECEASED (Non-Executor)

SECTION III - VETERAN'S SERVICE INFORMATION

The following information should be furnished for the periods of the VETERAN'S ACTIVE SERVICE

14A. ENTERED SERVICE		14B. SERVICE NUMBER	14C. SEPARATED FROM SERVICE		14D. GRADE, RANK OR RATING, ORGANIZATION AND BRANCH OF SERVICE
DATE *(MM/DD/YYYY)*	PLACE		DATE *(MM/DD/YYYY)*	PLACE	
01-01-1968	**Sioux Falls, SD**		**09-30-1974**	**Ft. Lewis, WA**	**E5 Army**

15. IF VETERAN SERVED UNDER NAME OTHER THAN THAT SHOWN IN ITEM 1, GIVE FULL NAME AND SERVICE RENDERED UNDER THAT NAME

SECTION IV - INFORMATION REGARDING FINAL RESTING PLACE

16. PLACE OF BURIAL PLOT, INTERMENT SITE, OR FINAL RESTING PLACE OF DECEASED VETERAN'S REMAINS

- [x] CEMETERY/GRAVEYARD
- [ ] PRIVATE RESIDENCE
- [ ] MAUSOLEUM/VAULT/TOMB/ENCRYPT
- [ ] OTHER *(SPECIFY)* _____

17. WAS THE VETERAN BURIED IN A NATIONAL CEMETERY, OR ONE OWNED BY THE FEDERAL GOVERNMENT?

- [ ] YES
- [x] NO *(If "Yes," provide name of cemetery)* _____

18. WAS THE VETERAN BURIED IN A CEMETERY OWNED BY THE STATE OR TRIBAL TRUST LAND?

- [ ] YES, State Cemetery
- [ ] YES, Tribal Trust Land
- [x] NO *(If "Yes," provide name and zip code of cemetery or Tribal Trust Land below)*

Name: Zip Code: _____

19A. DID A FEDERAL/STATE GOVERNMENT OR THE VETERAN'S EMPLOYER CONTRIBUTE TO THE BURIAL?	19B. AMOUNT OF GOVERNMENT OR EMPLOYER CONTRIBUTION
[ ] YES [x] NO *(If "Yes," complete Item 19B)*	$ .00

SECTION V - CLAIM FOR BURIAL ALLOWANCE

20A. SELECT TYPE OF BURIAL ALLOWANCE YOU ARE CLAIMING *(May apply for more than one.)*

- [ ] NON-SERVICE-CONNECTED BURIAL ALLOWANCE
- [x] SERVICE-CONNECTED BURIAL ALLOWANCE
- [ ] UNCLAIMED REMAINS OF THE VETERAN *(If claimed, you must answer question 20B)*

20B. WHERE DID THE VETERAN'S DEATH OCCUR? *(Check one)*

- [ ] NURSING HOME/FACILITY (NOT PAID BY VA) OR VETERAN'S RESIDENCE
- [ ] NURSING HOME/FACILITY (PAID BY VA)*
- [x] VA MEDICAL CENTER*
- [ ] STATE VETERANS FACILITY*
- [ ] OTHER (Specify place of death)* _____

*Please provide veteran's specific place of death including the name and location of the nursinghome, VA Medical Center or State veteran facility

21. IF YOU ARE THE DECEASED VETERAN'S SPOUSE, DID YOU PREVIOUSLY RECEIVE A VA BURIAL ALLOWANCE? [ ] YES [x] NO

22A. ARE YOU RESPONSIBLE FOR THE VETERAN'S BURIAL EXPENSES? [x] YES [ ] NO

22B. DO YOU CERTIFY THE REMAINS OF THE DECEASED VETERAN HAVE NOT BEEN CLAIMED BY RELATIVES OR FRIENDS **AND** THERE ARE NOT SUFFICENT RESOURCES AVAILABLE IN THE VETERAN'S ESTATE TO COVER THE BURIAL AND FUNERAL EXPENSES? *(Required only if claiming unclaimed remains of veteran)*

[ ] YES [ ] NO

SECTION VI - CLAIM FOR PLOT AND/OR TRANSPORTATION ALLOWANCE

23. ARE YOU RESPONSIBLE FOR THE VETERAN'S PLOT OR INTERMENT EXPENSES? [x] YES [ ] NO

24. ARE YOU RESPONSIBLE FOR THE VETERAN'S TRANSPORTATION EXPENSES FROM THE PLACE OF DEATH TO THE FINAL RESTING PLACE?
(You must include an itemized receipt.) [x] YES [ ] NO

SECTION VII - CLAIM CERTIFICATION AND SIGNATURES (MUST COMPLETE)

CLAIMANT CERTIFICATION AND SIGNATURE

- [x] I WANT my claim processed under the FDC program. I CERTIFY and authorize the release of information. I CERTIFY that the statements in this document are true and complete to the best of my knowledge. I AUTHORIZE any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me and the veteran, and I WAIVE any privilege which makes the information confidential. I CERTIFY I have received the notice attached to this application titled, *Application for Burial Benefits*, and, I CERTIFY I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; or, I have no additional information or evidence to give VA to support my claim.
- [ ] I do not want my claim processed under the FDC program. I am indicating I want my claim processed under the standard claim process because I plan to submit further evidence in support of my claim.

25A. SIGNATURE OF CLAIMANT **(REQUIRED)** *(Physical Signature OR E-Signature) (If signed using an "X", complete Items 27A through 28B) (If signing for a firm, corporation, or State agency, complete Items 26A through 26B)*	25B. PRINTED NAME OF CLAIMANT **Ann Veteran**
26A. FULL PRINTED NAME AND ADDRESS OF PERSON, FIRM, CORPORATION, OR STATE AGENCY SIGNING AS CLAIMANT *(If different from Item 7)*	26B. OFFICIAL POSITION OF PERSON SIGNING ON BEHALF OF FIRM, CORPORATION OR STATE AGENCY

SECTION VIII - WITNESSES TO SIGNATURE

NOTE - If the claimant signed above using an "X", a signature must be witnessed by two persons to whom the person making the statement and the signatures and addresses of such witnesses must be shown below.

27A. SIGNATURE OF WITNESS (Physical Signature) *(Only sign if the signature in Item 25A used an "X")*	27B. PRINTED NAME AND ADDRESS OF WITNESS

28A. SIGNATURE OF WITNESS *(Physical Signature) (Only sign if the signature in Item 25A used an "X")*	28B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION IX: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (REQUIRED ONLY IF ITEM 25A IS BLANK)

I CERTIFY THAT by signing on behalf of the claimant, I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; AND, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I UNDERSTAND that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

29A. ALTERNATE SIGNER SIGNATURE **(REQUIRED only if 25A is blank)** *(Physical Signature)*	29B. DATE SIGNED *(MM/DD/YYYY)* **04-16-2024**

PRIVACY ACT INFORMATION: The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law and is required to obtain benefits. Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine your eligibility for burial benefits. Title 38, United States Code, 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. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain.

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false.

DEPARTMENT OF VETERANS AFFAIRS HEADSTONES AND MARKERS

The Department of Veterans Affairs will furnish, upon request, a Government headstone or marker at the expense of the United States for the unmarked graves of certain individuals eligible for burial in a national cemetery, but not buried there. These individuals may include any veterans with an other than dishonorable discharge who dies after service or any servicemember who dies on active duty. Certain other individuals may also be eligible for the headstone or marker. Headstones or Markers for all individuals in a national or post cemetery are furnished automatically without a request from the family. For additional information on burial benefits go to the web site, https://www.cem.va.gov/burial_benefits/index.asp . To obtain VA Form 40-1330, Application for Standard Government Headstone or Marker go to www.va.gov/vaforms or contact your local VA regional office. The address of that office can be found at www.va.gov/directory .

OMB Control No. 2900-0013
Respondent Burden: 15 Minutes
Expiration Date: 04-30-2024

Department of Veterans Affairs — APPLICATION FOR UNITED STATES FLAG FOR BURIAL PURPOSES

PRIVACY ACT NOTICE: 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 the veteran's SSN account information is voluntary. Refusal to provide the veteran's SSN by itself will not result in the denial of benefits. 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 entitlement to benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.
RESPONDENT BURDEN: We need this information to determine eligibility for issuance of a burial flag to a family member or friend of a deceased veteran (38 U.S.C. 2301). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IMPORTANT - Postmaster or other issuing official: Submit this form to address listed in block 22.

INFORMATION ABOUT THE DECEASED VETERAN *(Complete as much as possible)*
(Information provided is considered essential when applying for other VA benefits.)

1. FIRST, MIDDLE, LAST NAME OF VETERAN *(Print or type)*	2. MAIDEN NAME OR OTHER NAME(S) VETERAN USED WHILE ON ACTIVE DUTY *(Print or type)*

3. VA FILE NUMBER	4. SOCIAL SECURITY NUMBER	5. MILITARY SERVICE NUMBER/SERIAL NUMBER

6. BRANCH OF SERVICE *(Check box)*

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ SPACE FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ SELECTED SERVICE

☐ OTHER *(Specify)*

7. DATE ENTERED ACTIVE DUTY *(or Selected Reserve)*	8. DATE RELEASED FROM ACTIVE DUTY *(or Selected Reserve)*	9. DATE OF BIRTH	10. DATE OF DEATH

11. DATE OF BURIAL	12. PLACE OF BURIAL *(Name of cemetery, city, and State)*

13. HAS DOCUMENTATION BEEN PRESENTED OR ATTACHED THAT SHOWS THE VETERAN MEETS THE ELIGIBILITY CRITERIA? *(See Paragraphs C, D, and E of the "Instructions")*

☐ YES ☐ NO *(If "No," explain in Item 15, "Remarks" (See paragraph E of the "Instructions"))*

INFORMATION ABOUT THE FLAG RECIPIENT AND APPLICANT

14A. NAME OF PERSON ENTITLED TO RECEIVE FLAG	14B. RELATIONSHIP OF DECEASED VETERAN *(See Paragraph F of the "Instructions")*

14C. ADDRESS OF PERSON ENTITLED TO RECEIVE FLAG *(Number and street or rural route, city or P.O., State and ZIP Code)*	14D. TELEPHONE NUMBER

15. REMARKS

I CERTIFY that the statements made in this document are true and complete to the best of my knowledge. I further certify that the deceased veteran is eligible, in accordance with the attached instructions, for issue of a United States flag for burial purposes, and such flag has not been previously applied for or furnished.

16. SIGNATURE OF APPLICANT *(Sign in INK)*	17. ADDRESS OF APPLICANT *(Number and street or rural route, city or P.O., and ZIP Code)*	18. RELATIONSHIP TO DECEASED VETERAN	19. DATE SIGNED

PENALTY - **The law provides that whoever makes any statement of a material fact knowing it to be false shall be punished by a fine, imprisonment, or both.**

ACKNOWLEDGMENT OF RECEIPT OF FLAG (ONLY ONE FLAG MAY BE ISSUED FOR EACH DECEASED VETERAN)

20. SIGNATURE OF PERSON RECEIVING FLAG *(Sign in INK)*	21. DATE FLAG ISSUED

When the burial flag is issued, send the completed VA Form 27-2008 to:
NCA Field Programs Evidence Intake Center
PO Box 5237
Janesville, WI 53547

INSTRUCTIONS

A. How can I contact VA if I have questions?
If you have questions about this form, how to fill it out, or about benefits, contact your nearest VA regional office. You can locate the address of the nearest regional office in your telephone book blue pages under "United States Government, Veterans" or call 1-800-827-1000 (Hearing Impaired TDD relay line is 711). You may also contact VA by Internet at https://iris.custhelp.va.gov/.

B. How do I apply for a burial flag?
Complete VA Form 27-2008, and submit it to any VA regional office or U.S. Post Office. When a burial is in a national cemetery a burial flag will be provided by a funeral home.

Note: Applicants residing overseas can apply for burial flags at U.S. embassies and consulates.

C. Who is eligible for a burial flag?
Generally, veterans with an other than dishonorable discharge. *Note:* This includes veterans who served in the Philippine military forces while such forces were in the service of the U.S. armed forces under the President's Order of July 26, 1941 and died on or after April 25, 1951, and veterans who served in the Philippine military services are eligible for burial in a national cemetery.

Veterans who were entitled to retired pay for service in the reserves, or would have been entitled to such pay but not for being under 60 years of age.

Members or former members of the Selected Reserve (Army, Air Force, Coast Guard, Marine Corps, or Naval Reserve; Air National Guard; or Army National Guard) who served at least one enlistment or, in the case of an officer, the period of initial obligation, or were discharged for disability incurred or aggravated in line of duty, or died while a member of the Selected Reserve.

D. Who is not eligible for a burial flag?
Veterans who received a dishonorable discharge.

• Members of the Selected Reserve whose last discharge from service was under conditions less favorable than honorable.

• Peacetime veterans who were discharged before June 27, 1950 and did not serve at least one complete enlistment or incur or aggravate a disability in the line of duty.

• Veterans who were convicted of a Federal capital crime and sentenced to death or life imprisonment, or were convicted of a State capital crime and sentenced to death or life imprisonment without parole, or were found to have committed a Federal or State capital crime but were not convicted by reason of not being available for trial due to death or flight to avoid prosecution.

• Discharged or rejected draftees, or members of the National Guard, who reported to camp in answer to the President's call for World War I service but who, when medically examined, were not finally accepted for military service.

• Persons who were discharged from World War I service prior to November 12, 1918, on their own application or solicitation by reason of being an alien, or any veterans discharged for alienage during a period of hostilities.

D. Who is not eligible for a burial flag? *(Continued)*

• Persons who served with any of the forces allied with the United States in any war, even though United States citizens, if they did not serve with the United States armed forces.

• Persons inducted for training and service who, before entering such training and service were transferred to the Enlisted Reserve Corps and given a furlough.

• Former temporary members of the United States Coast Guard Reserve.

E. What documentation is required in order to receive a burial flag?
Provide a copy of the veteran's discharge documents that shows service dates and the character of service, such as DD Form 214, or verification of service from the veteran's service department or VA. Various information requested, is considered essential to the proper processing of the application. Ensure these areas are completed as fully as possible. *Note:* If the claimant is unable to provide documentary proof, a flag may be issued when a statement is made by a person of established character and reputation that he/she personally knows the deceased to have been a veteran who meets the eligibility criteria.

F. Who is eligible to receive a burial flag?
Only one flag may be issued for each deceased veteran. Generally, the flag is given to the next-of-kin as a keepsake after its use during the funeral service. The flag is given to the following person(s) in the order of precedence listed:

• surviving spouse

• children, according to age

• parents, including adoptive, stepparents, and foster parents

• brothers or sisters, including brothers or sisters of half blood

• uncles or aunts

• nephews or nieces

• others, such as cousins or grandparents

Note: When there is no next-of-kin, VA will furnish the flag to a friend making a request for it. If there is no living relative or one cannot be located, and no friend requests the flag, it must be returned to the nearest VA facility.

G. Can a burial flag be replaced?
VA cannot replace a burial flag if it is lost, destroyed or stolen. However, some veteran organizations or community groups may be able to help you get another flag.

USE OF THE FLAG

1. This flag is issued on behalf of the Department of Veterans Affairs to honor the memory of one who has served our country.

2. When used to drape the casket, the flag should be placed as follows:

(a) Closed Casket - When the flag is used to drape a closed casket, it should be so placed that the union (blue field) is at the head and over the left shoulder of the deceased.

(b) Half Couch (Open) - When the flag is used to drape a half-couch casket, it should be placed in three layers to cover the closed half of the casket in such a manner that the blue field will be the top fold, next to the open portion of the casket on the deceased's left.

(c) Full Couch (Open) - When the flag is used to drape a full-couch casket, it should be folded in a triangular shape and placed in the center part of the head panel of the casket cap, just above the left shoulder of the deceased.

3. During a military commitment ceremony, the flag which was used to drape the casket is held waist high over the grave by the pallbearers and, immediately after the sounding of "Taps," is folded in accordance with the illustration below.

4. Folding the flag (see illustration below):

5. The flag should not be lowered into the grave or allowed to touch the ground. When taken from the casket, it should be folded as shown (see illustration).

6. The flag should form a distinctive feature of the ceremony of the unveiling of a statue or monument, but it should never be used as a covering for the statue or monument.

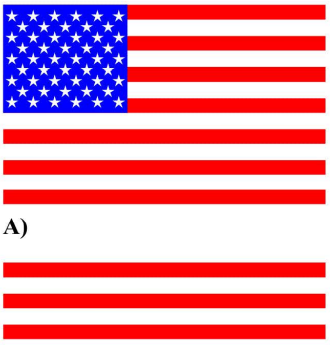
7. The flag should never be fastened, displayed, used, or stowed in such a manner as will permit it to be easily torn, soiled, or damaged in any way.

8. The flag should never have placed upon it, nor any part of it, nor attached to it, any mark, insignia, letter, word, figure, design, picture, or drawing of any nature.

9. The flag should never be used as a receptacle for receiving, holding, carrying, or delivering anything.

10. The flag, when badly worn, torn, or soiled should no longer be publicly displayed, but privately destroyed by burning in such a manner as to convey no suggestion of disrespect or irreverence.

CORRECT METHOD OF FOLDING THE UNITED STATES FLAG



(A) Straighten out the flag to full length and fold lengthwise once, folding the lower striped section of the flag over the blue field.

(B) Fold the flag lengthwise a second time to meet the open edge, making sure that the union of stars on the blue field remains outward in full view.

(C) A triangular fold is then started by bringing the striped corner of the folded edge to the open edge.

(D) The outer point is then turned inward, parallel with the open edge to form a second triangle.

(E) The diagonal or triangular folding is continued toward the blue union until the end is reached, with only the blue showing and the form being that of a cocked (three corner) hat.

Headstone Request (Processed at Memorial Affairs in Quantico, VA)
40-1330
DD 214 – Certified
Death Certificate

Medallion Request (Processed at Memorial Affairs in Quantico, VA)
40-1330M
DD 214 – Certified
Death Certificate

Commemorative Urn and Plaque
40-1330UP
DD 214 – Certified
Death Certificate

Form approved, OMB No. 2900-0222
Expiration Date: Sept. 30, 2024
Respondent Burden: 15 minutes

VA U.S. Department of Veterans Affairs

CLAIM FOR STANDARD GOVERNMENT HEADSTONE OR MARKER

IMPORTANT: Please read the General Information Sheet before completing this form. Type or print clearly all information except for signatures. Illegible printing could result in an incorrect headstone or marker or delivery. Failure to complete each block may result in delayed processing. *Blocks outlined in bold are optional inscription items.* **PLEASE INCLUDE MILITARY DISCHARGE DOCUMENTS.**

1. **TYPE OF REQUEST**
- [x] INITIAL REQUEST *(First time)*
- [ ] REPLACEMENT *(Specify reason in Block 33, Remarks)*

2. CHECK BOX IF REMAINS ARE NOT BURIED AND EXPLAIN IN BLOCK 33 (e.g., buried at sea, remains scattered, etc.)
- [ ] REMAINS NOT BURIED

3. NAME OF DECEASED TO BE INSCRIBED ON HEADSTONE OR MARKER ***(NO NICKNAMES OR TITLE PERMITTED)***

FIRST *(Or Initial)*	MIDDLE *(Or Initial)*	LAST	SUFFIX *(Sr., Jr., II, III, etc.)*
Joe	**P**	**Veteran**	

4. IS GRAVE CURRENTLY MARKED WITH A PRIVATELY PURCHASED, PERMANENT AND DURABLE MARKER
- [ ] YES
- [x] NO

5. RACE OR ETHNICITY *(You may select more than one. Information will be used for statistical purposes only.)*
- [ ] ASIAN OR ASIAN AMERICAN
- [ ] HISPANIC OR LATINO
- [x] WHITE
- [ ] AMERICAN INDIAN OR ALASKA NATIVE
- [ ] NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- [ ] BLACK OR AFRICAN AMERICAN
- [ ] NOT HISPANIC OR LATINO

6. SEX *(Information will be used for statistical purposes only.)*
- [x] MALE
- [ ] FEMALE
- [ ] UNSPECIFIED OR ANOTHER GENDER IDENTITY

VETERAN'S SERVICE AND IDENTIFYING INFORMATION (Use numbers only, e.g., 05-15-1941)

7. VETERAN'S SOCIAL SECURITY NO. AND/OR SERVICE NO.
SSN: **123-23-3456** AND/OR SVC. NO.:

8. PLACE OF BIRTH *(City and State or Country)*
Miller SD

9A. DATE OF BIRTH			9B. DATE OF DEATH		
MONTH	DAY	YEAR	MONTH	DAY	YEAR
09	**08**	**1947**	**03**	**24**	**2024**

PERIODS OF ACTIVE MILITARY DUTY *(For additional space use Block 33)*

10A. DATE(S) ENTERED			10B. DATE(S) SEPARATED		
MONTH	DAY	YEAR	MONTH	DAY	YEAR
01	**01**	**1968**	**09**	**30**	**1974**

11. **HIGHEST RANK ATTAINED** ***(Optional, but if included, no pay grades)***
E5

12. **PRISONER OF WAR** *(Optional, but if included, documentation must be provided))*
- [ ] POW
- [ ] FORMER POW (FPOW)

13. BRANCH OF SERVICE *(Check applicable box(es) - must be consistent with rank in Box 12)*

ARMY	NAVY	MARINE CORPS	COAST GUARD	AIR FORCE	ARMY AIR FORCES	MERCHANT MARINE	SPACE FORCE	PUBLIC HEALTH SVC.	OTHER *(Specify)*
[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

14. **VALOR OR PURPLE HEART AWARD(S)** ***(Optional, but if included, documentation must be provided)***

MEDAL OF HONOR	DST SVC CROSS	SILVER STAR	DST FLYING CROSS	PURPLE HEART	AIR MEDAL	OTHER *(Specify)*
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

15. *TYPE OF HEADSTONE OR MARKER REQUESTED (Please ensure marker selection is permitted at selected cemetery.)* (Check one)

FLAT BRONZE	FLAT GRANITE	UPRIGHT MARBLE	FLAT MARBLE	BRONZE NICHE	UPRIGHT GRANITE	SMALL FLAT GRANITE
[x] B	[ ] G	[ ] U	[ ] F	[ ] Z	[ ] V	[ ] L

16. **WAR SERVICE (Optional, but if included, check all applicable box(es)**
- [ ] WORLD WAR II
- [ ] KOREA
- [x] VIETNAM
- [ ] OTHER (Specify)
- [ ] PERSIAN GULF
- [ ] AFGHANISTAN
- [ ] IRAQ

17. **EMBLEM OF BELIEF** ***(Optional)***
EMBLEM NUMBER *(Specify)*
(See page 5 for available emblems)
- [ ]
- [ ] NONE

18. **ADDITIONAL INSCRIPTION/TERM OF ENDEARMENT** ***(Optional)*** *(Space will vary according to type of marker)*
Loving Husband

19A. NAME AND MAILING ADDRESS OF APPLICANT *(No., Street, City, State, and ZIP code)*
,

19b. DAYTIME OR CELL TELEPHONE NUMBER OF APPLICANT *(Include Area Code)* ( )

19c. E-MAIL ADDRESS *(Optional)*

19d. FAX NO. *(Optional)*

APPLICANT IS:
- [ ] FAMILY MEMBER *(Specify relationship)*
- [ ] VETERANS SERVICE OFFICER
- [ ] PERSONAL REPRESENTATIVE *(Person responsible for decisions concerning burial of decedent; include written authorization)*

21. IF REMAINS ARE UNCLAIMED, APPLICANT IS:
- [ ] FUNERAL HOME *(that received remains)*
- [ ] CEMETERY *(where remains are buried)*

22. PRESIDENTIAL MEMORIAL CERTIFICATE (bearing the signature of the current President) the number you request to be mailed to you. VA will send one certificate if no quantity is indicated and "none" is not selected.
NUMBER REQUESTED [ ] NONE

CERTIFICATION: By signing below I certify the headstone or marker will be installed in the cemetery listed in block 29 at no expense to the Government and all information entered on this form is true and correct to the best of my knowledge. I also certify, to the best of my knowledge, that the decedent has never committed a serious crime, such as murder or other offense that could have resulted in imprisonment for life, has never been convicted of a serious crime, and has never been convicted of a sexual offense for which the Veteran was sentenced to a minimum of life imprisonment.
PENALTY: The law provides severe penalties, which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false or for the fraudulent acceptance of any benefit to which you are not entitled.

23. SIGNATURE OF APPLICANT

24. DATE *(MM/DD/YYYY)*
04/16/2024

CERTIFICATION: By signing below I agree to accept prepaid delivery of the headstone or marker for placement on the gravesite for which it is requested, or if placement on the grave is impossible or impractical, as close to the grave as possible within the grounds of the private or local governmental cemetery where the grave is located.

25. NAME AND DELIVERY ADDRESS OF BUSINESS (CONSIGNEE) THAT WILL ACCEPT PREPAID DELIVERY *(No., Street, City, State, and ZIP Code; P.O. BOX IS NOT ACCEPTABLE)* **MUST SIGN IN BLOCK 27**
,

26. DAYTIME OR CELL PHONE NO. OF CONSIGNEE *(Include Area Code)*
-

27. **PRINTED NAME AND SIGNATURE** OF PERSON REPRESENTING BUSINESS (CONSIGNEE) NAMED IN BLOCK 25

28. DATE *(MM/DD/YYYY)*
04/16/2024

CERTIFICATION: By signing below I certify the type and placement of the headstone or marker in block 15 adheres to the policies and guidelines of the selected private cemetery in block 25.

29. NAME AND ADDRESS OF CEMETERY OR FAMILY PLOT WHERE GRAVE IS LOCATED (No., Street, City, State, and ZIP Code) **MUST SIGN IN BLOCK 31**
,

30. DAYTIME PHONE NO. OF CEMETERY *(Include Area Code)*

31. **PRINTED NAME AND SIGNATURE** OF CEMETERY OR OTHER RESPONSIBLE OFFICIAL

32. DATE *(MM/DD/YYYY)*

33. REMARKS

34. STATION NO. *(State/Tribal Cemetery Only)*

35. SECTION/GRAVE NO. *(State Cemetery Only)*

Form approved, OMB No. 2900-0222
Expiration Date: Sept. 30, 2024
Respondent Burden: 15 minutes

VA U.S. Department of Veterans Affairs

CLAIM FOR GOVERNMENT MEDALLION FOR PLACEMENT IN A PRIVATE CEMETERY

IMPORTANT: Please read the General Information Sheet before completing this claim. Type or print clearly all information except for signatures. Illegible printing could result in incorrect delivery of the medallion. Failure to complete each block may result in delayed processing. **PLEASE INCLUDE MILITARY DISCHARGE DOCUMENTS.**

1. CHECK BOX BELOW IF REMAINS ARE NOT BURIED AND EXPLAIN BELOW *(e.g., buried at sea, remains scattered, etc.)*
☐ REMAINS NOT BURIED

2. NAME OF DECEASED VETERAN

FIRST *(Or Initial)*	MIDDLE *(Or Initial)*	LAST	SUFFIX
Joe	**P**	**Veteran**	

3. THERE MUST BE A SET HEADSTONE, MAUSOLEUM, OR CRYPT IN PLACE TO AFFIX THE MEDALLION. IS GRAVE CURRENTLY MARKED WITH A PRIVATELY PRUCHASED PERMANENTAND DURABLE MARKER?
☐ YES ☐ NO

4. RACE OR ETHNICITY *(You may select more than one. Information will be used for statistical purposes only.)*
☐ ASIAN OR ASIAN AMERICAN
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ BLACK OR AFRICAN AMERICAN
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☑ WHITE

5. SEX *(Information will be used for statistical purposes only.)*
☑ MALE
☐ FEMALE
☐ UNSPECIFIED OR ANOTHER GENDER IDENTITY

VETERAN'S SERVICE AND IDENTIFYING INFORMATION *(Use numbers only, e.g., 05-15-1941)*

6. VETERAN'S SOCIAL SECURITY NO. AND/OR SERVICE NO.
SSN: **123-23-3456** SVC. NO.:

7. PLACE OF BIRTH (City and State or Country)
Miller SD

PERIODS OF ACTIVE MILITARY DUTY

8A. DATE OF BIRTH			8B. DATE OF DEATH			9A. DATE(S) ENTERED			9B. DATE(S) SEPARATED		
MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR
09	**08**	**1947**	**03**	**24**	**2024**	**01**	**01**	**1968**	**09**	**30**	**1974**

10. BRANCH OF SERVICE (BOS) (Check applicable box(es)) **NOTE:** If one BOS is selected, it will be spelled out on the medallion, i.e. U.S. ARMY, U.S. AIR FORCE, etc. If more than one BOS is selected, they will be abbreviated on the medallion, i.e. USA, USAF, USN, USMC, USCG, etc.
☑ ARMY ☐ MARINE CORPS ☐ COAST GUARD ☐ MERCHANT MARINE ☐ NAVY ☐ AIR FORCE ☐ ARMY AIR FORCES (WW II)
☐ SPACE FORCE ☐ PUBLIC HEALTH SVC. ☐ NATL. OCEANIC AND ATMOSPHERIC ADMIN. ☐ OTHER *(Specify)*

11. MEDALLION SIZE REQUESTED (Check one) (Refer to general information sheet for exact sizes)
☑ LARGE (M5) ☐ MEDIUM (M3) ☐ SMALL (M1)

12. APPLICANT IS:
☐ FAMILY MEMBER *(Specify relationship)*
☐ VETERANS SERVICE OFFICER
☐ PERSONAL REPRESENTATIVE *(Person responsible for decisions concerning burial of decedent; include written authorization)*
☐ OTHER *(Specify)*

13. IF REMAINS ARE UNCLAIMED, APPLICANT IS:
☐ FUNERAL HOME *(that received remains)* ☐ CEMETERY (where remains are buried)

14. NAME AND MAILING ADDRESS OF APPLICANT *(No., Street, City, State, and ZIP Code)*	15. DAYTIME PHONE NO. OF APPLICANT	16. E-MAIL ADDRESS *(Optional)*
57107		

17. PRESIDENTIAL MEMORIAL CERTIFICATE *(bearing the signature of the current President) the number you request to be mailed to you. VA will send one certificate if no quantity is indicated and "none" is not selected.*
NUMBER REQUESTED ☐ NONE

CERTIFICATION: By signing below I certify the medallion will be affixed to a privately purchased headstone or marker in the cemetery listed in Block 23 at no expense to the Government, and that I (or the party listed in Block 21) have agreed to accept delivery, and all information entered on this claim is true and correct to the best of my knowledge. I also certify, to the best of my knowledge, that the decedent has never committed a serious crime, such as murder or other offense that could have resulted in imprisonment for life, has never been convicted of a serious crime, and has never been convicted of a sexual offense for which the Veteran was sentenced to a minimum of life imprisonment.

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

19. SIGNATURE OF CLAIMANT	20. DATE *(MM/DD/YYYY)*
	04/16/2024

21. NAME AND DELIVERY ADDRESS FOR MEDALLION *(No., Street, City, State, and ZIP Code); (If same as applicant, please enter SAME)*	22. DAYTIME PHONE NO. *(Include Area Code)*	23. NAME AND ADDRESS OF CEMETERY WHERE PRIVATELY PURCHASED HEADSTONE OR MARKER OF THE DECEASED VETERAN IS LOCATED *(No., Street, City, State, and ZIP Code)*

CERTIFICATION: By signing below I certify the size medallion indicated above is permitted in the cemetery.

24. SIGNATURE OF CEMETERY OFFICIAL	25. DATE *(MM/DD/YYYY)*
	04/16/2024

CLAIM FOR COMMEMORATIVE URN OR PLAQUE FOR VETERANS' CREMAINS NOT INTERRED

GENERAL INFORMATION SHEET

RESPONDENT BURDEN - An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0937, and it expires 05/31/2027. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0937 in any correspondence. Do not send your completed VA Form 40-1330UP to this email address.

PRIVACY ACT - VA considers the responses you submit confidential (38 U.S.C. 5701). VA may only disclose this information outside the VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 48VA40B, published in the Federal Register. VA considers the requested information relevant and necessary to determine maximum benefits under the law.

BENEFIT PROVIDED:

a. COMMEMORATIVE URN: a container that signifies the deceased individual's status as a veteran, in which the individual's cremated remains may be placed at private expense.

b. COMMEMORATIVE PLAQUE: a commemorative plaque means a tablet that signifies the deceased individual's status as a veteran.

WHO CAN BE COMMEMORATED BY AN URN OR PLAQUE - A deceased Veteran who has been cremated with no portion of the remains interred* at any location at the time of application, and who was discharged under conditions other than dishonorable on or after April 6, 1917, or any Servicemember of the Armed Forces of the United States who dies on active duty whose remains have been cremated and is NOT interred at any location. **Service after September 7, 1980 for enlisted personnel, and October 16, 1981 for officer personnel, must be for a minimum of 24 months continuous active duty or be completed under special circumstances, e.g., death on active duty**. Persons who have only limited active duty service for training while in the National Guard or Reserves are not eligible unless there are special circumstances, e.g., death while on active duty, or as a result of training. Reservists and National Guard members who, at time of death, were entitled to retired pay, or would have been entitled, but for being under the age of 60, are eligible; please submit a copy of the Reserve Retirement Eligibility Benefits Letter with the claim. Reservists called to active duty other than training and National Guard members who are Federalized and who serve for the period called are eligible.

* *Interment means the burial or entombment of casketed or cremated remains, including the placement of cremated remains in a columbarium niche.*

BENEFITS FORFEITED IN-LIEU OF A COMMEMORATIVE URN OR PLAQUE - A commemorative urn or plaque may only be provided in-lieu of other benefits that will be forfeited. If VA provides an urn or plaque for a Veteran or Servicemember, VA is prohibited from interring the Veteran or Servicemember in a VA national cemetery or providing a headstone or marker or medallion that would mark the Veterans grave. If VA provides an applicant a commemorative urn or plaque to commemorate a Veteran it may also negatively impact interment in other cemeteries including, but not limited to, cemeteries operated by the Department of Defense, including Arlington National Cemetery. VA encourages potential applicants for a commemorative urn or plaque who might seek interment in the future to check directly with other cemeteries regarding its effect on potential interment at those cemeteries. VA encourages careful consideration of the consequences before applying to VA for a commemorative urn or plaque. Many Veterans and family members consider the benefits which will be forfeited to be of greater monetary and symbolic value than an urn or plaque. Consideration should also be given to the future disposition of the remains of a Veteran or Servicemember for whom an urn or plaque has been provided. Because options for future interment are more limited, there is greater risk for remains to become lost or unclaimed throughout time. For these reasons, it is critical that the family member consider the final disposition of the Veteran's remains and be certain of their decision before completing this application for an urn or plaque.

WHO MAY APPLY FOR AN URN OR PLAQUE TO COMMEMORATE A VETERAN - The family member who holds the entirety of the cremated remains and is authorized to make decisions about the disposition of the Veteran. Family members include the decedent's spouse or individual who was in a legal union as defined in 38 CFR 3.1702(b)(1)(ii) with the decedent; a child, parent, or sibling of the decedent, whether biological, adopted, or step relation; and any lineal or collateral descendant of the decedent.

HOW TO SUBMIT A CLAIM - Please attach a copy of the deceased Veteran's discharge certificate (DD Form 214 or equivalent), the VA Pre-Need Eligibility Determination letter, or a copy of other official document(s) establishing qualifying military service. If you are unable to locate copies of military records, apply anyway, as VA will attempt to obtain records necessary to make an eligibility determination. **Do not send original documents**; they will not be returned.

ELECTRONICALLY submit your claim and supporting documents by using Quick Submit at **access.va.gov**. You will be instructed to register during your first sign-on attempt.

If you prefer, you may
MAIL claims to: NCA FP Evidence Intake Center
PO Box 5237
Janesville, WI 53547

ASSISTANCE NEEDED - Should you have questions when filling out this form, you may contact our Applicant Assistance Unit toll free at: 1-800-697-6947, or at: ask.va.gov. No fee should be paid in connection with the preparation of this claim.

TRANSPORTATION AND DELIVERY OF URN OR PLAQUE - VA will ship the commemorative urn or plaque without charge to the applicant designated in block 10a of the claim.. The applicant must provide the full delivery address and telephone number. If you fail to include the required address and telephone number, we will not deliver the urn or plaque. Upon receipt, a signature will be required. Unless the urn or plaque was damaged during shipping, VA will not replace the product.

OMB Approved No. 2900-0937
Respondent Burden: 10 minutes
Expiration Date: 05/31/2027

VA U.S. Department of Veterans Affairs

CLAIM FOR COMMEMORATIVE URN OR PLAQUE FOR VETERANS' CREMAINS NOT INTERRED

IMPORTANT: Please read the General Information Sheet before completing this form. Type or print clearly all information except for signatures. Illegible printing could result in incorrect or delayed delivery. Failure to complete each block may result in delayed processing. *Blocks outlined in bold are optional inscription items.* **PLEASE INCLUDE MILITARY DISCHARGE DOCUMENTS.**

1. TYPE OF PRODUCT REQUESTED
☐ PLAQUE ☐ URN

VETERAN'S SERVICE AND IDENTIFYING INFORMATION *(Use numbers only, e.g., 05-15-1941)*

2. NAME OF DECEASED VETERAN TO BE COMMEMORATED

FIRST *(Or Initial)*	MIDDLE *(Or Initial)*	LAST	SUFFIX *(Sr., Jr., II, III, etc.)*
Joe	P	Veteran	

3. VETERAN'S SOCIAL SECURITY NO. AND/OR SERVICE NO.
SSN: 123-23-3456 SVC. NO.:

4. PLACE OF BIRTH *(City and State or Country)*
Pierre, SD

5. VETERAN'S RACE AND/OR ETHNICITY *(You may select more than one. Information will be used for statistical purposes only)*
☐ ASIAN OR ASIAN AMERICAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE
☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

6. SEX *(Information will be used for statistical purposes only)*
☒ MALE ☐ FEMALE ☐ UNSPECIFIED OR ANOTHER GENDER IDENTITY

PERIODS OF ACTIVE MILITARY DUTY

7A. DATE OF BIRTH *(MM/DD/YYYY)*	7B. DATE OF DEATH *(MM/DD/YYYY)*	8A. DATE(S) ENTERED *(MM/DD/YYYY)*	8B. DATE(S) SEPARATED *(MM/DD/YYYY)*
09/08/1947	03/24/2024	09/01/1960	08/28/1963

9. BRANCH OF SERVICE *(Check applicable box(es))*
☒ ARMY ☐ MARINE CORPS ☐ COAST GUARD ☐ MERCHANT MARINE ☐ NAVY ☐ AIR FORCE ☐ ARMY AIR FORCES *(WWII)*
☐ SPACE FORCE ☐ PUBLIC HEALTH SVC. ☐ NATL. OCEANIC AND ATMOSPHERIC ADMIN. ☐ OTHER *(Specify)*: _____

APPLICANT INFORMATION AND CERTIFICATION

10A. NAME AND MAILING ADDRESS OF APPLICANT *(No., Street, City, State, and ZIP Code)*	10B. DAYTIME PHONE NO. OF APPLICANT	10C. E-MAIL ADDRESS *(Optional)*
Ann Veteran 123 Tenbucktwo Ave Sioux Falls, SD 57104	605-123-3456	

11. BENEFITS FORFEITED IN-LIEU OF A COMMEMORATIVE URN OR PLAQUE

A commemorative urn or plaque may only be provided in-lieu of other benefits that will be forfeited. If VA provides an urn or plaque for a Veteran or Servicemember, VA is prohibited from interring the Veteran or Servicemember in a VA national cemetery or providing a headstone or marker or medallion that would mark the Veterans grave. If VA provides an applicant a commemorative urn or plaque to commemorate a Veteran it may also negatively impact interment in other cemeteries including, but not limited to, cemeteries operated by the Department of Defense, including Arlington National Cemetery. VA encourages potential applicants for a commemorative urn or plaque who might seek interment in the future to check directly with other cemeteries regarding its effect on potential interment at those cemeteries. VA encourages careful consideration of the consequences before applying to VA for a commemorative urn or plaque. Many Veterans and family members consider the benefits which will be forfeited to be of greater monetary and symbolic value than an urn or plaque. Consideration should also be given to the future disposition of the remains of a Veteran or Servicemember for whom an urn or plaque has been provided. Because options for future interment are more limited, there is greater risk for remains to become lost or unclaimed throughout time. For these reasons, it is critical that the family member consider the final disposition of the Veteran's remains and be certain of their decision before completing this application for an urn or plaque.

12. CERTIFICATION

I certify the decedent's remains were cremated and are not interred in any location. (*Interment means the burial or entombment of casketed or cremated remains, including the placement of cremated remains in a columbarium niche.)*

I certify that I (full name), Ann Veteran, understand and have considered the VA benefits that will be forfeited if I apply for, and VA provides, an urn or plaque (see Box 11 above); and I understand that interment in other cemeteries may be affected by the provision of a VA commemorative urn or plaque.

I certify that I am the spouse (familial relationship) of the Veteran or Servicemember (see Information Sheet and "Who May Apply");

I certify that I am the family member authorized to make decisions about the disposition of the decedent's cremated remains;

I certify that I am in possession of the entirety of the remains; and

I certify, to the best of my knowledge, that the decedent has never committed a serious crime, such as murder or other offenses that could have resulted in imprisonment for life, has never been convicted of a serious crime, and has never been convicted of a sexual offense for which the Veteran was sentenced to a minimum of life imprisonment or a period of 99 years or more.

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

13. SIGNATURE OF APPLICANT	14. DATE *(MM/DD/YYYY)*

VA HEALTH CARE BENEFITS

Basic Eligibility Requirements

The primary factor in determining eligibility for VA health care benefits is 'veteran's status' which is established by active duty service and a discharge or release under other than dishonorable conditions. In addition, the following veteran's must have completed 24 continuous months of active military service:

- You started on active duty before September 8, 1980, and you served at least 90 days on active duty with at least one day during wartime, or
- You started on active duty as an enlisted person after September 7, 1980, and served at least 24 months of the full period for which you were called or ordered to active duty (with some exceptions) with at least one day during wartime, or
- You were an officer and started on active duty after October 16, 1981, and you hadn't previously served on active duty for at least 24 months.

Exception to the 24-Month Active Duty Rule

The 24 continuous months of active duty service requirement does not apply to:

- Reservists who were called to active duty and who completed the term for which they were called, and who were granted an other than dishonorable discharge
- National Guard members who were called to active duty by federal executive order, and who completed the term for which they were called, and who were granted another than dishonorable discharge
- Veterans requesting benefits for or in connection with a service connected condition or disability
- Veterans who were discharged or released from active duty for a disability incurred or aggravated in the line of duty
- Veterans who have been determined by VA to have compensable service connected conditions
- Veterans for treatment and/or counseling of sexual trauma that occurred while on active military service, for treatment of conditions related to ionizing radiation or for head or neck cancer related to nose or throat radium treatment while in the military

Combat Veteran Eligibility

Enhanced Eligibility for Health Care Benefits

On January 28, 2008, Public Law 110-181 the 'National Defense Authorization Act of 2008' extended the period of eligibility for health care for veterans **who served in a theater of combat operations after November 11, 1998,** (commonly referred to as combat or OEF/OIF/OND Veterans).

Under the 'Combat Veterans' authority, the Department of Veterans Affairs (VA) provides cost-free health care services and nursing home care for **conditions possibly related to military service** and enrollment in Priority Group 6, unless eligible for enrollment in a higher priority group.

Combat veterans who were discharged or released from active service on **or after January 28, 2003,** are now eligible to enroll in the VA health care system for five years from the date of discharge or release.

The five-year enrollment period applicable to these veterans begins on the discharge or separation date of the service member from active duty military service, or in the case of multiple call-ups, the most recent discharge date.

Combat veterans, while not required to disclose their income information, may do so to determine their eligibility for a higher priority status, beneficiary travel benefits, and exemption of copays for care unrelated to their military service.

Documentation Used to Determine Combat Veterans Status

- Military service documentation that reflects service in a combat theater DD 214, or
- receipt of combat service medals, and/or
- receipt of imminent danger or hostile fire pay or tax benefits

Combat veterans who enroll with VA under this authority will continue to be enrolled even after their enhanced eligibility period ends. At the end of their enhanced eligibility period, veteran's enrolled in Priority Group 6 may be shifted to Priority Group 7 or 8, depending on their income level, and required to make applicable copays.

For those combat veterans who do not enroll during their enhanced eligibility period, eligibility for enrollment and subsequent care is based on other factors such as: a compensable service-connected disability, VA pension status, catastrophic disability determination, or the veteran's financial circumstances. For this reason, **combat veterans are strongly encouraged to apply** for enrollment within their enhanced eligibility period, even if no medical care is currently needed.

Copays

Veterans who qualify under this special eligibility are not subject to copays for conditions potentially related to their combat service. However, unless otherwise exempted, combat veterans must either disclose their prior year gross household income or decline to provide their financial information and agree to make applicable copays for care or services VA determines are clearly unrelated to their military service.

While income disclosure by a recently discharged combat veteran is not a requirement, this disclosure may provide additional benefits such as eligibility for travel reimbursement, cost-free medication and/or medical care for services unrelated to combat.

Dental Care

Eligibility for VA dental benefits is based on very specific guidelines and differs significantly from eligibility requirements for medical care. Combat veterans may be authorized dental treatment as reasonably necessary for the one-time correction of dental conditions if:

- They served on active duty and were discharged or released from active duty under conditions other than dishonorable from a period of service not less than 90 days and
- The certificate of discharge or release does not bear a certification that the veteran was provided, within the 90-day period immediately before the date of such discharge or release, a complete dental examination (including dental X-rays) and all appropriate dental service and treatment indicated by the examination to be needed and
- Application for VA dental treatment is made within 180 days of discharge or release

Additional Information: Visit the VA website at **www.va.gov/healtheligibility/.**

Enrollment

VA health care enrollment is a system providing veteran's access to a comprehensive package of VA health care services. Veterans must answer a few questions and are then assigned by VA to one of the priority groups.

Veterans may apply for enrollment anytime during the year by completing a VA Form 10-10EZ 'Application For Health Benefits'. The completed and signed form should be forwarded to the nearest VA health care facility. An important aspect of enrollment is for the veteran to identify which VA location of care he or she chooses as the preferred facility. This can be a community-based outpatient clinic (CBOC) or a VA medical center.

Once enrolled, most veterans will remain enrolled from year to year without further action on their part. However, certain veterans are required to provide income to determine their priority level. These veterans must provide a VA Form 10-10EZR for re-enrollment on an annual basis.

Hardship Determination

A hardship determination is a process by which a veteran may request to be placed in a different priority group based on a change in his/her financial situation for the previous year. Circumstances that may warrant hardship consideration would be the loss of employment, business bankruptcy, or out- of-pocket medical expenses. Veterans may request a hardship determination through the Business Office at the VAMC where they are receiving care on either a VA Form 10-10HS or detailed letter explaining the circumstances for the request.

Income Verification

The VA is authorized to verify a veterans' self-reported gross household income information by matching with records maintained by the Social Security Administration (SSA) and Internal Revenue Service (IRS). VA's Health Eligibility Center (HEC) verifies earned and unearned income reported by nonservice-connected and non-compensable service-connected veterans who are required to complete a financial assessment (means test).

An income verification case is created when the total gross household income reported to VA by a veteran is below established threshholds but the amount reported to IRS and SSA exceeds established income thresholds. Letters are mailed to the veteran and spouse (if applicable) to resolve the discrepancy. Below is a description for each type of letter informing the veteran what they can do to dispute the income as reported by IRS and SSA and/or reduce the total gross household income by providing proof of allowable deductible expenses.

1. The **initial letter** containing IRS and SSA reported income for a prior year is mailed to the veteran and spouse and they are given an opportunity to dispute income and/or to submit evidence of deductible expenses that may reduce total gross household income.

2. A **reminder letter** mailed if income verification has not received a response after 45 days. The veteran is provided another opportunity to dispute the information received and/or to submit documented deductible expenses.

3. A **final letter** is mailed if income verification has not received a response after 75 days from the date of the initial letter. It is very important that veteran's respond promptly to an income verification letter**. If there is no response**, VA will use the IRS and SSA reported income to determine veteran's copay exemption, priority group status, and continued enrollment.

Veterans are provided an opportunity to review the data reported by IRS and SSA and provide information regarding any discrepancies and to submit evidence of allowable deductible expenses. However, if the veteran's total gross household income is still above the threshold, his/her enrollment priority status may be changed and VA facilities that provided any care may charge co-pays for health services the veteran's received.

Assessed Copay Charges

There are three options if a veteran is unable to pay the assessed copay charges:

1. Request a **Waiver of Debt** which can be granted when there has been a significant change in income and the veteran has experienced significant expenses for medical care, funeral expenses or educational expenses. A Waiver of Debt excuses all existing bills but does not prevent future charges.

   A waiver must be requested in writing by completing VA Form 5655 'Financial Status Report'. The request must specify each copayment for which a waiver is being requested. There is no limit on the amount that the veteran can request to be waived. The veteran must request a waiver in writing within 180 days from the date on the bill.

2. Request a **Hardship Determination** to prevent future billing. A Hardship Determination is an exemption from copay for a determined period of time. If a veteran's current year income is substantially reduced from the prior year, a veteran may request a Hardship Determination.

   To request a Hardship Determination, contact the Enrollment Coordinator at the VA Medical Center where the veteran receives their care.

3. Request an **Offer in Compromise** which is an offer for past debts only, and acceptance of a partial payment in settlement and full satisfaction, of the debt at the time the offer is made. VA will consider both the current and anticipated future income in making these determinations. Most offers in Compromise that are accepted must be for a lump sum payment payable in full 30 days from the date of acceptance of the offer.

   Offers in Compromise must be requested in writing and by completing VA Form 5655 'Financial Status Report'. There is no limit on the amount that the veteran can request for the Offer in Compromise. To request an Offer in Compromise, contact the Revenue Office at the VA Medical Center where the veteran receives their care.

Hearing Aids and Eye Glasses

Under the VA's preventative care package, all veterans **who are enrolled** in the VA health care system may receive glasses and hearing aids (VHA Handbook 1173.1). Those veterans in Priority Groups 6-8 may be required to make a copayment.

Veterans who are not required to be enrolled to receive these services include those who are:

- 10% or more, service-connected for any condition, or
- 0% or more service-connected for hearing loss or an eye condition.

Chiropractic Care

Chiropractic care is included in the medical benefits package. The standard health benefits plan are generally available to all enrolled veterans. When it is not offered on-site at local VA, chiropractic care is available through non-VA care or Care in the Community.

Fee Basis Care

All veterans are potentially eligible for fee basis care; however, the decision to utilize such care is left to the VA facility providing the care. By law, fee basis care can only be provided when the treating VA facility cannot provide the veteran with the required care.

Existing Healthcare Coverage

Veterans are allowed to keep their current healthcare coverage and are encouraged to do so. Veterans with private insurance or other coverage such as DOD, Medicare or Medicaid may find these coverage's to be a supplement to their VA enrollment. The use of other available healthcare coverage does not affect a veteran's enrollment status. VA does not charge the veteran for insurance company copayments and deductibles.

When applying for medical care, all veterans will be asked to provide information pertaining to health insurance coverage, including policies held by spouses. VA is authorized to submit claims to insurance carriers for the recovery of costs for medical care provided to **nonservice- connected veterans and service-connected veterans for nonservice-connected conditions.** Veterans will not be responsible for portions of an insurance claim not covered by policy. Veterans above certain income levels are responsible for the copayments required by federal law.

Beneficiary Travel Benefits – Rates

Certain veterans may be eligible for mileage reimbursement or special mode transport in association with obtaining VA health care services. The eligibility criteria are as follows:

Beneficiary Travel

- Veterans who have a service-connected rating of 30%, or more, or
- Veterans who are traveling for treatment of a service-connected condition, or
- Veterans who are receiving a VA pension, or
- Veterans whose income does not exceed the maximum annual pension rate, or
- Veterans traveling for a scheduled compensation or pension examination.

Special Mode Transportation (ambulance, wheelchair van, etc.)

- Veterans whose medical condition requires an ambulance or specially equipped van as determined by a VA clinician, and
- Who meet one of the above criteria for beneficiary travel, and
- The travel is pre-authorized (authorization is not required for emergencies if a delay would be hazardous to life or health)

Mileage Rates
General Travel ……$0.415 (41.5 cents) per mile

Scheduled appointments qualify for round-trip mileage. Unscheduled visits may be limited to return mileage only.

Deductible (effective January 9, 2009) ……$3 one-way ($6 round trip)

Deductible requirement is subject to a monthly cap of $18. Upon reaching $18 in deductibles or 6 one-way (3 round) trips, whichever comes first, travel payments made for the balance of that particular month will be free of deductible charges.

Waiver of Deductible

A waiver of the deductible may be provided if the veteran is eligible for travel and

- Is in receipt of a VA pension, or
- Is a nonservice-connected veteran's whose previous year's and current year's income does not exceed the applicable VA pension rate, or
- Is a service-connected veteran's whose previous year's and current year's income does not exceed the applicable means test income threshold, or
- Is traveling for a scheduled compensation or pension exam

VA HEALTHCARE COPAY RATES – RATES

Veterans in Priority Group I do not pay for medications. Effective February 27, 2017, veterans in Priority Groups 2-8, are required to pay for each 30-day or less supply of medication for treatment of nonservice-connected condition (unless otherwise exempt).

Copay Amount for VA Prescriptions

Medication Tier	Drug	Co-Pay Amount	Co-Pay Amount	Co-Pay Amount
		1-30 Day Supply	31-60 Day Supply	61-90 Say Supply
Tier 1	Preferred Generic	$5	$10	$15
Tier 2	Non-Preferred Generic/Some over counter drugs	$8	$16	$24
Tier 3	Brand Name	$11	$22	$33

(Veteran's in Priority Groups 2 through 8 are limited to $700 annual cap.)

Outpatient Services
Basic Care Services - $15/visit (Services provided by a primary care clinician)
Specialty Care Services - $50/visit

Services provided by a clinical specialist such as surgeon, radiologist, audiologist, optometrist, cardiologist, and specialty tests such as magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, and nuclear medicine studies.

Copay amount is limited to a single charge per visit regardless of the number of health care providers seen in a single day. The copay amount is based on the highest level of service received. There is no copay requirement for preventive care services such as screenings and immunizations.

Inpatient Services

Priority Group 8
Inpatient copay for first 90 days of care during a 365-day period - $1,632
Inpatient copay for each additional 90 days during a 365--day period - $816
Per diem charge - $10/day

Priority Group 7
Inpatient copay for first 90-days of care during a 365 -day period - $326.40
Inpatient copay for each additional 90 days during a 365-day period $163.20
Per diem charge - $2/day

Long Term Care

Nursing home care/Inpatient respite care/Geriatric evaluation maximum of $97/day
Adult day health care/Outpatient geriatric evaluation/Outpatient maximum respite care $15/day
Domiciliary care maximum of $5/day

Copays for Long Term Care services start on the 22nd day of care during any 12-month period – there is no copay requirement for the first 21 days. Actual copay charges will vary from veteran to veteran depending upon financial information submitted on VA Form 10-10EC.

Priority Group	Enrollment Priority Groups
1	• Veterans with VA-rated service-connected disabilities 50% or more disabling • Veterans determined by VA to be unemployable due to service-connected conditions
2	• Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	• Veterans who are Former Prisoners of War (POWs) • Veterans awarded a Purple Heart medal • Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty • Veterans with VA-rated service-connected disabilities 10% or 20% disabling • Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" • Veterans awarded the Medal of Honor (MOH)
4	• Veterans who are receiving aid and attendance or housebound benefits from VA • Veterans who have been determined by VA to be catastrophically disabled
5	• Nonservice-connected veterans and non-compensable service-connected veterans rated 0% disabled by VA with annual income and net worth below the VA National Income Thresholds for their resident location • Veterans receiving VA pension benefits • Veterans eligible for Medicaid programs
6	• World War I veterans • Compensable 0% service-connected veteran's • Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki • Project 112/SHAD participants • Veterans who served in the Republic of Vietnam between November 1, 1955, and May 7, 1975, • Veterans of the Persian Gulf War that served between August 2, 1990, and November 11, 1998, • Veterans who served in the theater of combat operations after November 11, 1998, as follows: Currently enrolled Veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge • Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987. • Blue Water Navy Veterans who served from February 28, 1961 to May 7, 1975. • **Note**: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group their unique eligibility status at that time qualifies for.
7	• Veterans with gross household income below the geographically-adjusted income threshold (GMT) for their resident location and who agree to pay copay.

8	• Veterans with gross household income above the VA national income thresholds and the geographically-adjusted income threshold for their resident location and who agree to pay copays • **Veterans eligible for enrollment**: Non-compensable 0% service-connected and: • Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status • Subpriority b: Enrolled on or after June 15, 2009, whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less • **Veterans eligible for enrollment**: Nonservice-connected and: • Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this subpriority due to changed eligibility status • Subpriority d: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less • **Veterans not eligible for enrollment**: Veterans not meeting the criteria above: • Subpriority e: Non-compensable 0% service-connected • Subpriority g: Nonservice-connected

Click here to view VA annual income limits for health benefits

OMB Approved No. 2900-0091
Estimated Burden Avg. 35 min.
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

- [x] **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)
- [ ] **REGISTRATION** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME
Veteran Joe P	**Joe**	**Sailor**

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU HISPANIC OR LATINO?
[x] MALE [ ] FEMALE	[x] MAN [ ] WOMAN [ ] TRANSGENDER MAN [ ] TRANSGENDER WOMAN [ ] NON-BINARY [ ] PREFER NOT TO ANSWER [ ] A GENDER NOT LISTED HERE	[ ] YES [x] NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
[ ] ASIAN [ ] AMERICAN INDIAN OR ALASKA NATIVE [ ] BLACK OR AFRICAN AMERICAN [x] WHITE [ ] NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER [ ] CHOOSE NOT TO ANSWER	**123-23-3456**

7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. PREFERRED LANGUAGE	9. RELIGION
09-08-1947	**Miller SD**	**English**	**Lutheran**

10A. MAILING ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY
123 Tenbucktwo Ave	**Sioux Falls**	**SD**	**57107**	**Minnehaha**

10F. HOME TELEPHONE NO. *(optional)*	10G. MOBILE TELEPHONE NUMBER *(optional)*	10H. E-MAIL ADDRESS *(optional)*
(605)123-2345 *(Include area code)*	**(605)123-2345** *(Include area code)*	

11A. HOME ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E. COUNTY
123 Tenbucktwo Ave	**Sioux Falls**	**SD**	**57107**	**Minnehaha**

12. CURRENT MARITAL STATUS

[x] MARRIED [ ] NEVER MARRIED [ ] SEPARATED [ ] WIDOWED [ ] DIVORCED

13A. NEXT OF KIN NAME	13B. NEXT OF KIN ADDRESS	13C. NEXT OF KIN RELATIONSHIP
Ann Veteran	**123 Tenbucktwo Ave Sioux Falls SD 57107**	**Spouse**

13D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14A. EMERGENCY CONTACT NAME	14B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code)*
(605)123-2345	**Ann Veteran**	**(605)123-2345**

15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (Note: This does not constitute a will or transfer of title)

Ann Veteran

16. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	17. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
Sioux Falls VA Healthcare System	[x] YES [ ] NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(mm/dd/yyyy)*	1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*	1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*
Army	**01-01-1968**		**09-30-1974**

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER
Honorable	

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	[ ]	[x]	D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	[ ]	[x]
B. ARE YOU A FORMER PRISONER OF WAR?	[ ]	[x]	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	[ ]	[x]
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	[ ]	[x]	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	[x]	[ ]

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle Name)* **Veteran Joe P**	SOCIAL SECURITY NUMBER **123-23-3456**

SECTION II - MILITARY SERVICE INFORMATION *(Continued)*

3. MILITARY EXPOSURE INFORMATION *(Check yes or no)*	YES	NO
A. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP? *(Hiroshima and Nagasaki cleanup or Enewetak Atoll, cleanup of Air Force B-52 bomber carrying nuclear weapons off the coast of Palomares, Spain, response to the fire onboard an Air Force B-52 bomber carrying nuclear weapons near Thule Air Force Base in Greenland.)*	☐	☑
B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS? *(Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, Yemen, Lebanon, Somalia, Afghanistan, Israel, Egypt, Turkey, Syria, Jordan, Djibouti, Uzbekistan, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, and the Red Sea.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE**: Please provide an approximate time-frame (mm/yyyy)* FROM: _____ TO: _____	☐	☑
C. WERE YOU DEPLOYED IN SUPPORT OF ANY OF THE FOLLOWING OPERATIONS? *(Enduring Freedom, Freedom's Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission)*	☐	☑

	YES	NO
D. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE (e.g. Agent Orange) LOCATIONS? *(Republic of Vietnam to include 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a c-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE**: Please provide an approximate time-frame (mm/yyyy)* FROM: **02-02-1969** TO: **02-03-1970**	☑	☐

E. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? *(Check all that apply)*
Veterans can locate additional military exposure categories on VA's Public Health website at: https://www.publichealth.va.gov/exposures/

- ☐ AIR POLLUTANTS *(burn pits, sand, oil well/sulfur fires)*
- ☐ CHEMICALS *(pesticides, herbicides, contaminated water)*
- ☐ CONTAMINATED WATER AT CAMP LEJEUNE
- ☐ RADIATION ☐ SHAD *(Shipboard Hazard and Defense)*
- ☐ OCCUPATIONAL HAZARDS *(jet fuel, industrial solvents, lead, firefighting foams)*
- ☐ ASBESTOS ☐ MUSTARD GAS
- ☐ WARFARE AGENTS *(nerve agents, chemical and biological weapons)*
- ☐ OTHER *(Specify)*:

WHEN WERE YOU EXPOSED?
***NOTE**: Please provide an approximate time-frame (mm/yyyy)*
FROM: _____ TO: _____

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*
Tricare 107 W Capital Ave Philadelphia PA 67501

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE
Joe Veteran	**987546214**	**24**

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6B. EFFECTIVE DATE *(mm/dd/yyyy)*	6C. MEDICARE NUMBER:
☑ YES ☐ NO	☑ YES ☐ NO	**09-08-2012**	**65432841**

SECTION IV - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)

1. SPOUSE'S NAME *(Last, First, Middle Name)*
Veteran Ann P

1A. SPOUSE'S SOCIAL SECURITY NUMBER
666-66-6666

1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*
09-03-1946

1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY
- ☐ MAN ☑ WOMAN ☐ TRANSGENDER MAN
- ☐ TRANSGENDER WOMAN ☐ NON-BINARY
- ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*
10-15-1975

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*
123 Tenbucktwo Ave
Sioux Fall SD 57107
(605)123-2345

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*

2B. CHILD'S SOCIAL SECURITY NO.

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*
$

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME (Last, First, Middle) **Veteran Joe P**	SOCIAL SECURITY NUMBER **123-23-3456**

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one).*	1B. DATE OF RETIREMENT. *(mm/dd/yyyy)*
☑ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	**09-08-2012**

1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired -Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*
State of South Dakota	**123 Minnesota Ave #234 Sioux Falls SD 57107**	**(987)456-1123**

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND**) may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII**. If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☑ **Yes, I will provide my household financial information for last calendar year**. Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$ **0**	$ **0**	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$ **0**	$ **0**	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension interest, dividends)* EXCLUDING WELFARE.	$ **24,520.00**	$ **24,982.00**	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$ **4,005.00**
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$ **0**
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$ **0**

SECTION IV - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan(HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT: _____ DATE: *(mm/dd/yyyy)* **04-23-2024**
(Sign in ink)

Click here to view VA Healthcare copay rates.

Health Care Eligibility

If you meet the requirements, you can get free VA health care for any condition related to your service for up to 10 years from the date of your most recent discharge or separation. You can also enroll at any time during this period and get any care you need, but you may owe a copay for some care

At least one of these must be true of your active-duty service

- You served in a theater of combat operations during a period of war after the Persian Gulf War, **or**
- You served in combat against a hostile force during a period of hostilities after November 11, 1998

And this must be true for you

- You were discharged or released on or after October 1, 2013

What if I was Discharged or Released Before October 1, 2013?

If you meet the requirements listed here, you can receive care and enroll during a special enrollment period between **October 1, 2022,** and **October 1, 2023**.

At least one of these must be true of your active-duty service

- You served in a theater of combat operations during a period of war after the Persian Gulf War, or
- You served in combat against a hostile force during a period of hostilities after November 11, 1998

And both of these must be true for you

- You were discharged or released between September 11, 2001, and October 1, 2013, **and**
- You haven't enrolled in VA health care before

Education

State Approving Agency Defined

Each State has a State Approving Agency (SAA) and a few states have two or three. Some states have one agency to approve all school programs, another agency to approve all on-the-job training programs, and then possibly a third agency to approve the flight schools.

Congress determined that each State should create an agency to approve the programs within its borders and to determine in which programs it was appropriate for veterans to enroll, in order for them to utilize their VA educational benefits. The first State Approving Agencies were formed for veterans after World War II. After a few years States realized that a National Association was needed and in 1948 it was formed.

The National Association of State Approving Agencies (NASAA) assisted states in coordinating their efforts to do a better job for the veterans. In addition, it was a tool to resolve mutual problems.

In many ways, the fundamental role of state approving agencies is the same today, as it was when they were founded. As state entities acting on behalf of the Federal Government, the SAA's have been an outstanding example of the workability of the State-Federal partnership, allowing Federal interests to be pursued at the local level while preserving the identity, interests, and sovereignty of States' Rights in education.

The primary responsibility and focus of the SAA's continues to be the review, evaluation and approval of quality programs of education and training under State and Federal criteria. SAA's continue to conduct on-site supervisory visits to approved institutions and schools seeking approval. They continue to provide technical assistance to all interested parties and are engaged in outreach activities to foster the usage of the GI Bill®. Further, they continue to act as state liaison in assisting military installations to provide base personnel with quality educational offerings.

Yet, while the fundamental role of the SAA has remained the same, the SAA's have grown with the changes in our society over the past fifty years. They have become advocates for quality education and training for veterans and other eligible persons. They have become educational partners with the institutions themselves, facilitating even greater and more diverse educational opportunities for veterans. They have become strong advocates for the usage of the GI Bill® and have developed a working partnership with the Federal government, which other Federal agencies have tried to emulate.

As State and National priorities change, as the function of government undergoes perpetual re-examination, and as the needs of our veterans evolve with changes in American society, state approving agencies stand ready to meet the challenges before them. Yet in spite of the need for new approaches and technologies, differing styles of oversight and enhanced criteria for performance, the fundamental reasons for which the SAA's were originally created remain as valid today as they were fifty years ago.

The programs that can be approved are found in institutions of higher learning (colleges and universities), non-degree institutions (vocational and technical colleges), apprenticeship programs, on-the-job training programs, licensing/certification tests and flight training schools. Each state reviews the appropriateness of each program as to its own standards and laws in addition to VA rules and regulations along with any other applicable laws and/or regulations. Then it is either approved or disapproved; continuous supervision is required of approved programs.

The approval process is on-going and involves regular monitoring of the programs. South Dakota has over 2,000 eligible people enrolled in programs. The programs are found in approximately 80 schools and over 200 training establishments and businesses.

The South Dakota State Approving Agency is located in Pierre with the Department of Veterans Affairs and it approves all programs. For information or assistance, call (605) 773-3269.

Facts About On-the-Job-Training and Apprenticeship Training

- The training content of the program must be adequate to qualify the trainee for appointment to the job for which he or she is being trained.
- There is reasonable certainty that the job for which the training is provided will be available to the trainee at the end of the training period.
- The job is one within which progression and appointment of the next higher classification are based upon skills learned through organized training on the job and not just on such factors as length of service and normal turnover.
- The wages to be paid the trainee during the training period are not less than those paid to non-veteran trainees in a similar training position. The wages paid to a trainee at the start of training must be at least 50 percent of the wages paid to a fully trained worker. There must be at least one increase in wages during the training period. No later than the last full month of training, the wages must be at least 85 percent of the wages paid to a fully trained employee. Immediately upon completion of training, the wage should be increased to the full amount of a trained worker's wage. The 85 percent regulation does not apply to local, state, or federal governments.
- The job customarily requires a period of training of not less than six months and not more than two years of full-time training On-the-Job Training; for apprenticeships the length of time can be from two to four years for training and payment purposes.

- The length of the training period is not longer than that customarily required by the establishment and other establishments in the community to provide trainees with the required skills, technical information and other facts which the trainee will need to learn in order to become competent on the job for which they are being trained.
- Provisions are made for related instruction for the individual veteran or eligible person who may need it.
- The establishment must have adequate space, equipment, instructional material, and instructor personnel to provide satisfactory training on the job.
- Adequate records will be kept to show the progress made by the veteran or eligible person toward his or her job objective and will be made available to representatives of the Department of Veterans Affairs and/or the State Approving Agency at their request.
- Appropriate credit will be given the trainee for previous training or experience, whether obtained in the military service or elsewhere. The beginning wage must be adjusted to the level to which credit for prior training and experience advances the trainee, and the training period will be reduced proportionately.
- A signed copy of the training agreement for each veteran or eligible person, including the approved training program and wage scale, will be provided by the employer to the trainee, the VA Regional Office, and the State Approving Agency; the employer retains a copy for their files.
- Upon completion of the training, the trainee will be given a certificate by the employer indicating the length and type of training provided and that the trainee has completed the program of training satisfactorily.

All records pertaining to the training program, including payroll records, **are to be kept for a period of three years after completion of the training**; and available to representatives of the Veterans Administration at their request.

Interested employers and trainees can contact

State Approving Agency Personnel at:
(605) 773-3565 or (605) 773-3269
Or contact local County/Tribal Veteran's Service Officer

Training Program Approval - Procedural Summary

For new approvals

1. **Phone interview with veteran and employer**
2. **Check veteran's eligibility**
3. **Conduct site visit with employer**
4. **Finish up approval process**
5. **Send approval to VA**
6. **Once approved, enroll veteran**

If training program is already approved:

1. **Phone interview with veteran**
2. **Check veteran's eligibility**
3. **Send out enrollment packet**
4. **Enroll veteran**

Montgomery GI Bill® – Active Duty (MGIB – AD) Chapter 30 - Eligibility

The Montgomery GI Bill® (Active Duty), also known as Chapter 30, is a program of education benefits generally for individuals who enter active duty for the first time after June 30, 1985. Active duty for benefits purposes includes full-time National Guard duty performed after June 30, 1985. The participant generally must serve continuously on active duty for three years of a three-year or greater initial enlistment or, for a lesser benefit, two years of an initial active duty obligation of less than three years. An individual also may qualify for the full benefits by initially serving two continuous years on active duty, followed by four years of Selected Reserve service. In the latter case, the participant must enter the Selected Reserve within one year of release from active duty.

The participant must meet the requirements for a high school diploma or an equivalency certificate before the first period of active duty ends. Completing 12 credit hours toward a college degree meets this requirement. Individuals, who initially serve a continuous period of at least

three years of active duty, even though they were initially obligated to serve less, will be paid at the higher basic rate.

Participation Requirements

Participation in the Montgomery GI Bill®® requires that servicepersons have their military pay reduced by $100 a month for the first 12 months of active duty. If an individual decides not to participate in this program, this decision cannot be changed at a later date.

An exception is made under specific conditions for servicepersons who are involuntarily separated from active duty with an honorable discharge after February 2, 1991. Those who previously decided not to participate in this program and who voluntarily separate from active duty after December 4, 1991, under the Special Separation Benefit or the Voluntary Separation Incentive Program may elect to participate. If the serviceperson decides to participate before separation, military pay will be reduced before separation, and education or training may take place following separation.

Discharges and Separations

For the Montgomery GI Bill® program, the discharge must be honorable. Discharges designated "under honorable conditions" and "general" do not establish eligibility for education benefits. A discharge for one of the following reasons could result in a reduction of the required length of active duty

- Convenience of the government
- Disability
- Hardship
- A medical condition existing before service
- Force reductions
- A medical condition, which prevents satisfactory performance of duty.

Period of Eligibility

For the most part, benefits under Chapter 30 end 10 years from the date of the veteran's last discharge or release from active duty. VA can extend this 10-year period if the veteran was prevented from training during this period because of a disability or because he or she was held by a foreign government or power. The 10-year period can also be extended if an individual reenters active duty for 90 days or more after becoming eligible. Veterans serving periods of active duty of less than 90 days can qualify for extensions under certain circumstances. If the veteran's discharge is upgraded by the military, the10-year period begins on the date of the upgrade.

If eligibility is based on two years of active duty and four years in the Selected Reserve, the veteran's eligibility will end the later of:

- 10 years from release from active duty; or
- 10 years from completion of the four-year Selected Reserve obligation.

This four-year obligation, however, does not apply to certain individuals discharged because of downsizing the military between October 1, 1991, and September 30, 1995.

Vocational Readiness and Employment – Chapter 31

Veterans and service members who served in the Armed Forces on or after September 16, 1940, are eligible for VRE if three conditions are met:

1. They suffered a service-connected disability or disabilities in active service which entitle them to at least 20 percent compensation or would do so but for receipt of military retirement pay. Veterans with a 10 percent disability also may be found eligible if they have a serious employment handicap.
2. They were discharged or released under other than dishonorable conditions or are hospitalized awaiting separation for disability.
3. VA determines that they need vocational rehabilitation consistent with their abilities, aptitudes, and interests to overcome an employment impairment. Their service-connected disabilities must materially contribute to this handicap.

Period and Length of Rehabilitation Program

Generally, the veterans must complete a rehabilitation program 12 years from the date VA notifies him or her of entitlement to compensation. This period may be deferred or extended if a medical condition prevented the veteran from training for a period or if the veteran has a serious employment handicap.

Disabled veterans may receive services until they have reached their rehabilitation goal, but the duration of a rehabilitation program generally may not exceed 48 months. VA may provide counseling, job placement and post-employment services for an additional period not to exceed 18 months.

Benefits

A disabled veteran will be given an evaluation to establish entitlement. A disabled veteran may receive employment assistance, self- employment assistance, training in a rehabilitation facility, and college and other training. Severely disabled veterans may receive assistance to improve their ability to live independently.

Post 9/11 GI Bill® – Chapter 33

Who is Eligible for Benefits Under the Post-9/11 GI Bill®

Individuals who serve at least 90 days of aggregate service after September 10, 2001 are eligible.

To be eligible for 100% of the benefit, an individual must have served an aggregate of 36 months of active duty service, or have been discharged for a service-connected disability after 30 days of continuous service.

Active-duty service time required by graduates of a Service Academy or ROTC does not count toward the three years necessary to qualify for full benefits.

For those who served fewer than 36 months, the percentage of benefit ranges from 50% to 100%:

- 100% - 36 months (including service on active duty in entry level and skill training)
- 90% - 30 months (including service on active duty in entry level and skill training)
- 80% - 24 months (excluding service on active duty in entry level and skill training)
- 70% - 18 months (excluding service on active duty in entry level and skill training)
- 60% - 6 months (excluding service on active duty in entry level and skill training)
- 50% - 90 days (excluding service on active duty in entry level and skill training).

For example, an individual with five months of qualifying service could receive 50% of the tuition benefit, 50% of the monthly housing allowance, and a maximum of $500 books and supplies stipend.

Veterans must have an honorable discharge or other qualifying discharge (e.g. hardship, condition interfering with duty, etc.) to be eligible.

What Benefits do Students Receive Under the Post-9/11 GI Bill®

Depending on each individual's situation, benefits could include payment of tuition and fees, a monthly housing allowance, a stipend for books and supplies, college fund ("kicker") payments, a rural benefit payment, and a Yellow Ribbon benefit. Post-9/11 GI Bill® benefits differ from other education assistance programs in that each type of payment is issued separately, with some payments made directly to the school and others issued to the individual.

Tuition and Fees

Not to exceed the maximum in-state tuition and fees at a public Institution of Higher Learning. These payments are issued to the school on behalf of the individual at the time the certificate of enrollment is processed.

Not on Active Duty

For individuals not on active duty, the amount is prorated according to length of service. The amount paid is limited to the highest amount of tuition and fees charged for full-time, undergraduate training at a public institution of higher learning in the state where the student is enrolled.

On Active Duty

Individuals on active duty may receive the total amount of tuition and fees. The amount is not limited to the state maximum.

Monthly Housing Allowance

This payment is issued directly to the student at the beginning of each month for education and training pursued the previous month. The amount is based on an E-5 with dependents, and prorated based on length of service.

Active duty personnel are not eligible for the Post-9/11 GI Bill® monthly housing allowance. Students enrolled solely in distance learning are paid based on eligible percentage of $894.50.

Books and Supplies Stipend

This payment issued directly to the student when the school certifies and VA processes the enrollment. This benefit is prorated based on length of service. Click here to view rates.

Active duty personnel are eligible for the Post-9/11 GI Bill® books and supplies stipend.

Yellow Ribbon payments

The Yellow Ribbon Program allows degree- granting institutions to enter into a voluntary agreement with VA to fund tuition expenses that exceed the highest public in-state undergraduate tuition rate for individuals eligible for the 100% payment tier. The institution
can contribute up to 50% of those expenses and VA will match the same amount as the institution. This payment is issued to the school when the school certifies and VA processes the student's enrollment.

College Fund or "Kicker"

These payments are issued directly to the student based on "rate of pursuit" (full- or part-time study) and the education benefits program under which the kicker is payable. Post-9/11 GI Bill® kickers will be issued monthly with the housing allowance; all other kickers will be issued in a lump sum when the student's enrollment certification is processed.

Rural Benefit Payments

This one-time, lump-sum payment of $500 is issued directly to a student who resides in a county with six persons or fewer per square mile (as determined by the most recent decennial census), and who either:

- physically relocates at least 500 miles to attend an educational institution, or
- relocates by air (any distance) to physically attend an educational institution, if no other land-based transportation exists.

What Kind of Education and Training Does the Post-9/11 GI Bill® Cover

Approved training under the Post-9/11 GI Bill® includes graduate and undergraduate degrees. All training programs must be offered by a degree-granting institution of higher learning (IHL) and approved for GI Bill® benefits. Additionally, tutorial assistance and reimbursement for one licensing or certification test reimbursement are available under the Post- 9/11 GI Bill®.

If an individual is eligible for the Post 9/11 GI Bill® as well as other GI Bill® benefits, he/she will be required to make an irrevocable choice of which benefit to receive. Individuals who were previously eligible for the Montgomery GI Bill®-Active Duty (MGIB-AD, Chapter 30), Montgomery GI Bill®-Selected Reserve (MGIB-SR, Chapter 1606), or the Reserve Educational Assistance Program (REAP, Chapter 1607) may continue to receive benefits for approved programs not offered by degree-granting institutions. These programs include flight, correspondence, apprenticeship/ on-the-job training, preparatory courses, and national tests. Individuals in these programs will be paid as if they are still receiving benefits under Chapters 30, 1606, and 1607.

What is the Eligibility Period

The period of eligibility for the Post 9/11 GI Bill® ends 15 years from the date of the last discharge or release from active duty if date is prior to January 1, 2013. If after January 1, 2013, then they have the Forever GI Bill®.

- 90 consecutive days
- 30 days but less than 90 days if released for a service-connected disability, or
- 15 years from the date of discharge for the last period of service used to meet the minimum service requirements of 90 aggregate days of service if date is prior to January 1, 2013. If after January 1, 2013, then they have the Forever GI Bill®.

For more information, visit the VA GI Bill® Website at: http://www.gibill.va.gov

Transfer of Post-9/11 GI Bill® Benefits to Dependents (TEB)

For the first time in history, service members enrolled in the Post-9/11 GI Bill® program were able to transfer unused educational benefits to their spouses or children which started Aug. 1, 2009. Posted below is the published Department of Defense guidance, issued June 23, 2009, establishing the criteria for eligibility and transfer of those education benefits**.**

You must have the transfer before you separate from the service.

Who is Eligible for the Transfer

Any member of the Armed Forces (active duty or Selected Reserve, officer or enlisted) on or after August 1, 2009, who is eligible for the Post-9/11 GI Bill®, and:

- Has at least six years of service in the Armed Forces on the date of election and agrees to serve 4 additional years in the Armed Forces from the date of election.
- Has at least ten years of service in the Armed Forces (active duty and/or selected reserve) on the date of election, is precluded by either standard policy (service or DoD) or statute from committing to four additional years, and agrees to serve for the maximum amount of time allowed by such policy or statute

Eligible Dependents

An individual approved to transfer an entitlement to educational assistance under this section may transfer the individual's entitlement to:

- The individual's spouse
- One or more of the individual's children
- Any combination of spouse and child

A family member must be enrolled in the Defense Eligibility Enrollment Reporting System (DEERS) and be eligible for benefits, at the time of transfer to receive transferred educational benefits.

A child's subsequent marriage will not affect his or her eligibility to receive the educational benefit; however, after an individual has designated a child as a transferee under this section, the individual retains the right to revoke or modify the transfer at any time.

A subsequent divorce will not affect the transferee's eligibility to receive educational benefits; however, after an individual has designated a spouse as a transferee under this section, the eligible individual retains the right to revoke or modify the transfer at any time.

Nature of Transfer

An eligible service member may transfer up to the total months of unused Post-9/11 GI Bill® benefits, or the entire 36 months if the member has used none. Family member use of transferred educational benefits is subject to the following:

Spouse

- May start to use the benefit immediately.
- May use the benefit while the member remains in the Armed Forces or after separation from active duty.
- Is not eligible for the monthly stipend or books and supplies stipend while the member is serving on active duty.
- Can use the benefit for up to 15 years after the service member's last separation form active duty.

Child

- May use the benefit while the eligible individual remains in the Armed Forces or after separation from active duty.
- May not use the benefit until he/she has attained a secondary school diploma (or equivalency certificate), or reached 18 years of age.
- Is entitled to the monthly stipend and books and supplies stipend even though the eligible individual is on active duty.
- Is not subject to the 15-year delimiting date, but may not use the benefit after reaching 26 years of age.

How to Apply for Transfer:

First, you must go to the DoD transferability application website to determine if your dependents are eligible to receive the transferred benefits. This website is only available to military members. Upon approval, family members may apply to use transferred benefits with VA by completing VA Form 22-1990e. VA Form 22-1990e should only be completed and submitted to VA by the family member *after* DoD has approved the request for TEB.

Do not use VA Form 22-1990e to apply for TEB.

Survivors and Dependents Educational Assistance Program – Chapter 35

Eligibility

Education and training benefits are available to children, spouse, or surviving spouse of veterans who:

- Died of a service-connected disability; or
- Are permanently and totally disabled from a service- connected disability (including a total rating based on unemployability if permanent in nature); or
- Were permanently and totally disabled from service- connected disability at time of death; or
- Have been listed as MIA or POW for a period of more than 90 days

Payments

For current GI Bill® Education rates, please see: http://www.gibill.va.gov/

Period Of

Benefits to a spouse end 10 years from the date VA first finds the individual eligible. VA may grant an extension of this period if a physical or mental disability prevented the individual from using some portion of the education benefits. The disability must occur during the individual's 10-year period of eligibility. Children generally must be between the ages of 18 and 26 to receive education benefits. Extensions may be granted, including those for time the child spends on active military duty. No extension can go beyond the individual's 31st birthday.

Montgomery GI Bill® - Selected Reserve (MGIB-SR) Chapter 1606

The Montgomery GI Bill® - Selected Reserve program may be available to you if you are a member of the Selected Reserve. The Selected Reserve includes the Army Reserve, Navy Reserve, Air Force Reserve, Marine Corps Reserve and Coast Guard Reserve, and the Army National Guard and the Air National Guard.

You may use this education assistance program for degree programs, certificate or correspondence courses, cooperative training, independent study programs, apprenticeship/on-the-job training, and vocational flight training programs. Remedial, refresher and deficiency training are available under certain circumstances.

Eligibility for this program is determined by the Selected Reserve components. VA makes the payments for this program.

You may be entitled to receive up to 36 months of education benefits.

If your eligibility to this program began on or after October 1, 1992, your period of eligibility ends 14 years from your beginning date of eligibility, or on the day, you leave the Selected Reserve.

Eligibility

To qualify, you must meet the following requirements:

- Have a six-year obligation to serve in the Selected Reserve signed after June 30, 1985. If you are an officer, you must have agreed to serve six years in addition to your original obligation. For some types of training, it is necessary to have a six-year commitment that begins after September 30, 1990;
- Complete your initial active duty for training (IADT);
- Meet the requirement to receive a high school diploma or equivalency certificate before completing IADT.
- Remain in good standing while serving in an active Selected Reserve unit.

You will also retain MGIB - SR eligibility if you were discharged from Selected Reserve service due to a disability that was not caused by misconduct. Your eligibility period may be extended if you are ordered to active duty.

VA Work Study Program

If you are a full-time or 3/4-time student in a college degree program, or a vocational or professional program, you can "earn while you learn" with a VA work-study allowance.

Who is Eligible

The VA work-study allowance is available to persons training under the following programs:

- Montgomery GI Bill®--Active Duty (38 U.S.C. Chapter 30)
- Vocational Training and Rehabilitation for Veteran's With Service Connected Disabilities (38 U.S.C. Chapter 31)
- Dependents' Educational Assistance Program (38 U.S.C. Chapter 35)
- Montgomery GI Bill®--Selected Reserve (10 U.S.C. Chapter 1606)
- Post9/11 GI Bill® (Chapter 33)

VA Will Select Students for the Work-Study Program Based on Different Factors

Such factors include:

- Disability of the student
- Ability of the student to complete the work-study contract before the end of his or her eligibility to education benefits
- Job availability within normal commuting distance to the student
- VA will give the highest priority to a veteran who has a service-connected disability or disabilities rated by VA at 30% or more.

The number of applicants selected will depend on the availability of VA- related work at your school or at VA facilities in your area.

Payments

- You will earn an hourly wage equal to the Federal minimum wage or your State minimum wage, whichever is greater. If you are in a work-study job at a college or university, your school may pay you the difference between the amount VA pays and the amount the school normally pays other work-study students doing the same job as you.
- You may elect to be paid in advance for 40 percent of the number of hours in your work-study agreement, or for 50 hours, whichever is less.
- After you have completed the hours covered by your first payment, VA will pay you each time you complete 50 hours of service.
- You may work during or between periods of enrollment. You can arrange with VA to work any number of hours you want during your enrollment. But, the total number of hours you work can't be more than 25 times the number of weeks in your enrollment period.

What Type of Work

Services you perform under a VA work-study program must be related to VA work.

Examples of acceptable work are:

- Processing VA paperwork at schools or VA offices;
- Performing outreach services under the supervision of a VA employee;
- Performing services at VA medical facilities or the offices of the National Cemetery Administration

The work you actually do will depend on your interests and the type of work available.

Application Process

For forms and information, one or more of the following offices or representatives can assist you:

- Any VA Regional Office
- Any VA office or Veteran Center
- Local County/Tribal Veterans Service Officers
- SD Department of Veterans Affairs

OMB Approved No. 2900-0009
Respondent Burden: 10 minutes
Expiration Date: 08/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERAN READINESS AND EMPLOYMENT FOR CLAIMANTS WITH SERVICE-CONNECTED DISABILITIES

(Chapter 31, Title 38, U.S.C.)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden information on page 2. Use this form to apply for Veteran Readiness and Employment Services. For more information contact us online at www.va.gov/contact-us or call 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 if returning by mail, mail to: Department of Veterans Affairs, Veteran Readiness and Employment (VR&E) Intake Center, P.O. Box 5210, Janesville, WI 53547-5210.

SECTION I: CLAIMANT'S INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly, insert one letter per box to help expedite processing of the form.

1. CLAIMANT'S NAME *(First, Middle Initial, Last)*
Joe P Veteran

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER *(If different from Item 2)*	4. DATE OF BIRTH *(MM-DD-YYYY)*
123-23-3456	**123233456**	**09-08-1947**

5. MAILING ADDRESS *(Number and street or rural route, City, State and ZIP Code, OR write "None," if no mailing address)*

No. & Street **123 Tenbucktwo Ave**

Apt./Unit Number City **Sioux Falls**

State/Province **SD** Country **US** ZIP Code/Postal Code **57107**

6. MAIN TELEPHONE NUMBER *(Include Area Code, or check "None" if no available telephone number)*
(605)123-2345 ☐ None Enter International Phone Number *(If applicable)* ———————

7. CELL PHONE NUMBER *(Include Area Code, or check "None" if no available telephone number)*
(605)123-2345 ☐ None

8. E-MAIL ADDRESS OF CLAIMANT ☐ I agree to receive electronic correspondence from VA in regards to my claim.

9. IF YOU ARE MOVING WITHIN THE NEXT 30 DAYS, PROVIDE YOUR NEW ADDRESS BELOW

No. & Street

Apt./Unit Number City

State/Province Country **US** ZIP Code/Postal Code

10. NUMBER OF YEARS OF EDUCATION
12

SECTION II: CERTIFICATION AND SIGNATURE

I HEREBY CERTIFY THAT the information I have entered on this form is true and complete to the best of my knowledge and belief. I realize that making willful false statements concerning a material fact in a claim for chapter 31 benefits is a punishable offense that may result in a fine or imprisonment, or both. *(Reference: 38 U.S.C. 3802(a))*

11A. SIGNATURE OF CLAIMANT	11B. DATE SIGNED *(MM-DD-YYYY)*
	05-06-2024

Home Loan Guaranty

The main purpose of the VA Loan Guaranty program is to help veterans finance the purchase of homes. The VA does this by encouraging lenders to offer more favorable loan terms at a rate of interest that is competitive with the rate charged on other types of mortgage loans. VA guaranteed loans are made by private lenders such as banks, savings and loan associations, or mortgage companies.

Although the VA will back many types of loans, it is still necessary for the veterans to find a lender to loan the money.

Veterans who are interested in obtaining a home loan should always be advised to 'shop around' before making a final decision on how to finance the purchase. With the multitude of financing options and programs available, the VA Home Loan Guaranty program is not always the most advantageous program for the homebuyer. In a nutshell, this is how the loan guaranty program works:

- Apply for a Certificate of Eligibility (COE) or have your lender apply online using the webLGY application. Veterans can also request the COE by using https://www.va.gov/housing-assistance/home-loans/how-to-request-coe/.
- Decide on a home you want to buy and sign a purchase agreement conditioned on approval of your VA home loan.
- If you haven't already done so, select a lender, present them with your COE and complete a loan application.
- Order an appraisal from VA (this is usually done by the lender). The lender will request VA to assign a licensed appraiser to determine the reasonable value for the property. A Notice of Value will be issued.
- The lender will let you know the decision on the loan. You should be approved if the established value and your credit and income are acceptable.
- Attend the loan closing. The lender or closing attorney will explain the loan terms and requirements as well as where and how to make the monthly payments. All relevant papers are signed and a move-in is determined.
- The lender applies to VA for evidence of guaranty.

To obtain a VA loan, the law requires that:

- The applicant must be an eligible veteran who has available home loan entitlement.
- The loan must be for an eligible purpose.
- The veteran's must occupy or intend to occupy the property as his or her principal home within a reasonable period of time after the loan closes.
- The veteran must have enough income to meet the new mortgage payments on the loan, cover the costs of owning a home, take care of other obligations and expenses and still have enough income left over for family support.
- The veteran must be a satisfactory credit risk.

Certificate of Eligibility

The Certificate of Eligibility (COE) is perhaps the most important document associated with the VA's loan guaranty program. It is this document that starts the process and certifies that the veteran, or service member, is eligible for a VA guaranteed loan. After receiving the certificate, the veteran takes it to the lender when applying for a loan. COE's do not expire for veterans. COE's for active duty persons expire when they are discharged from service and they must then reapply as veteran. Application for the COE is made on VA Form 26-1880 `Request for Determination of Eligibility and Available Loan Guaranty Entitlement.'

Send the VA Form 26-1880 and proof of service to:
U.S. Department of Veteran's Affairs
St. Paul Regional Loan Center
1 Federal Drive – Fort Snelling
St. Paul, MN 55111-4050

VA has developed an alternate procedure for lenders. It can be accessed through the automated system at www.benefits.va/gov/homeloans. This website will help the lender navigate the VA Home Loan Process.

The lender uses the webLGY, a web based application that is able to determine eligibility and issue a COE.

Not all cases can be processed through webLGY. If there is insufficient data in VA records, the certificate will have to be requested from VA.

VA guaranteed loans may also be used for

Refinancing

Refinancing loans are available to pay off the mortgage and/or other liens of record on the home. Usually the loan may not exceed 90% of the reasonable value of the home as determined by an appraisal, plus the funding fee, if required.

Farm Loans

VA home loans can be made when a farm residence will be personally occupied by the veteran. A veteran cannot obtain a farm loan if they will not be living on the property.

Restoration of Entitlement

A veteran who has used all or part of, his or her entitlement can have it restored to purchase another home under the following circumstances:

- The loan is paid in full and the property which secured the loan has been disposed of by the veteran or
- The loan is paid in full and the property is destroyed by fire or other natural hazard or
- Another qualified veteran buyer substitutes his or her entitlement and assumes the loan or
- Effective November 2, 1994, on a ONE TIME ONLY basis, entitlement may be restored if the prior loan is paid in full even if the veteran has not disposed of the property securing that loan.

Service Requirements

Wartime: Veterans must have served **at least 90 days on active duty**, any part of which was during the following periods, and must have been discharged or released under other than dishonorable conditions. Veterans who served less than 90 days may qualify if discharged for a service connected disability.

• WW II	September 6, 1940 to July 25, 1947
• Korea	June 27, 1950 to January 31, 1955
• Vietnam	February 28, 1961 to May 7, 1975
• Gulf War	August 2, 1990 to a date to be determined (requires service for two years or the full period for which ordered to active duty)

Peacetime

Veterans must have served **at least 181 days on active duty** and have been discharged or released under other than dishonorable conditions. Veterans who served less than 181 days may qualify if they were discharged for a service connected disability.

Veterans whose entire period of active duty was between September 7, 1980, (enlisted) or October 16, 1981, (officers) and August 1, 1990, must meet one of the following:

- Completed 24 months of active duty or the full period (at least 181 days) for which called or ordered to active duty or
- If the time served on active duty was for a shorter period, discharge must have been for reasons of 'hardship' or 'reduction in force' or
- Was discharged for a service connected disability.

Active Duty Personnel

Servicepersons on active duty are eligible after having served on continuous active status for at least 90 days during wartime or 181 days during peacetime. They remain eligible as long as they remain on active duty under honorable conditions.

Selected Reserve

Members who have been ordered to active duty may also qualify as veteran, based on their active duty service for example: Reservists and National Guard members who have been ordered to active duty for the hostilities in Southwest Asia.

Individuals who are not otherwise eligible and who have **completed at least six years** in the Selected Reserves or National Guard will be eligible if they meet at least ONE of the following criteria:

- Were discharged from the service with an honorable discharge or
- Were placed on the retired list or
- Were transferred to an element of the Ready Reserve other than the Selected Reserve or
- Continue to serve in the Selected Reserve.

Surviving Spouses

Surviving spouses may also be eligible if:

- They are the unremarried spouse of a veteran who died while in service or from a service connected disability, or
- They are the spouse of a serviceperson missing in action or a prisoner of war.

Surviving spouses who remarry on or after attaining age 55, and on or after December 16, 2003, may be eligible for home loan eligibility.

Direct Loans

Direct loans are available for eligible Native American veterans who wish to purchase, construct or improve a home on trust lands. Veterans do not have to make a down payment but there will be closing costs such as a funding fee, appraisal, credit reports, etc.

To obtain a VA direct loan, the law requires that:

- Applicant must be an eligible Native American veteran who has available entitlement
- Tribal organization must have signed a Memorandum of Understanding with the VA spelling out the conditions under which the program will operate on its trust land

- Loan must be to purchase, construct, or improve a home on trust land. Individually allotted land is considered trust land for this purpose
- Veteran must occupy the property as his or her home
- Veteran must be a satisfactory credit risk.

Interested veterans should contact the local housing authority or tribal council for additional information pertaining to the area in which they would like to buy or build a home.

Specially Adapted Housing (SAH) Grant

The Specially Adapted Housing Grant is available to veterans or servicemembers who are entitled to compensation for permanent and total service-connected disability due to:

- Loss, or loss of use, of both lower extremities such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair or
- Blindness in both eyes having only light perception, plus loss or loss of use of one lower extremity or
- Loss, or loss of use, of one lower extremity together with (1) residuals of organic disease or injury, or (2) the loss or loss of use of one upper extremity. (Items 1 and 2 must so affect the functions of balance or propulsion as to preclude locomotion without the aid of braces, canes, crutches, or a wheelchair) or
- Loss, or loss of use, of both upper extremities, so as to preclude use of the arms at or above the elbows or
- Permanent and total disability is due to a severe burn injury (as so determined).

Eligibility

To be eligible for the housing grant:

- Must be medically feasible for the veteran or servicemember to reside in the house.
- House must be adapted to be suitable to the veteran's or servicemember's needs for living purposes.
- It must be financially feasible for the veteran or servicemember to acquire the house, with the assistance provided by the grant.

Specially Adapted Housing Grant

There is no time limit on the use of the grant. An eligible veteran or servicemember may receive a VA grant of not more than 50 percent of the cost of a specially adapted house, up to the aggregate maximum amount allowable by law. Click here to view the current maximum grant amount allowable.

Public Law 109-233 authorized up to three usages of grant benefits. Public Law 110-289 provided for annual increases in the maximum grant amount, to keep pace with the residential cost-of-construction index. When the maximum grant amounts are increased, veterans or servicemembers who have not used the assistance available to them up to the allowable three times may be entitled to a grant equal to the increase in the maximum grant amount at that time.

An eligible veteran or servicemember has the option to use up to the full amount of the grant under any one of the following plans:

Plan 1: To construct a home on land to be acquired for that purpose.

Plan 2: To build a home on land already owned if it is suitable for specially adapted housing.

Plan 3: To remodel an existing home if it can be made suitable for specially adapted housing.

Plan 4: To apply against the unpaid principal mortgage balance of a specially adapted home that he/she has already acquired without the assistance of a VA grant.

A temporary grant (TRA) may be available to veterans and servicemembers who are/will be temporarily residing in a home owned by a family member. This assistance may be used to adapt the family member's home to meet the veteran's or servicemembers special needs at that time. Click here to view the maximum amount available to adopt a family member's home for the SAH grant and for the SHA grant.

Special Housing Adaptation (SHA)

The Special Housing Adaptation grant is available to veterans or servicemembers who are entitled to compensation for permanent and total service-connected disability due to:

- Blindness in both eyes with 5/200 visual acuity or less, or
- The anatomical loss or loss of use of both hands, or
- The permanent and total disability is due to a severe burn injury (as so determined).

There is no time limit on the use of the grant. An eligible veteran or servicemember may receive a VA grant for the actual cost to adapt a house or for the appraised market value of necessary adapted features already in a house when it was purchased, up to the maximum grant amount allowable by law. Click here to view the current maximum grant amount allowable. This amount will be adjusted annually based on a cost-of-construction index.

Public Law 109-233 authorized up to three usages of grant benefits. Public Law 110-289 provided for annual increases in the maximum grant amount, to keep pace with the residential cost-of-construction index. When the maximum grant amounts are increased, veterans or

servicemembers who have not used assistance available to them up to three times may be entitled to the increase in the maximum grant amount at that time.

The veteran or servicemember has the option to use the grant under any one of the following plans:

Plan 1: To adapt a house which he/she plans to purchase and reside in.

Plan 2: To adapt a house, which a member of his/her family plans to purchase and in which he/she intends to reside.

Plan 3: To adapt a house, which he/she already owns and intends to reside in.

Plan 4: To adapt a house, which is already owned by a member of his/her family and in which he/she intends to reside.

Plan 5: To purchase a house, which has already been adapted with special features that VA has determined are reasonably necessary and in which he/she intends to reside.

Temporary Residence Adaptation (TRA)

TRA grants are for eligible Veterans and Servicemembers who are temporarily residing in a home owned by a family member that needs modifications to accommodate the veteran's or servicemember's needs. Click here to view the current maximum TRA grant for SAH-eligible veterans and servicemembers, and for SHA-eligible veterans and servicemembers.

Application Procedures

VA Form 26-4555 'Veteran's Application in Acquiring specially Adapted Housing or Special Home Adaptation Grant' is used to apply for either of these grants.

When the veteran's or servicemember's request for the grant is approved, he/she will receive a commitment letter from VA setting forth the terms and conditions under which the funds will be made available. Any contract executed by the veteran or servicemember must include the condition that it is subject to VA approval and his/her obtaining the grant.

Veterans and servicemembers may not be entitled for reimbursement of costs incurred prior to receipt of a disability rating and/or in anticipation of receipt of a grant approval. Please contact VA prior to incurring such costs.

Veteran's Mortgage Life Insurance

Most veterans and servicemembers who receive a Special Adapted Housing (SAH) or a Special Housing Adaptation (SHA) grant are eligible for Veterans Mortgage Life Insurance (VMLI) covering the unpaid principal, not to exceed $90,000, on the mortgage loan.

VA Form 29-8636 'Veterans Mortgage Life Insurance Statement' is used to apply for the insurance. VMLI can only be issued to veterans and servicemembers age 69 and younger. Once issued, VMLI will remain in effect, regardless of age, if there is mortgage indebtedness. Questions concerning VMLI should be directed to the Insurance Center located in Philadelphia at 1-800-669-8477.

Home Improvement and Structural Alterations (HISA)

Veterans with service-connected or nonservice-connected disabilities may receive assistance for any home improvement necessary for the continuation of treatment or for disability access to the home under the HISA program.

The veteran must have received a medical determination indicating that improvements and structural alterations are necessary or appropriate for the effective and economical treatment of his/her disabilities. A veteran may receive both a HISA grant and either a Special Home Adaptation (SHA) grant or a specially Adapted Housing (SAH) grant.

Click here to view home improvement benefits for **service connected** veteran and **nonservice connected** veteran.

HISA grants may be used for:

- Allowing entrance or exit from the veteran's home
- Improving access for use of essential lavatory and sanitary facilities
- Improving access to kitchen and bathroom counters
- Handrails
- Lowered electrical outlets and switches
- Improving paths or driveways
- Improving plumbing/electrical work for dialysis patients

Application Procedures

In order to receive a HISA grant, the veteran must first have a prescription from a VA or fee-basis physician. This must include

- Specific items required
- The diagnosis with medical justification
- The veteran's name, address, SSN and phone number.

VA Form 10-0103 'Veterans Application for Assistance in Acquiring Home Improvement and Structural Alterations' is used to apply for the grant.

Reference Sheet — How to Label Scanned/Uploaded Documents

County:

Forms: Use the VA Form Number and Date

Examples: VAForm21526EZ_ddmmyyyy
DDForm214

If you are uploading miscellaneous documents just name them accordingly. Be descriptive when possible.

Example: DivorceDecree_Veteran
DeathCertificate_Spouse
PrivateTreatmentRecords_Sanford_ddmmyyyy
MedicalOpinion_DrSmith

Claims Office/SDDVA:

Documents uploaded from VBMS should be labeled as follows:

DevelopmentLetterddmmyyyy
RatingDecisionNarrativeddmmyyyy
RatingDecisionCodeSheetddmmyyyy
NotificationLetterddmmyyyy

use the term notification letter if the decision resulted in no award of monetary benefits from VA

AwardLetterddmmyyyy

use the term Award Letter if the decision resulted in an award of monetary benefits from the VA

Debt Management Overpayment Notifications:

DMCDemandLetterddmmyyyy

When uploading documents, it proves helpful to put a brief description after the type of document & date. When possible please describe what you are uploading.

Example: RatingDecisionNarrativeddmmyyyy_BLHearingLossTinnitusGranted
NotificatonLetterddmmyyyy_DrillPayAdjustment

Claims Cheat Sheet

Intent to File –ITF (preserves date of claim) – To: ADJ Compensation or ADJ Pen & Survivor Benefits

21-22 & SDDVA policy statement & HIPPA Disclosure (VA Form 21-4142) On File
21-0966 - Claims Office can sign if we have POA - Formalize within one year
**DO NOT send Pension ITFs D2D

Compensation – To: ADJ Compensation

21-22 & SDDVA policy statement & HIPPA Disclosure (VA Form 21-4142), On File
DD 214 - if not already on file
21-526EZ - Claims Office can sign if we have POA, but not on original claim
PTSD Claims - VA form 21-0781 - if no qualifying combat award or 21-0781a for personal assault
Reserve/National Guard must provide Service Treatment Records (STRs)
Private treatment records
Dependency 21-686c, if applicable

Additional Benefits

IU – 8940 & 4192 (1 rating at least 60% or Combined 70% 1 being 40% or more)
Specially Adapted Housing or Special Home Adaptation –26-4555
Auto Allowance – 21-4502

Veterans Pension – To: ADJ Pension & Survivor Benefits

21-22 & SDDVA policy statement & HIPPA Disclosure (VA Form 21-4142) On File
DD 214 - if not already on file
21P-527EZ Application for Pension
21P-0969 - Income and Asset Statement, if applicable
21P-8416 - if more room needed for medical expenses
Medical Records if under 65

Special Monthly Pension

21-0779 - Nursing home
21-2680 - Aid and Attendance or Housebound
Title XIX documentation (Medicaid), if applicable

Vet must have served at least one day during war time and be over age 65 or have a disability preventing work and meet income guidelines.

Survivors Pension – To: ADJ Pension & Survivor Benefits

21-22 & SDDVA policy statement & HIPPA Disclosure (VA Form 21-4142) On File DD 214 - if not already on file
21P-534EZ - Application for Death Pension
21P-0969 - Income and Asset Statement, if applicable
21P-8416 if more room needed for medical expenses
Death Certificate
Marriage/ Divorce/ Birth Certificates, (if not listed on award)

Special Monthly Pension

21-0779 - Nursing home

21-2680 Aid and Attendance or Housebound
Title XIX documentation (Medicaid), if applicable

Established Pension -Going to $90 Rate – To: ADJ Pension & Survivor Benefits
21P-8416 – Showing all medical expenses
21-4138 – Waive Due Process
Title XIX documentation (Medicaid-DSS Notice of Action Letter)
21-0779 - If moving into Nursing Home

Dependency and Indemnity Compensation (DIC) – To: ADJ Pension & Survivor Benefits
21-22 & SDDVA policy statement & HIPPA Disclosure (VA Form 21-4142) On File
DD 214 - Certified
21P-534EZ - Application for DIC
Death Certificate
Marriage/ Divorce/ birth certificates (if not listed on award)

Supplemental Claim – Reopen and Reconsideration – To: ADJ Compensation or ADJ Pen & Survivor
21-22 & Policy Statement & HIPPA Disclosure (VA Form 21-4142), On File
20-0995 - Decision Review Request: Supplemental Claim - Records of new evidence (i.e., medical records, medical opinions, statements)
21-4138 (optional) - Explain Evidence if needed
Higher Level Review – Reopen and Reconsideration - To: ADJ Compensation or ADJ Pen & Survivor
21-22 & Policy Statement & HIPPA Disclosure (VA Form 21-4142), if applicable
20-0996 - Decision Review Request: Higher Level Review
21-4138 (Optional) – Explain new evidence if needed

Board Appeal (Notice of Disagreement) – To: Board of Veterans Appeals Washington
VA10182 – Decision Review Request: Board Appeal (Notice of Disagreement)
Choose one of the three options and attach evidence in accordance with the option chosen

Champ VA (Processed at CAMPVA in Denver) – To: CHAMPVA
21-22 & Policy Statement & HIPPA Disclosure (VA Form 21-4142), On File
10-7959c (even if they don't have other health insurance)
10-10d
Copy of other health insurance cards front and back

Burial Benefits (Processed at PMC in St. Paul, MN) - To: ADJ Pension & Survivor Benefits
21-22 & Policy Statement & HIPPA Disclosure (VA Form 21-4142) On File
21P-530 – Application for Burial Benefits
DD 214 – Certified If not already of record
Death Certificate
Paid & Itemized Funeral Statement

For burial benefits – two-year time limit, must have been receiving benefits or passed away in the VA facility

Headstone Request
(Processed at Memorial Affairs in Quantico, VA) To: Memorial Affairs
21-22 & Policy Statement & HIPPA Disclosure (VA Form 21-4142) On File
40-1330 Claim for Standard Government Headstone or Marker OR
40-1330M for Medallion
DD 214 - if not already on file
Death Certificate

For Headstone – no time limit, must have Active Duty or retired National Guard or Reservist

FORMS

VA Form	(Version)	Form Description
10-10EZ	(Mar 2024)	Application for Health Benefits
10-10d	(May 2023)	Application for ChampVA Benefits
10-1394	(Jan 2008)	Application for Adaptive Equipment Motor Vehicle
10-8678	(Jun 2015)	Application for Annual Clothing Allowance
10-7959c	(Aug 2013)	Champ VA Other Health Insurance Certification
20-0995	(May 2024)	Decision Review Request: Supplemental Claim
20-0996		Decision Review Request: Higher Level Review
21-22	(Jul 2023)	Appointment of Veterans Service Organization as Claimant's Rep.
21-526EZ	(Nov 2022)	Application for Disability and Related Compensation Benefits
21-527EZ	(Feb 2023)	Application for Pension
21P-530EZ	(Aug 2022)	Application for Burial Benefits
21P-534EZ	(Jul 2022)	Application for DIC, Death Pension, and/or Accrued Benefits
21-686c	(Aug 2022)	Declaration of Status of Dependents
21-0516-1	(Jul 2021)	Improved Pension Eligibility Verification Report (Vet w/ no children)
21-0779	(Sep 2023)	Request for Nursing Home Information in Connection with Claim for A&A
21-0781	(March 2024)	Statement in Support of Claim for Service Connection for PTSD
21-0781A	(Jun 2021)	Statement in Support of Claim for Service Connection for PTSD Secondary to Personal Assault
21-0966	(Feb 2023)	Intent to File
21P-0969	(Nov 2023)	Income and Asset Statement in Support of Claim for Pension or Parents' DIC
21-2680	(Feb 2023)	Examination for Housebound Status or Permanent Need for Regular A&A
21-4138	(Jun 2021)	Statement in Support of Claim
21-4142	(Jul 2021)	Authorization and Consent to Release Information to the Dept. of the VA
21-4142A	(Jul 2021)	General Release for medical Provider Information to the Dept. of the VA
21-4192	(Jul 2021)	Request for Employment Information in Connection with Claim for Disability Benefits
21-4502	(Jul 2021)	Application for Automobile or Other Conveyance and Adaptive Equipment
21P-8416	(Oct 2023)	Medical Expense Report
21-8940	(Jun 2021)	Veteran's Application for Increased Compensation Based on Unemployability
26-4555	(Jun 2021)	Application for Acquiring Specially Adapted Housing
26-4555C	(Jan 2021)	Supplemental Application for Acquiring Specially Adapted Housing
28-1900	(Aug 2022)	Disabled Veterans Application for Veterans Readiness and Employment
40-1330	(Aug 2022)	Claim for Standard Government Headstone or Marker
40-1330M	(Aug 2022)	Claim for Government Medallion for Placement in Private Cemetery
10182	(Mar 2022)	Decision Request: Board Appeal (Notice of Disagreement)
DOD Form	**(Version)**	**Form Description**
DD-2860	(Jul 2011)	Claim for Combat-Related Special Compensation (CRSC)

VSO Manual Acronym Reference Sheet

38 U.S.C. (Title 38 United States Code) - U.S. Codified law relating to Veteran's Benefits.

38 CFR (Title 38, Code of Federal Regulations) - The U.S. government's rules and regulations pertaining to Pensions, Bonuses, and Veterans' Relief. 38 CFR Part 3 (Pension, Compensation, and Dependency) & Part 4 (Schedule for Rating Disabilities) are the two primary chapters that VSO's will reference in their job.

M21-1MR (VA Adjudication Procedure Manual) - The VA.'s procedure manual that tells them how the regulations in 38 CFR are to be applied to the law contained in Title 38 United States Code.

ChampVA (Civilian Health and Medical Program of the Department of Veterans Affairs) - A comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries.

CTVSO (County/Tribal Veterans Service Officer) - Veterans Service Officers appointed by their respective county commission or tribal councils.

DBQ (Disability Benefits Questionnaire) - Downloadable forms that allow veterans more control over the disability claims process by giving them the option of completing an examination with their own healthcare provider instead of at a Veterans Affairs facility. Veterans are responsible for any fees their private provider may charge for completing a DBQ. This is also a good tool to review before the veteran completes a VA scheduled compensation and pension evaluation.

DMC (Debt Management Center) - The DMC collects debts resulting from veterans, members of the Armed Forces, and family members' participation in most VA compensation, pension, and education programs.

DPRIS (Defense Personnel Records Information Retrieval System) - Department of Defense records database containing military personnel records for veterans discharged after 1999. Primarily used to obtain a veteran's DD-214.

FSO (Field Service Officer} - A South Dakota Department of Veterans Affairs state employee, an FSO supports, assists, and trains CTVSOs.

NCA (National Cemetery Administration} - The VA agency that provides burial benefits for veterans and eligible family members. This can include: a gravesite in any of the national cemeteries, a government headstone, marker or medallions, a burial flag, and Presidential Memorial Certificate(s). Burial allowances may also be available.

PMC (Pension Management Centers} - PMC's process all pension related actions including original claims and adjustments to benefits payments necessitated by changes in income, net worth, or dependency status.

SAA (State Approving Agencies} - SAA's are VA contracted entities established in each state. Their role includes initially approving programs of education for GI Bill participants to ensure they meet VA requirements and to conduct compliance surveys on educational programs and review student files.

SHARE (Not an Acronym) - VA database containing a veteran's rating and payments information.

TRIP (Training Responsibility Involvement and Preparation of claims} - VA database containing training programs. VSO's must complete this training to receive accreditation.

UME (Unreimbursed Medical Expenses} - Unreimbursed medical expenses paid by the beneficiary that may be used to reduce the beneficiary's countable income when applying for a VA pension.

VARO (Veterans Affairs Regional Office} - Houses the various VA entities deal with veteran benefits.

VBA (Veterans Benefits Administration} - An agency of the VA, the VBA provides financial and other forms of assistance to veterans and their dependents.

VBMS (Veterans Benefits Management System} - An electronic benefit filing system used to modernize and streamline the filing and processing of veterans' claims.

VETRA SPEC - A centralized, secure claims management database allowing Veterans Service Officers to access their data from any computer with internet access. All information for a veteran's claim is input into this database and forms uploaded for submission to the SDDVA Claims Office.

VSO (Veterans Service Officer) - Provides information, assistance, counseling and referrals on a wide range of subjects, benefits, and veterans programs.

Service Connected Matrix

There are additional benefits that you may be eligible for that are based on a favorable decision for a VA benefit and/or based on special circumstances. These are known as derivatives.

Non-Compensable 0 percent disability rating	• 10-point veteran preference in federal hiring • No cost health care and prescription drugs for service-connected disabilities (if income limits are met) • Travel allowance for scheduled appointments for care at a VA medical facility or VA authorized health care facility • Commissary and Exchange Privileges • Use of commissaries, exchanges, and morale, welfare and recreation (MWR) retail facilities, in-person and online.
Compensable 0 percent disability rating* **Note: In some instances there are individuals who have separate and more than two zero percent service connected disabilities who are paid at the minimum 10 percent. (38 CFR 3.324)*	• 10-point veteran preference in federal hiring • No cost healthcare and prescription drugs for service-connected disabilities (if income limits are met) • Travel allowance for scheduled appointments for care at a VA medical facility or VA authorized health care facility • Waiver of VA funding fee for VA home loan • Burial and plot allowance • Commissary and Exchange Privileges • Use of commissaries, exchanges, and morale, welfare and recreation (MWR) retail facilities, in-person and online.
Service-connected disability rated at 10%	• No cost health care • Prescription medications for service-connected disabilities • Travel allowance for scheduled appointments for care at a VA medical facility or VA authorized health care facility • Waiver of VA funding fee for home loan • 10-point veteran preference in federal hiring • Vocational Rehabilitation & Employment (with a serious employment handicap) • Burial and plot allowance • Commissary and Exchange Privileges • Use of commissaries, exchanges, and morale, welfare and recreation (MWR) retail facilities, in-person and online.

Service-connected disability rating at 20%	• No cost health care • Prescription medications for service-connected disabilities • Travel allowance for scheduled appointments for care at a VA medical facility or VA authorized health care facility • Waiver of VA funding fee for home loan • 10-point veteran preference in federal hiring • Vocational Rehabilitation & Employment • Burial and plot allowance • Commissary and Exchange Privileges • Use of commissaries, exchanges, and morale, welfare and recreation (MWR) retail facilities, in-person and online.
Service-connected disability rating at 30 - 40%	• No cost health care • Prescription medications for service-connected disabilities • Travel allowance for scheduled appointments for care at a VA medical facility or VA authorized health care facility • Waiver of VA funding fee for home loan • 10-point veteran preference in federal hiring • Direct hire authority • Vocational Rehabilitation & Employment • Additional compensation for eligible dependents (may include aid and attendance for eligible spouse) • Burial and plot allowance • Commissary and Exchange Privileges • Use of commissaries, exchanges, and morale, welfare and recreation (MWR) retail facilities, in-person and online.
Service-connected disability rating at 50%	• No cost health care and prescription medications • Travel allowance for scheduled appointments for care at a VA medical facility or VA authorized health care facility • Waiver of VA funding fee for home loan • 10-point veteran preference in federal hiring • Direct hire authority • Vocational Rehabilitation & Employment • Additional compensation for eligible dependents (may include aid and attendance for eligible spouses) • Concurrent receipt of military retired pay • Burial and plot allowance • Commissary and Exchange Privileges • Use of commissaries, exchanges, and morale, welfare and recreation (MWR) retail facilities, in-person and online.
Service-connected disability rating at 60 - 90%	• No cost health care and prescription medications • Travel allowance for scheduled appointments for care at a VA medical facility or VA authorized health care facility • Waiver of VA funding fee for home loan • 10-point veteran preference in federal hiring Direct hire authority • Vocational Rehabilitation & Employment • Additional compensation for eligible dependents (may include aid and attendance for eligible spouses) • Concurrent receipt of military retired pay

	• Individual Unemployability (must be unemployable due to service connected disabilities) • Dependents Educational Assistance (unemployable condition must be considered permanent) • Special restorative training • CHAMPVA–Civilian Health and Medical Program (unemployable condition must be considered permanent) • Dental care (if rated unemployable) • Burial and plot allowance • Commissary and Exchange Privileges • Use of commissaries, exchanges, and morale, welfare and recreation (MWR) retail facilities, in-person and online.
Service-connected disability rating at 100%	• No cost health care and prescription medications • Travel allowance for scheduled appointments for care at a VA medical facility or VA authorized health care facility • No cost dental care • Waiver of VA funding fee for home loan • 10-point veteran preference in federal • hiring Direct hire authority • Vocational Rehabilitation & Employment • Additional compensation for eligible dependents (may include aid and attendance for eligible spouses) • Concurrent receipt of military retired pay • Dependents Education Assistance (must be considered permanent.) • Special restorative training • CHAMPVA–Civilian Health and Medical Program (must be considered permanent) • Burial and plot allowance • Uniformed Services ID card South Dakota special license plates South Dakota state park entrance fee waiver and some reduced parking and camping fees South Dakota property tax exemption of $200,000
Service-connected disability rating at 100% with an additional separate 60 percent service connected disability rating	• Statutory Housebound • Commissary and Exchange Privileges • Use of commissaries, exchanges, and morale, welfare and recreation (MWR) retail facilities, in-person and online.