Hillsborough County Florida

How to Apply for Financial Assistance from the U.S. Department of Veterans Affairs for Aid and Attendance or Housebound Improved Pension for Wartime Veterans and/or Survivors

- Ensure criteria on Tab “A” is met before continuing.
- Obtain required documents and applicable information in Tab “B”.
- Provide required information on Tab “C” Worksheet.
- Have a physician complete the enclosed VA Form 21-2680.
- Complete **ONE** of the following:
    - Tab “D” for Assisted Living Facility (ALF)
    - Tab “E” for Home Care Assistance.

Deliver the completed documents with supporting documentation to a Veterans Service Officer. Locations are listed on the website below or by calling.
(Please Do not fax or mail)

Consumer and Veterans Services Office
Main location

311 Pauls Dr. Suite 100
Brandon, FL 33511

Main phone: (813) 635-8316
Fax: (813) 272-5002

E-mail: cvs@HCFLGov.net

Website: www.HCFLGov.net/Veterans

This is NOT a VA application

VA PENSION CRITERIA

Generally, a Veteran must have at least 90 days of active duty service, with at least one day during a wartime period to qualify for a VA Pension. If you entered active duty after September 7, 1980, generally you must have served at least 24 months or the full period for which you were called or ordered to active duty (with some exceptions), with at least one day during a wartime period.

In addition to meeting minimum service requirements, the Veteran must be:

- Age 65 or older, **OR**
- Totally and permanently disabled, **OR**
- A patient in a nursing home receiving skilled nursing care, **OR**
- Receiving Social Security Disability Insurance, **OR**
- Receiving Supplemental Security Income **AND**
- Must be receiving care in either an assisted living facility (ALF) or with a Home Health provider prior to submittal.

Your yearly family income must be less than the amount set by Congress to qualify for the Veterans Pension benefit. If eligible, your pension benefit is the difference between your "countable" income and the annual pension limit set by Congress. VA generally pays this difference in 12 equal monthly payments.
http://www.benefits.va.gov/pension/index.asp

Eligible Wartime Periods

Under current law, VA recognizes the following wartime periods to determine eligibility for VA Pension benefits:

- World War II (December 7, 1941 – December 31, 1946)
- Korean conflict (June 27, 1950 – January 31, 1955)
- Vietnam era (February 28, 1961 – May 7, 1975 for Veterans who served in the Republic of Vietnam during that period; otherwise August 5, 1964 – May 7, 1975)
- Gulf War (August 2, 1990 – through a future date to be set by law or Presidential Proclamation)

Aid & Attendance (A&A)

The Aid & Attendance (A&A) increased monthly pension amount may be added to your monthly pension amount if you meet one of the following conditions:

- You require the aid 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 yourself from the hazards of your daily environment
- You are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment
- You are a patient in a nursing home due to mental or physical incapacity
- Your eyesight is limited to a corrected 5/200 visual acuity or less in both eyes; or concentric contraction of the visual field to 5 degrees or less

Housebound

This increased monthly pension amount may be added to your monthly pension amount when you are substantially confined to your immediate premises because of permanent disability.

REQUIRED SUPPORTING DOCUMENTATION FOR PENSION

- **DISCHARGE / SEPARATION MILITARY PAPERS (DD-214):**
  - To request Military discharge or records, complete form SF-180 or refer to the following website: **https://www.archives.gov/**

- **COPY OF MARRIAGE CERTIFICATE:**
  - If previously married: Please provide information for both the Veteran and spouse. Include the name, date and place of both the marriage and end of marriage as well as the reason for termination of marriage.

- **COPY OF DEATH CERTIFICATE (WIDOW ONLY):**
  - Must show cause of death (This will be the long form if the death occurred in Florida.)

- **COPY OF CURRENT SOCIAL SECURITY AWARD LETTER**

- **PROOF OF ALL MONTHLY GROSS INCOME:**
  - Retirement pensions, Income, Interest, Trusts, etc. You will need to provide for both the Veteran and spouse

- **NET WORTH INFORMATION:**
  - Checking, Savings, Stocks, Bonds, IRAs, CDs, Annuities, etc.

- **BANKING INFORMATION FOR DIRECT DEPOSIT OF PENSION:**
  - Include voided check for savings or checking for Direct Deposit purposes

- **PRIVATE INSURANCE PREMIUMS:**
  - Not reimbursed by Insurance, Medicare, or Medicaid.

- **PHYSICIAN'S FORM (VA FORM 21-2680):**
  - Must show complete diagnosis, inability to live independently and the need of assistance with activities of Daily Living (ADLs).
  - Physician's signature, address, and telephone number is required. (PA, RN or Facility Administrator is **NOT** acceptable)

- **MAY NEED ONE OF THE FOLLOWING:**
  - Assisted Living Facility Expense form (Tab D) or In Home Health Care Memorandum (Tab E)

2017 VA PENSION (Maximum Monthly Amounts are set by Congress)

BASIC PENSION

Single Veteran	$1,075.00
Married Veteran	$1,408.00
Surviving Spouse	$ 721.00

AID and ATTENDANCE PENSION

Single Veteran	$1,794.00
Married Veteran	$2,127.00
Surviving Spouse	$1,153.00

WORKSHEET

POINT OF CONTACT	
ADDRESS	
CITY, STATE, ZIP	
TELEPHONE	
EMAIL	

VETERAN'S INFORMATION

NAME		SSN	
DATE OF BIRTH		DATE ENTERED	
PLACE OF BIRTH		MIL/SERVICE NUMBER	
DATE OF DEATH		DATE LEFT MILITARY	
PLACE OF DEATH		BRANCH OF SERVICE	

SPOUSE'S INFORMATION

NAME		DATE OF BIRTH	SSN
DATE OF MARRIAGE		PLACE OF MARRIAGE	

MONTHLY GROSS INCOME

VETERAN'S INCOME		SPOUSE'S INCOME	
SOCIAL SECURITY		SOCIAL SECURITY	
PENSION		PENSION	
INTEREST		INTEREST	
OTHER SOURCES		OTHER SOURCES	

TOTAL ASSETS

(DO NOT INCLUDE HOME OR AUTOMOBILE)		
	VETERAN	**SPOUSE**
CHECKING		
SAVINGS		
STOCKS		
BONDS		
CDs		
ETC		

TOTAL MONTHLY EXPENDITURES

	VETERAN	**SPOUSE**
ASSISTED LIVING FACILITY		
IN HOME HEALTH CARE		
MEDICARE PART (B)		
MEDICARE PART (D)		
PRIVATE MEDICAL INS.		
OTHER		

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 5-31-2018

Department of Veterans Affairs

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	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? ☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*	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 *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

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

14. NUTRITION	15. GAIT

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

20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

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

☐ YES ☐ NO

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "No," provide explanation)*

☐ YES ☐ NO

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*

☐ YES ☐ NO

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

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*

☐ YES ☐ NO

26. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*

☐ YES ☐ NO

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

☐ YES ☐ NO

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

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

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

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

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

☐ YES
☐ NO *(If "YES," give distance) (Check applicable box or specify distance)* ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

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

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records. 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation Records - VA, and published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 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 pate 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.

Tab "D"

ASSISTED LIVING MONTHLY EXPENSE INFORMATION

DATE: ___/___/_____

_____ (client) was admitted on ___/___/_____ (date) to the Personal care Unit of _____ (facility name).

Total monthly expenses for services provided $_____ (all inclusive).

- ☐ Meals – needs help or nutritional assistance.
- ☐ Hands on assist with shower/bathing, personal hygiene and dressing.
- ☐ Incontinence of urine and needs assistance for hygiene and assessment of skin.
- ☐ Supervision of ambulation for safety, as well as other interventions as needed.
- ☐ Supervision of medication which includes ordering, controlling and assistance with self-administration.
- ☐ Diminished dexterity needing additional help for daily activities of living (ADLs).
- ☐ Frequent verbal direction and mental stimulation due to diminished mental status.
- ☐ Speech/communication of deficiency which inhibits resident's ability to convey needs.
- ☐ Within a 24 hour period, Requires on an average of 2 hours of Certified Nursing Aid (CNA) and 30 minutes of Licensed Practical Nurse (LPN) monthly to manage daily activities of living (ADLs).

Assisted Living Administrator/ Representative

_____ / _____
(Printed Name) (Signature)

_____ / _____
(Title) (License #)

Address of Facility:

_____ Telephone: (____) _____
(Street)
_____ Fax: (____) _____
(City, State, Zip)

Email (Optional): _____

Claimant's VA File Number: _____ *(For Official Use Only)*

IN HOME HEALTH CARE MEMORANDUM

DATE: ___/___/_____

This is a statement of home care services that I _____ (caregiver) provide to_____ (Veteran / Surviving Spouse) on a monthly basis.

I charge $_____ per month and began providing these services on ___/___/_____ (date).

- ☐ Prepare meals and plan nutritional needs.
- ☐ Hands on assist with shower/bathing, personal hygiene and dressing.
- ☐ Incontinence of urine and needs assistance for hygiene and assessment of skin.
- ☐ Supervision of ambulation for safety, as well as other interventions as needed.
- ☐ Basic home up keep to include: making bed, laundry, dishes, etc.
- ☐ Transportation to and from: Medical facilities, Dentist's, Grocery store, etc.
- ☐ Supervision of medication which includes ordering, controlling and assistance with self-administration.
- ☐ Frequent verbal direction and mental stimulation due to diminished mental status.
- ☐ Speech/communication of deficiency which inhibits resident's ability to convey needs.
- ☐ Within a 24 hour period, Requires on an average of 2 hours of Certified Nursing Aid (CNA) and 30 minutes of Licensed Practical Nurse (LPN) monthly to manage daily activities of living (ADLs).

In Home Health Care Provider

_____ / _____
(Printed Name) (Signature)

_____ / _____
(Title) (License # if applicable)

Address of provider:

_____ Telephone: (____) _____
(Street)

_____ Fax: (____) _____
(City, State, Zip)

Email (Optional): _____

Claimant's VA File Number: _____ *(For Official Use Only)*