



Pension Application Packet

QUALIFICATIONS FOR VA DISABILITY PENSION

VA disability Pension is a program that provides financial support to low income wartime veterans. Under this program, the amount of pension depends upon total income of the veteran. Countable income may be reduced by paid, unreimbursed medical expenses. Asset limitation is \$80,000.

ELIGIBILITY

- Veteran must have 90 days or more active duty, one of which must have been during a war-time.
- Veteran must be determined by the VA to be 100% disabled
- Veteran must meet income guidelines

WAR TIME DATES

World War II	December 7, 1941 to December 31, 1946
Korea	June 27, 1950 to January 31, 1955
Vietnam	August 5, 1964 to May 7, 1975
Gulf/Iraq/Afghanistan	August 1, 1990 to present

INCOME GUIDELINES (effective 12/01/20013)

Single Veteran	\$12,652
Veteran with One Dependent	\$16,569
Each Additional Dependent add	\$2,161
Single Veteran determined to be Housebound	\$15,462
Veteran with One Dependent Housebound	\$19,380
Single Veteran in need of Aid & Attendance	\$21,107
Veteran with One Dependent in need of Aid & Attendance	\$25,022

MEDICAL EXPENSES

The only medical expenses that will be counted to start with are continuing medical expenses such as but not limited to:

- Medicare premiums
- Supplemental insurance premiums
- Nursing home/Assisted Living
- Sitters fee

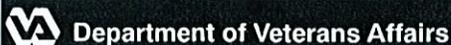
Please note that once you apply for this benefit start keeping receipts for all unreimbursed medical expenses for your household. Once the benefit is granted they may request this information.

You will need your DD-214 & a copy of Marriage license/divorce decrees (if applicable). If Veteran is living in an assisted living facility a letter is required from that facility stating when veteran entered & how much veteran pays.

Below is a detailed explanation of the forms in this packet. Not all forms are necessary. Please refer to the chart for more detailed information concerning each form.

VA Form Number	Explanation	Required
VA Form 21-527ez Application for Pension	This is the pension Application.	Required—All questions must be answered and signature is required
VA Form 21-2680 Examination for house-bound status or permanent need for regular A&A	When you need help from someone with activities of daily living. Your doctor has to complete this form.	Required — if applicable
VA Form 21-22 Appointment of Veterans service Organization as Claimant's Representative	The American Legion becomes your representative. Our office is accredited with this organization and files claims through them. This will allow this office to speak on your behalf with the VA.	Required—Please sign and return with application packet
VA Form 21-0845 Authorization to disclose personal information to a third party	Giving a family member permission to speak to the VA for you. This allows that person to call the VA and talk to them directly without you having to be there.	Complete and sign this form if you want the VA to speak to the family member you list on this form
VA Form 21-0779 Request for Nursing Home Information for A&A	If veteran lives in a Nursing Home Facility this form needs to be completed by that facility.	Required — if applicable
VA Form 21-4138 Statement in support of claim (Caregiver's Fee Form)	Caregiver to complete & sign if you have someone coming into your home to help you with your medical needs.	Required — if applicable
Pension Disclaimer	This states that all information provided is true.	Required — please complete and return with packet

Please bring completed application packet back into our office for review and submission to the U.S. Department of Veterans Affairs



VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR PENSION

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 8 before completing the form.

SECTION I: VETERAN'S PERSONAL INFORMATION (MUST COMPLETE)

1. VETERAN'S NAME (Last, first, middle)		2. SOCIAL SECURITY NUMBER		3. DATE OF BIRTH (MM,DD,YYYY)	
4. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		5. HAVE YOU EVER FILED A CLAIM WITH VA? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," provide your file number in Item 6)		6. VA FILE NUMBER	
7A. MAILING ADDRESS Street address, rural route, or P.O. Box _____ Apt. number _____ City _____ State _____ ZIP Code _____ Country _____				7B. TELEPHONE NUMBERS (Include Area Code) DAYTIME () EVENING () CELL PHONE ()	
8A. PREFERRED E-MAIL ADDRESS (If applicable)			8B. ALTERNATE E-MAIL ADDRESS (If applicable)		
9. WHAT DISABILITY(IES) PREVENTS YOU FROM WORKING?					
A. DISABILITY(IES)			B. DATE DISABILITY(IES) BEGAN		
10. LIST ANY VA MEDICAL CENTERS WHERE YOU RECEIVED TREATMENT FOR YOUR CLAIMED DISABILITY(IES) AND PROVIDE TREATMENT DATES					
A. NAME AND LOCATION OF VA MEDICAL CENTER			B. DATE(S) OF TREATMENT		

SECTION II: VETERAN'S SERVICE INFORMATION (MUST COMPLETE)

11A. DID YOU SERVE UNDER ANOTHER NAME? <input type="checkbox"/> YES (If "Yes," complete Item 11B) <input type="checkbox"/> NO (If "No," skip to Item 12A)		11B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER			
12A. I ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)		12B. BRANCH OF SERVICE		12C. RELEASE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE SERVICE	
12D. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001? <input type="checkbox"/> YES <input type="checkbox"/> NO			12E. PLACE OF LAST OR ANTICIPATED SEPARATION		
13A. ARE YOU CURRENTLY ACTIVATED TO FEDERAL ACTIVE DUTY UNDER THE AUTHORITY OF TITLE 10, U.S.C. (National Guard)? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," provide date of activation in Item 13B)				13B. DATE OF ACTIVATION (MM,DD,YYYY)	
14A. WHAT IS THE NAME AND ADDRESS OF YOUR RESERVE/NATIONAL GUARD UNIT?				14B. WHAT IS THE TELEPHONE NUMBER OF YOUR CURRENT UNIT? (Include Area Code) ()	
15A. HAVE YOU EVER BEEN A PRISONER OF WAR? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Item 15B) (If "No," skip to Item 16A)			15B. DATES OF CONFINEMENT ON (MM,DD,YYYY) From: _____ To: _____		
16A. DID YOU RECEIVE ANY TYPE OF SEPARATION/SEVERANCE RETIRED PAY? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," complete Items 16B and 16C)		16B. LIST AMOUNT (If known) \$ _____		16C. LIST TYPE (If known)	

SECTION III: VETERAN'S WORK HISTORY (MUST COMPLETE)

NOTE: In the table below, tell us about all of your employment, including self-employment, for one year before you became disabled to the present.

17A. WHAT WAS THE NAME AND ADDRESS OF YOUR EMPLOYER?	17B. WHAT WAS YOUR JOB TITLE?	17C. WHEN DID YOUR JOB-BEGIN?	17D. WHEN DID YOUR JOB END?	17E. HOW MANY DAYS WERE LOST DUE TO DISABILITY?	17F. WHAT WERE YOUR TOTAL ANNUAL EARNINGS?
					\$
					\$

SECTION IV: MARITAL STATUS (MUST COMPLETE)

18A. WHAT IS YOUR MARITAL STATUS? (Check one)

MARRIED DIVORCED WIDOWED NEVER MARRIED (Skip to Section VI if never married)

TELL US ABOUT YOUR MARRIAGE/PREVIOUS MARRIAGES

18B. HOW MANY TIMES HAVE YOU BEEN MARRIED (including current marriage)?

19A. DATE (month, day, year) AND PLACE OF MARRIAGE (city/state or country)	19B. TO WHOM MARRIED (first, middle, last name)	19C. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	19D. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	19E. DATE (month, day, year) AND PLACE MARRIAGE TERMINATED (city/state or country)

19F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 19C, PLEASE EXPLAIN:

SECTION V: CURRENT MARITAL INFORMATION (COMPLETE ONLY IF YOU ARE CURRENTLY MARRIED)

Note - Skip to Section VI if not currently married.

TELL US ABOUT YOUR SPOUSE'S MARRIAGE/PREVIOUS MARRIAGES

20. HOW MANY TIMES HAS YOUR SPOUSE BEEN MARRIED (including current marriage)?

21A. DATE (month, day, year) AND PLACE OF MARRIAGE (city/state or country)	21B. TO WHOM MARRIED (first, middle, last name)	21C. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21D. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	21E. DATE (month, day, year) AND PLACE MARRIAGE TERMINATED (city/state or country)

21F. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21C, PLEASE EXPLAIN:

22A. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (month, day, year)	22B. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?	22C. IS YOUR SPOUSE ALSO A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	22D. WHAT IS YOUR SPOUSE'S VA FILE NUMBER (if any)?
22E. DO YOU LIVE WITH YOUR SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes," skip to Section VI) (If "No," complete Items 22F - 22H)		22F. WHAT IS YOUR SPOUSE'S ADDRESS? (Number and street or rural route, city or P.O., State, ZIP Code and country)	
22G. TELL US THE REASON WHY YOU ARE NOT LIVING WITH YOUR SPOUSE (i.e., illness, work, etc.)		22H. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? \$	

SECTION VI: DEPENDENT CHILDREN (COMPLETE IF YOU HAVE DEPENDENT CHILDREN)

Note - Skip to Section VII if you have no dependent children.

23A. NAME OF DEPENDENT CHILD (First, middle initial, last)	23B. DATE AND PLACE OF BIRTH (city, state or country)	23C. SOCIAL SECURITY NUMBER	(Check all that apply)						
			23D. BIOLOGICAL	23E. ADOPTED	23F. STEPCCHILD	23G. 18-23 YEARS OLD (in school)	23H. SERIOUSLY DISABLED	23I. CHILD MARRIED	23J. CHILD PREVIOUSLY MARRIED
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note - In Items 24A through 24D, tell us about the children listed in Item 23A who **do not** live with you.

24A. NAME OF DEPENDENT CHILD (First, middle initial, last)	24B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	24C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	24D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			\$
			\$
			\$

SECTION VII: INCOME VERIFICATION - NET WORTH (MUST COMPLETE)

25. NET WORTH (DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")

Report total net worth for your household. You must report your net worth and the net worth of your dependents (spouse, child, etc.), if any. Identify the **specific** owner for each net worth source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	\$		REAL PROPERTY <i>(Not your home, vehicle, furniture, or clothing)</i>	\$	
INTEREST-BEARING BANK ACCOUNTS	\$		ALL OTHER PROPERTY <i>(Please write source)</i>	\$	
IRA'S, KEOGH PLANS, ETC.	\$		ALL OTHER PROPERTY <i>(Please write source)</i>	\$	
STOCKS, BONDS, MUTUAL FUNDS, ETC.	\$		OTHER <i>(Provide source)</i>	\$	

SECTION VIII: INCOME VERIFICATION - MONTHLY INCOME (MUST COMPLETE)

26. GROSS MONTHLY INCOME (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report total monthly income for your household. You must report your income and the income of your dependents (spouse, child, etc.), if any. Identify the **specific** income recipient for each income source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	\$		SERVICE RETIREMENT	\$	
SOCIAL SECURITY	\$		SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE	\$	
U.S. CIVIL SERVICE	\$		OTHER <i>(Provide source)</i>	\$	
U.S. RAILROAD RETIREMENT	\$		OTHER <i>(Provide source)</i>	\$	
BLACK LUNG BENEFITS	\$		OTHER <i>(Provide source)</i>	\$	

SECTION IX: EXPECTED INCOME (MUST COMPLETE)

27. EXPECTED INCOME - NEXT 12 MONTHS (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report expected total household income for the next 12 months. You must report your expected income and the expected income of your dependents (spouse, child, etc.), if any. Identify the **specific** income recipient for each income source, yourself or another person in your household, as applicable.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	\$		OTHER INCOME EXPECTED <i>(Provide source)</i>	\$	
GROSS WAGES AND SALARY	\$		OTHER INCOME EXPECTED <i>(Provide source)</i>	\$	
TOTAL DIVIDENDS AND INTEREST	\$		OTHER INCOME EXPECTED <i>(Provide source)</i>	\$	

SECTION X: MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES (MUST COMPLETE)

28. MEDICAL, LEGAL, OR OTHER UNREIMBURSED EXPENSES (IF NONE WRITE "0" OR "NONE")

Report your family medical expenses and certain other expenses actually paid by you that may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction you paid 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 paid by you for the last illness and burial of a spouse or child at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Show medical, legal or other expenses you paid because of a disability for which civilian disability benefits have been awarded. When determining your income, we may be able to deduct them from the disability benefits for the year in which the expenses are paid. **Do not include any expenses for which you were reimbursed.**

AMOUNT PAID BY YOU	DATE PAID (mm/dd/yy)	PURPOSE (Doctor's fees, hospital charges, attorney fees, tuition, education materials, etc.)	PAID TO (Name of doctor, hospital, pharmacy, etc.)	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.)
\$				
\$				
\$				
\$				

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. Please attach a voided personal check or deposit slip or provide the information requested below in Items 29, 30, and 31 to enroll in direct deposit. If you **do not** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. 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.

29. 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.: _____ Account No.: _____

30. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)

31. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

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 Veteran of Evidence Necessary to Substantiate a Claim for Veterans Non-Service Connected 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 32, 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.

32. 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.

33A. VETERAN'S SIGNATURE (REQUIRED)

33B. DATE SIGNED

SECTION XIII: WITNESSES TO SIGNATURE (MUST COMPLETE ONLY IF VETERAN SIGNED ITEM 33A WITH AN "X")

34A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

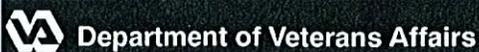
34B. PRINTED NAME AND ADDRESS OF WITNESS

35A. SIGNATURE OF WITNESS (If veteran signed above using an "X")

35B. PRINTED NAME AND ADDRESS OF WITNESS

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 Vocational Rehabilitation 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 pension. 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.



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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN			2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT <i>(If other than veteran)</i>		3. RELATIONSHIP OF CLAIMANT TO VETERAN	
4A. VETERAN'S SOCIAL SECURITY NUMBER		4B. CLAIMANT'S SOCIAL SECURITY NUMBER		5. CLAIM NUMBER		
6. DATE OF EXAMINATION			7. HOME ADDRESS			
8A. IS CLAIMANT HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Items 8B and 9)</i>		8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL			
NOTE: EXAMINER PLEASE READ CAREFULLY The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.						
10. COMPLETE DIAGNOSIS <i>(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)</i>						
11A. AGE	11B. SEX	12. WEIGHT ACTUAL: LBS. ESTIMATED: LBS.		13. HEIGHT FEET: INCHES:		
14. NUTRITION				15. GAIT		
16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?			
20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED From 9 PM To 9 AM: From 9 AM To 9 PM:						
21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? <i>(If "No," provide explanation)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO						
22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? <i>(If "Yes," provide explanation)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO						
23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? <i>(If "Yes," provide explanation)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO						
24A. IS THE CLAIMANT LEGALLY BLIND? <i>(If "Yes," provide explanation)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO				24B. CORRECTED VISION		
				LEFT EYE		RIGHT EYE
25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? <i>(If "Yes," provide explanation)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO						
26. DOES CLAIMANT REQUIRE MEDICATION MANAGEMENT? <i>(If "Yes," provide explanation)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO						
27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? <i>(If "No," provide explanation)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO						

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

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

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

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

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

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

NO

35A. PRINTED NAME OF EXAMINING PHYSICIAN

35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN

35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY

36B. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c) (1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115 (1)(e), 1311(c) and (d), 1315 (h), 1122, 1541 (d) (e), and 1502(b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, "Appointment of Individual as Claimant's Representative."

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM.

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER <i>(Include prefix)</i>
3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS <i>(See list on reverse side before selecting organization)</i> The American Legion	
3B. NAME AND JOB TITLE OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 3A <i>(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)</i>	
3C. E-MAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 3A VAOffice@lancastercountysc.net	

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER (OR SERVICE NUMBER, IF NO SSN)	5. INSURANCE NUMBER(S) <i>(Include letter prefix)</i>	
6. NAME OF CLAIMANT <i>(If other than veteran)</i>	7. RELATIONSHIP TO VETERAN	
8. ADDRESS OF CLAIMANT <i>(No. and street or rural route, city or P.O., State and ZIP Code)</i>	9. CLAIMANT'S TELEPHONE NUMBERS <i>(Include Area Code)</i>	
	A. DAYTIME	B. EVENING
	10. E-MAIL ADDRESS <i>(If applicable)</i>	
11. DATE OF THIS APPOINTMENT		

12. 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 3A 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 above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT - I authorize disclosure of records related to treatment for all conditions listed in Item 12 except:

<input type="checkbox"/> DRUG ABUSE	<input type="checkbox"/> INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
<input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE	<input type="checkbox"/> SICKLE CELL ANEMIA

14. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 3A to act on my behalf to change my address in my VA records.

I authorize any official representative of the organization named in Item 3A 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 3A is not my appointed fiduciary.

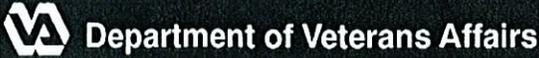
I, the claimant named in Items 1 or 6, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), 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 20.608. *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.

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

15. SIGNATURE OF VETERAN OR CLAIMANT <i>(Do Not Print)</i>	16. DATE SIGNED
17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B <i>(Do Not Print)</i>	18. DATE SIGNED

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO: <input type="checkbox"/> VR&E FILE <input type="checkbox"/> EDU FILE <input type="checkbox"/> LG FILE <input type="checkbox"/> INSURANCE FILE	DATE SENT	ACKNOWLEDGED <i>(Date)</i>	REVOKED <i>(Reason and date)</i>
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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.



(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

INSTRUCTIONS: Use this form if you want to give the Department of Veterans Affairs permission to release your personal beneficiary or claim information to a third party. This form may not be executed by any beneficiary recognized as incompetent for VA purposes, nor can VA accept this form from any beneficiary recognized as incompetent for VA purposes.

1. FIRST, MIDDLE, LAST NAME OF VETERAN <i>(Print clearly)</i>	2. FIRST, MIDDLE, LAST NAME OF BENEFICIARY/CLAIMANT WHO IS NOT THE VETERAN <i>(Print clearly)</i>
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3. ADDRESS OF BENEFICIARY/CLAIMANT *(No. and Street or rural route, City or P.O., State and ZIP Code)*

4. VA FILE NUMBER	5. SOCIAL SECURITY NUMBER
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6. CONTACT INFORMATION

A. DAYTIME PHONE NUMBER	B. CELL PHONE NUMBER	C. E - MAIL ADDRESS <i>(If applicable)</i>
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7. I (beneficiary/claimant) authorize the Department of Veterans Affairs (VA) to contact the person or organization listed below for the purposes of providing the following information pertaining to my VA record. *(Check only one box below to tell VA the specific benefit or claim information you want disclosed.)*

Any Information (Go to Item 9)
 Limited Information (Go to Item 8)

8. IF YOU SELECTED "LIMITED INFORMATION", CHECK ALL THAT APPLY

<input type="checkbox"/> Status of pending claim or appeal	<input type="checkbox"/> Amount of money owed VA	<input type="checkbox"/> Other
<input type="checkbox"/> Current benefit and rate	<input type="checkbox"/> Request a benefit payment letter	_____
<input type="checkbox"/> Payment history	<input type="checkbox"/> Change of address or direct deposit	_____

9. IF YOU SELECTED "ANY INFORMATION", THE TERMS OF SUCH RELEASE OF INFORMATION WILL BE:

One time only
 From the date of signing below until _____
 (Specify date - month, day, year)

Ongoing until written notice is given to VA to terminate

10. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION AS SPECIFIED ABOVE TO THE PERSON OR ORGANIZATION LISTED BELOW. NOTE: IF AUTHORIZATION IS FOR AN ORGANIZATION, PLEASE PROVIDE THE FIRST AND LAST NAME OF THE ORGANIZATION'S REPRESENTATIVE. *(Please print clearly)*

A. NAME OF PERSON OR ORGANIZATION	B. ADDRESS OF PERSON OR ORGANIZATION

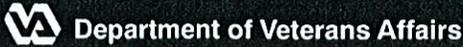
11. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY ONE SECURITY QUESTION BOX IN 11A AND PROVIDE THE ANSWER IN 11B.

A. SECURITY QUESTION	B. ANSWER
<input type="checkbox"/> The city and state your mother was born in	
<input type="checkbox"/> The name of the high school you attended	
<input type="checkbox"/> Your first pet's name	
<input type="checkbox"/> Your favorite teacher's name	
<input type="checkbox"/> Your father's middle name	

12A. SIGNATURE <i>(Do NOT print)</i>	12B. DATE SIGNED
--------------------------------------	------------------

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 voluntary. 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 release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



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

VA DATE STAMP
 (Do Not Write In This Space)

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

Section I - IDENTIFICATION INFORMATION

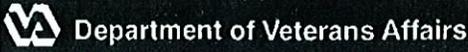
1A. NAME OF NURSING HOME		1B. ADDRESS OF NURSING HOME	
2. ADDRESS OF VA REGIONAL OFFICE			
3. FIRST NAME - MIDDLE INITIAL - LAST NAME OF CLAIMANT			
4. SOCIAL SECURITY NUMBER		5. VA FILE NUMBER	

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

6. DATE ADMITTED TO NURSING HOME (Month, Day, Year)		7. DATE MEDICAID BEGAN (Month, Day, Year)	
8. AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET \$			
9. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: (Check one) <input type="checkbox"/> SKILLED NURSING CARE <input type="checkbox"/> INTERMEDIATE NURSING CARE			
10. NURSING HOME OFFICIAL'S NAME (First & Last) (Please print)			
11. NURSING HOME OFFICIAL'S TITLE (Please print)		12. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER (Include Area Code)	
13A. SIGNATURE OF NURSING HOME OFFICIAL		13B. DATE SIGNED	

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 5, Code of Federal Regulations 1.526 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.



STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: 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, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. 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. 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). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). 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.whitehouse.gov/omb/library/OMB/INVA.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN (<i>Type or print</i>)	SOCIAL SECURITY NO.	VA FILE NO. C/CSS -
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The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

I, _____, have been the caregiver for the name
veteran above from :
_____ to _____
beginning date present/future

(Check all that apply)

- Help with getting out of bed
- Help with dressing
- Help with ambulating
- Help with bathing
- Help with feeding
- Help with toileting
- Help with incontinence
- Supervision for wandering
- Supervision to prevent injury or fall
- Preparing meals
- Doing housework and laundry
- Supervising or providing reminders for medications
- Providing transportation
- Help with answering the telephone
- Help with keeping track of money and paying bills
- Other (please list below)

I have received the following payments from the
veteran listed above for my services:

- \$ _____ for _____ (month & year)

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

SIGNATURE	DATE SIGNED	
ADDRESS	TELEPHONE NUMBERS (<i>Include Area Code</i>)	
	<table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none; padding: 5px;">DAYTIME</td> <td style="width:50%; border: none; padding: 5px;">EVENING</td> </tr> </table>	DAYTIME
DAYTIME	EVENING	

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.



Veterans Affairs Office

101 North Main Street
P.O. Box 1809
Lancaster, South Carolina 29721
Phone: (803) 283-2469
Fax: (803) 416-9497

Beth Raffaldt
Asst. Veterans Affairs Officer

Robin A. Helms
Veterans Affairs Officer

Dena J. Adams
Veterans Affairs Representative

DISCLAIMER

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G

DATE: _____

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I, _____, was counseled by _____, Representative of the Lancaster County Veterans Affairs, as to my responsibilities in the reporting of all family income and net worth to the U.S. Department of Veterans Affairs, for the purpose of accepting pension payments.

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I understand that I must report all my current family income and net worth which includes any future income adjustments to the U.S. Department of Veterans Affairs. My failure to report said income and net worth constitutes fraudulent reporting on my part, which may result in legal actions against me by the U.S. Department of Veterans Affairs.

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I hereby relieve South Carolina Division of Veterans Affairs, The American Legion and Lancaster County Veterans Affairs from any responsibility for my failure to properly report said income and new worth as stated above.

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CLAIMANT

SCDVA/AL REPRESENTATIVE
LCDVA REPRESENTATIVE