Hillsborough County Florida
Consumer & Veterans Services

U.S. Dept. of Veterans Affairs Financial Assistance: Aid and Attendance or Housebound Pension For Surviving Spouses of Wartime Veterans

- Ensure criteria on Tab "A" is met before continuing
- Obtain required documents and applicable Information in Tab
- Provide required information on Tab "C" Worksheet
- Provide The VA Form 21-2680, Examination for Housebound Status or Permanent Need for Aid and Attendance. Be sure that every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS).
- Complete ONE of the following:
    - Tab D-1 and D-2 for Assisted Living Facility (ALF)
    - Tab E-1 and E-2 for In Home Care Assistance

Deliver the completed documents with supporting documentation to a Veterans Service Officer. Please do *not* fax or mail. Our main office is open Monday-Friday from 8 a.m. – 4:30 p.m., located on the grounds of Veterans Memorial Park:

Consumer & Veterans Services:
3602 U.S. Hwy 301 N., Building 3610
Tampa, FL 33619
Phone: (813) 635-8316
Fax: (813) 272-5002 Email: cvs@hcflgov.net

Please check **HCFLGov.net/Veterans** for hours/days of operation at these additional locations:

Brandon Regional Service Center:
311 Pauls Dr., #100
Brandon, FL 33511

South Shore Regional Service Center:
410 30th St., S.E., #115
Ruskin, FL 33570

James A. Haley VA Primary Care Annex:
13615 Lake Terrace Ln., #2A-201G
Tampa, FL 33637

VA So-Hi (South Hillsborough) Clinic:
12920 Summerfield Crossing Blvd.
Riverview, FL 33579

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 In-Home Health Care provider at the time of submission of or prior to submission of the claim.

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. For additional information, please visit:
http://www.benefits.va.gov/pension/index.asp

Eligible Wartime Periods

Under current law, VA uses 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(s)

☐ PROOF OF ALL MONTHLY GROSS INCOME:
Retirement pensions, Income, Interest, Trust, etc. You will need to provide for both the Veteran and spouse. Often listed on monthly bank statements.

☐ HOUSEHOLD NET WORTH INFORMATION:
All banking; Stocks, Bonds, IRA's, CD's, Annuities, Properties other than primary residence.

☐ HOUSEHOLD PRIVATE INSURANCE PREMIUMS: Not reimbursed.

☐ VOIDED CHECK FOR DIRECT DEPOSIT OF PENSION

☐ 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). Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS). Provider's signature, address, and telephone number is required.

☐ APPLICABLE CARE WORKSHEETS: Assisted Living (Tab D-1 & D-2) / In Home Attendant (Tab E-1 & E-2)

☐ VA Form 21P-0969, INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DIC may need to be completed along with the pension or survivor pension form in many cases due to the net worth transfer reporting requirements.
The VAF 21P-0969 must be completed if the Veteran or Survivor has income other than Social Security, has land that can be sold without selling their primary residence, and/or has more than $10,000 in assets or has transferred assets in the previous 3 years.

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: 09-30-2021

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

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN/BENEFICARY NAME *(First, Middle Initial, Last)*

2. SOCIAL SECURITY NUMBER ___ – ___ – ____

3. VA FILE NUMBER *(If applicable)*

4. DATE OF BIRTH *(MM/DD/YYYY)* Month ___ – Day ___ – Year ____

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. GENDER ☐ MALE ☐ FEMALE

7. TELEPHONE NUMBER *(Include Area Code)*

8. PREFERRED E-MAIL ADDRESS *(Optional)*

9. PREFERRED 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 II: CLAIM INFORMATION

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

11. CLAIMANT'S SOCIAL SECURITY NUMBER ___ – ___ – ____

12. RELATIONSHIP OF CLAIMANT TO VETERAN

13. BENEFIT YOU ARE APPLYING FOR (*Choose One*)

☐ **Special Monthly Compensation (SMC) -** Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid <u>without</u> eligibility to compensation.

☐ **Special Monthly Pension (SMP) -** Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

SECTION III: INFORMATION OF EXAMINATION

14. DATE OF EXAMINATION

15. HOME ADDRESS

16A. IS CLAIMANT HOSPITALIZED?

☐ YES ☐ NO *(If "Yes," complete Items 16B and 16C)*

16B. DATE ADMITTED

16C. NAME AND ADDRESS OF HOSPITAL

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

17. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 25 through 39)*

18A. AGE	18B. WEIGHT ACTUAL: LBS. ESTIMATED: LBS.	18C. HEIGHT FEET: INCHES:

19. NUTRITION	20. GAIT

21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

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

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

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

☐ YES ☐ NO

29A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)* ☐ YES ☐ NO	29B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE

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

☐ YES ☐ NO

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

☐ YES ☐ NO

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? *(If "No," provide examples and rationale to support your conclusion.)*

☐ YES ☐ NO

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

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

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

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

36. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

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

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

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

☐ YES
☐ NO

(If "YES," give distance) (Check applicable box or specify distance)

☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

40A. PRINTED NAME OF EXAMINING PHYSICIAN	40B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	40C. DATE SIGNED

41A. NAME AND ADDRESS OF MEDICAL FACILITY	41B. 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 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 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.

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

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

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

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

(If "NO," continue to Step 2)

◯ YES ◯ NO (If "YES," ***all*** payments to the facility qualify as medical expenses in Items 45A thru 45F. You are finished completing this worksheet)

STEP 2. Do ***all*** of the following apply to the facility?
- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with caregivers.

◯ YES ◯ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

◯ YES ◯ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension or special monthly DIC in Item 37?

◯ YES ◯ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the ***primary reason*** you live in the facility (or attend day care in the facility)?

◯ YES ◯ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension or special monthly DIC. Please report the amount you pay the facility for lodging and meals separate from the amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** as medical expenses in Items 45A thru 45F. Skip to Step 8)
(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay the facility for: (1) ***health care services or assistance with ADLs provided by a health care provider***; and (2) ***custodial care***. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disabilty, and (2) describes the mental or physical disabilty)
(If "NO," claim payments you pay this facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 7. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the ***primary reason*** the disabled person lives in the facility (or attends day care in the facility)?

(If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)

◯ YES ◯ NO (If "NO," ***only*** claim payments you pay the facility for assistance with ***health care and/or assistance with custodial care*** as medical expenses in Items 45A thru 45F. Payment to this facility for meals and lodging ***do not*** qualify)

STEP 8. Facility Certification: Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received.

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to _____
(Name of person staying at your facility)
and his or her care at this facility_____.
(Name and address of facility)

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

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)*

VETERAN'S SOCIAL SECURITY NUMBER ___ – ___ – ____

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: Only complete this worksheet if you are claiming expenses for in-home care.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.

Follow the steps below to determine whether or not:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care

STEP 1. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

◯ YES ◯ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Item 37?

◯ YES ◯ NO (If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to this in-home attendant ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 45A thru 45F amounts you pay an in-home attendant for: (1) health-care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs, and (3) custodial care. Skip to Step 6)

(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider and (2) custodial care. Skip to Step 6)

STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," the attendant ***must be a health care provider***. Only report payments to the in-home attendant for ***health care services or assistance with ADLs*** provided by the health care provider as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs do not qualify as medical expenses. Skip to Step 6)

STEP 5. Is the ***primary responsibility*** of the in-home attendant to provide the disabled person with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 45A thru 45F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 45A thru 45F. Payments for assistance with IADLs ***do not*** qualify as medical expenses)

STEP 6. Check all activities below that the attendant assists the veteran or disabled person with:

ADLs: ◯ EATING ◯ BATHING/SHOWERING ◯ DRESSING ◯ TRANSFERRING ◯ USING THE TOILET

IADLs: ◯ SHOPPING ◯ FOOD PREPARATION ◯ HOUSEKEEPING ◯ LAUNDERING ◯ MANAGING FINANCES ◯ HANDLING MEDICATIONS ◯ USING THE TELEPHONE ◯ TRANSPORTANTION FOR NON-MEDICAL PURPOSES

STEP 7. **In-Home Attendant Certification**: Please submit a current breakdown of the time the attendant spends assisting the veteran or disabled person with health care services, ADLs and IADLs.

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and

reflects the current environment pertaining to _____
(Name of Person Requiring Care)

and his or her care from _____.
(Name of Attendant)

_____ _____
(Name, Signature and Title of Certifying Official) (Date Certified)

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)*

2021 Monthly VA Pension and DIC Benefit Rates

(Amounts set by the U.S. Congress)

Basic Pension

- **Single Veteran - $ 1,160.00**
- **Married Veteran - $ 1,520.00**
- **Surviving Spouse - $ 778.00**

Aid and Attendance Pension

- **Single Veteran - $ 1,936.00**
- **Married Veteran - $ 2,295.00**
- **Surviving Spouse - $ 1,244.00**

***The net worth limit to qualify for Veterans Pension benefit as of December 1, 2020*: $ 130,773.00**

***2021 Dependency and Indemnity Compensation (DIC) basic monthly rate:* $ 1,357.56**

For more information, or to speak with one of our accredited Veteran Service Officers, call (813) 635-8316 or visit HCFLGov.net/Veterans.

Hillsborough County Florida