

THIS IS NOT A VA APPLICATION

VA Long Term Health Care?

War Time Veterans or their Survivors

How to Apply for Financial Assistance from the U.S. Department of Veterans Affairs

- **Ensure criteria on (Tab A) is met before continuing.**
- **Gather required documents & other applicable information. See (Tab B)**
- **Provide as much information as possible on Worksheet (Tab C)**
- **Take the enclosed VA Form 21-2680 to a medical doctor.**
- **If the person is being placed in:**
 1. **Assisted Living or Nursing Home for care, have the Administrator of the facility complete (Tab D)**
 2. **Home for Home Health Care, complete (Tab E)**
- **Deliver documents to the Veteran Service Officer at Veterans Affairs Office for review and further action.**

**Veterans Affairs Office
10119 Windhorst Rd.
Tampa, FL 33619
(813) 975-2181
(813) 274-6600**

PENSION MAY BE AVAILABLE TO VETERANS WHO MEET THE FOLLOWING CRITERIA (TAB A)

- 90 DAYS OF ACTIVE MILITARY SERVICE WITH AT LEAST ONE DAY OF WAR TIME SERVICE
- PERMANENT & TOTAL DISABILITY OR 65 YEARS OF AGE AND OLDER RECEIVING SOCIAL SECURITY BENEFITS
- INCOME LIMITS MUST BE MET AND MEDICAL EXPENSES PAID OR EXPECTED TO BE PAID MAY BE USED TO REDUCE OTHER INCOME IN ORDER TO QUALIFY FOR VA PENSION BENEFITS
- IF THE VETERAN WAS ENTITLED TO PENSION BENEFITS, THE **UNREMARIED** SURVIVING SPOUSE MAY QUALIFY IF WIDOWS INCOME LIMITS ARE MET

THREE LEVELS OF DISABILITY PENSION BENEFITS

- VETERAN MEDICALLY DETERMINED TO BE PERMANENTLY & TOTALLY DISABLED, OR
- BE 65 YEARS OF AGE AND ENTITLED TO SOCIAL SECURITY BENEFITS
- **UNREMARIED** SURVIVING SPOUSE NEED NOT BE PERMANENTLY & TOTALLY DISABLED NOR 65 YEARS OF AGE

HOUSEBOUND MONTHLY (HB) BENEFIT

- VETERAN OR **UNREMARIED** SPOUSE CONFINED TO RESIDENCE DUE TO DISABILITY
- REPORT OF PHYSICAL ASSESSMENT FORM (See Tab "B") OR OTHER SUITABLE ASSESSMENT DOCUMENT
- NEEDS ASSISTANCE WITH SOME BASIC NEEDS OF DAILY LIVING

AID AND ATTENDANCE (A&A) MONTHLY BENEFIT

- VETERAN OR **UNREMARIED** SPOUSE CONFINED TO RESIDENCE DUE TO DISABILITY
- AID AND ATTENDANCE OF ANOTHER INDIVIDUAL TO ATTEND TO THE BASIC NEEDS OF DAILY LIVING
- MUST BE DOCUMENTED WITH MEDICAL DOCTOR STATEMENTS, DIAGNOSIS, AND PROGNOSIS.
- REPORT OF PHYSICAL ASSESSMENT FORM (See Tab "B") OR OTHER SUITABLE ASSESSMENT DOCUMENT

WARTIME SERVICE PERIODS:

World War II. December 7, 1941, through December 31, 1946, inclusive. If the veteran was in service on December 31, 1946, continuous service before July 26, 1947, is considered World War II service.

Korean conflict. June 27, 1950, through January 31, 1955, inclusive.

Vietnam era. The period beginning on February 28, 1961, and ending on May 7, 1975, inclusive, in the case of a veteran who served in the Republic of Vietnam during that period. The period beginning on August 5, 1964, and ending on May 7, 1975, inclusive, in all other cases. (Authority: 38 U.S.C. 101(29))

Persian Gulf War. August 2, 1990, through date to be prescribed by Presidential proclamation or law. (Authority: 38 U.S.C. 101(33))

REQUIRED DOCUMENTATION

- DD FORM 214, DISCHARGE CERTIFICATE (ORIGINAL OR CERTIFIED COPY PREFERRED)
- LATEST SOCIAL SECURITY AWARD LETTER & OTHER SOURCES OF INCOME
- SUPPORTING MEDICAL ASSESSMENT OR MEDICAL STATEMENTS (21-2680)

OTHER INFORMATION (AS NEEDED)

- TOTAL DOLLAR AMOUNTS OF BANK DEPOSITS/STOCK/BONDS AND SOURCE FOR EACH (1099'S FROM LAST YR)
- ANNUAL DOLLAR AMOUNTS OF INTEREST (1099s) ON INVESTMENTS EARNED THE PREVIOUS YEAR
- ALL APPLICABLE SOCIAL SECURITY NUMBERS, IF APPROPRIATE FOR DEPENDENTS AND SPOUSE
- ASSISTED LIVING FACILITY EXPENSE LETTER (TAB "D")
- MEMORANDUM CONCERNING IN HOME HEALTH CARE SERVICE IF NECESSARY TO SUPPORT UNUSUAL MEDICAL EXPENSES (TAB "E")
- HEALTH INSURANCE PREMIUMS PAID THE PREVIOUS YEAR AND INSURANCE CONTRACT STATEMENT
- OPTIONAL DOCUMENTS – MARRIAGE/BIRTH/DIVORCE CERTIFICATES. IF APPLYING FOR DEATH PENSION AND VETERAN WAS NOT IN RECEIPT OF BENEFITS AT THE TIME OF DEATH, A COPY OF THE MARRIAGE CERTIFICATE SHOULD BE SUBMITTED.
- DEATH CERTIFICATE OF VETERAN IF UN-REMMARRIED SPOUSE IS CLAIMING BENEFITS
- CHECK BOOK OR CANCELED/VOIDED CHECK TO OBTAIN ROUTING NUMBER/ACCOUNT NUMBER INFORMATION

Mail: Veterans Affairs Office, 10119 Windhorst Rd., Tampa, FL 33619
 Telephone Number: 975-2181 Fax Number: 272-5002 Email: stromf@hillsboroughcounty.org
 Web Site: http://www.hillsboroughcounty.org/hss/veterans

Veterans Affairs will review the information included on the form to make a tentative determination for benefits. If benefits are anticipated, you will be contacted for further consideration and processing as necessary.

VETERAN or SURVIVOR INFORMATION WORKSHEET

ASSISTED LIVING FACILITY NAME: _____

POINT OF CONTACT _____ TELEPHONE NO. _____
 DATE _____ NAME OF CLIENT _____

VETERANS NAME _____ DATE OF BIRTH _____
 ADDRESS _____
 CITY/ZIP CODE _____ PHONE _____
VETERAN'S INFO (Complete as much information as possible before contacting Veterans Affairs)
 SOCIAL SECURITY # _____ VA CLAIM # (IF KNOWN) _____
 PLACE OF BIRTH _____ BRANCH OF SERVICE _____
 DATE OF DEATH _____
 Notes: _____
 MILITARY SERVICE NUMBER _____
 DATE ENTERED MILITARY _____
 DATE LEFT MILITARY _____

(SPOUSE/DEPENDENT CLIENT) CLIENTS INFO IF OTHER THAN THE VETERAN

NAME	SS#	DOB
	<u>Monthly Incomes</u>	<u>Monthly Medical Expenses</u>
	\$ _____ Soc Security (Vet)	Insurance
PLEASE ESTIMATE THE FOLLOWING	\$ _____ Soc Security (Wife)	Insurance
INCOME AND MEDICAL EXPENSE	\$ _____ Pension	Medical
INFORMATION:	\$ _____ Other	ALF
TOTAL MONTHLY INCOME →→→→→	\$ _____ Total	Other
WHAT IS THE MONTHLY COST OF ASSISTED LIVING EXPENSES →→→→→		Total
WHAT IS THE TOTAL VALUE OF FINANCIAL ASSETS (EXCLUDE AUTO/HOME) \$		



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			
<p>NOTE: EXAMINER PLEASE READ CAREFULLY</p> <p>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.</p> <p>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.</p> <p>Findings should be recorded to show whether the claimant is blind or bedridden.</p> <p>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.</p>								
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)* 1 BLOCK 5 or 6 BLOCKS 1 MILE OTHER *(Specify distance)* _____

NO *(Check applicable box or specify distance)*

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED
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36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY <i>(Include Area Code)</i>
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PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation 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.

ASSISTED LIVING MONTHLY EXPENSE INFORMATION

DATE: _____

SUBJECT: Monthly expenses for _____

To Whom It May Concern: _____ was admitted to the personal care unit of _____
_____ (Date) _____. Monthly expenses/services are itemized below:

Paid by Resident: Nursing Services/Attention: \$ _____. Other Source of Payment \$ _____ Total \$ _____

- Hands on assist with shower and dressing.
- Frequent verbal direction and mental stimulation due to diminished mental status.
- Incontinent of urine and needs assistance for hygiene and assessment of skin. Continent (normally of bowel).
- Supervision of ambulation for safety.
- Meals – needs help or nutritional assessment.
- Speech/communication deficiency which inhibits resident’s ability to convey needs.
- Diminished dexterity needing additional help for ADL’s.
- Supervision of medication which includes ordering, controlling and assistance with self-administration.
- Requires on an average of 2 hours of Certified Nursing Aid (CNA) and 30 minutes of Licensed Practical Nurse (LPN) time within 24 hour period, 30 days a month to manage daily activities of living (ADL).

ANCILLARY SERVICES: COST \$ _____.

1. Daily Housekeeping
2. Transportation to doctor appointments, shopping, activities, etc.
3. Laundry services
4. Activities
5. Semi-private room
6. Three meals a day

Paid by Resident Only: Nursing Services/Attention \$ _____ Ancillary Services \$ _____ Total \$ _____

_____ Assisted Living Administrator/Representative Signature	_____ Printed Name of Administrator Above
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Printed Address: _____ City: _____ State: _____ Zip: _____

Telephone _____ Fax _____ Email _____

(Use only for In-Home Health Care Providers)

MEMORANDUM CONCERNING IN HOME HEALTH CARE SERVICE

DATE _____

TO WHOM IT MAY CONCERN:

This is a statement of medical service that I provide to _____ on a weekly basis. For the service itemized below, I charge \$ _____ per month, normally _____ hours per day.

I began providing this service on _____ (date).

- Hands on assist with shower, personal hygiene and dressing.
- Frequent verbal direction and mental stimulation due to diminished mental status.
- Incontinent of urine and needs assistance for hygiene and assessment of skin.
- Supervision of ambulation for safety, make bed and pick-up house daily.
- Prepare meals, plan nutritional needs and clean house and provide occasional trips to grocery store.
- Speech/communication deficiency which inhibits resident's ability to convey needs.
- Transportation to and from medical facilities, dentists, doctor offices, etc.
- Supervision of medication which includes ordering, controlling and assistance with self-administration.
- Requires on an average of 2 hours of Certified Nursing Aid (CNA) and 30 minutes of Licensed Practical Nurse (LPN) time within 24 hour period, 30 days a month to manage daily activities of living (ADL).

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT.

_____ (Signature)_____

(Print Name)

Address: _____ Telephone () _____

City: _____ State: _____ Zip: _____