

# Pension Packet

(Aid and Attendance)

## Facility Forms



2650 LaFRANIER ROAD • TRAVERSE CITY, MI 49686-8972  
PHONE (231) 995-6070 • FAX (231) 929-1983 • TDD: (231) 922-4412  
EMAIL: [veterans@grandtraverse.org](mailto:veterans@grandtraverse.org)

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**Thank you for inquiring about the VA Benefit – Special Monthly Pensions.**

Enclosed is the **Aid & Attendance** packet that we require you to have filled out prior to making an appointment with our office. Please make sure all appropriate paperwork is filled out completely. We will go over all this information with you at your appointment.

Not all forms provided in the packet may be needed for your situation.

- **VA Form 21-2680** (*Examination for Housebound State or Permanent need for Regular Aid and Attendance*) **This form needs to be filled out by your primary physician.**
- **VA Form 21-0779** (*Request for Nursing Home Information in connection with Claim for Aid and Attendance*) **This form needs to be completed by Nursing home/ Assisted Living Facility official.**
- **VA Form 21p-0969** (*Income and Asset Statement in Support of Claim for Pension*)  
**This form needs to be filled out if claimant has more than \$10,000 in assets, or has transferred assets within last 3 years, or receives income other than social security.**
- **Attendant Certification Form 21-4138** (*Independent Living / In-home care provider*)  
**This form needs to be filled out if at home or in Senior Living facility party care provider.**
- **Worksheet for (In-Home Attendant Expenses OR Assisted Living, Nursing home)**  
**This form needs to be filled out by the facility official or in-home care provider**

Please call our office to schedule an appointment after you have compiled all necessary paperwork that is listed under *Documents needed to get started*.

We look forward to serving you.

Michael W. Roof  
Director

## Aid & Attendance Pension

The Aid & Attendance (A&A) Pension provides benefits for veterans and surviving spouses who require the regular attendance of another person to assist in eating, bathing, dressing & undressing, or taking care of the needs of nature. It also includes individuals who are blind or a patient in a nursing home because of mental or physical incapacity. *Assisted care in assisted living facility also qualifies.*

This benefit is available to any Veteran (or surviving spouse) that served at least 90 days of Active Service, at least one of those days being during wartime, including those who served stateside.

World War II	12/07/41-12/31/46
Korean Conflict	06/27/50-1/31/55
Vietnam War	11/1/55-5/7/75 (In Country ONLY)
	08/05/64-5/7/75 (Not in Country)
Persian Gulf War	8/2/90-present

To be eligible for Aid & Attendance (A&A), you must 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

**The A & A pension can provide up to \$2,300 per month to a Veteran or up to \$1,478 per month to a surviving spouse. A veteran, and a spouse up to \$2,727 per month. To qualify financially an applicant must have less than \$138,489 in assets, excluding a primary home and a vehicle. Pension benefits are needs-based and your "countable" family income must fall below the yearly limit set by law.**

Eligibility must be proven by filing the proper Veterans Application for Non-Service-Connected Pension or Survivor's Pension. This application will require the listed below documents. After you have gathered all of the following, please call 231-995-6070 for an appointment.

### Documents needed to get started:

- DD214/Discharge Papers.
- Marriage information (To include all previous marriages for veteran and spouse)
- Copy of Veteran's death certificate (for a surviving spouse)
- Copy of current Social Security Award letter(s)
- Proof of Net Worth information (bank accounts, CDs, trust, stocks, bonds, annuities, etc.)
- Proof of all income (pensions, work, retirement, interest income from investments, etc.)
- Physicians statement (Form 21-2680) that includes name & address of the doctor, current diagnosis, medical status, prognosis, ability to care for self, ability to travel unattended, etc.
- Nursing home or assisted living facility (if applicable) statement (Form 21-0779)
- Statement from facility breaking down the cost & care received
- Funeral payment information (for veteran or spouse)
- Current banking information for direct deposit of monthly payment (include voided check)

# Getting Started

These forms should be filled out and returned to the office as soon as possible; they will start the process and save an effective date for the claim

## Forms

VA Form 21-22 (**Claimant** needs to sign box 22A)

VA Form 21-0966 (**Claimant** needs to sign 14A)



VA DATE STAMP  
(DO NOT WRITE IN THIS SPACE)

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

**NOTE:** You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form

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Month                      Day                      Year

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6. INSURANCE NUMBER(S) (If applicable) (Include letter prefix)

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[illegible]

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City[illegible]

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Country 

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ZIP Code/Postal Code

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9. EMAIL ADDRESS (Optional)
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[illegible]

Month                      Day                      Year

-   -

[illegible]

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City \_\_\_\_\_[illegible]

State/Province

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Country 

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ZIP Code/Postal Code

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13. TELEPHONE NUMBER (Include Area Code)

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

064-National Association of County Veteran Service Officers

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 (This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

Veteran Service Officer

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

18. DATE OF THIS APPOINTMENT (MM/DD/YYYY)

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**SECTION IV: AUTHORIZATION INFORMATION**

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

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

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

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)  
☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

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

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

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

**SECTION V: SIGNATURES**

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

22A. SIGNATURE OF VETERAN OR CLAIMANT (Required)

22B. DATE SIGNED (MM/DD/YYYY)

23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A (Required)

23B. DATE SIGNED (MM/DD/YYYY)

**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.

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

**PENALTY:** The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.





### SECTION III: GENERAL BENEFIT ELECTION

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

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

☐ COMPENSATION      ☐ PENSION

**NOTE: ONLY CHECK THE BOX BELOW IF YOU ARE A SURVIVING DEPENDENT OF THE VETERAN.**

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

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

### SECTION IV: DECLARATION OF INTENT AND SIGNATURE

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

I acknowledge that:

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

20. SIGNATURE OF VETERAN/CLAIMANT/AUTHORIZED AGENT (REQUIRED)

21. DATE SIGNED (MM/DD/YYYY)

-  -

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

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

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

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

**PENALTY:** The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records-VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine the appropriate application and provide it to the claimant.

**RESPONDENT BURDEN:** We need this information to determine the intent of the claimant and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at [www.reginfo.gov/public/do/PRAMain](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.



# Doctor Certification

This form is for the claimant's doctor to fill out. This form  
the claimants need for Activities of Daily Life (ADL) care.  
Without this form, a claimant may not be eligible for  
benefits

Forms  
VA FORM 21-2680

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

**SECTION I: VETERAN'S IDENTIFICATION INFORMATION**

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$$10 - 1 = 10 - 10 = 0$$

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[illegible]

## SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION

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☐ SELF                      ☐ PARENT

☐ SPOUSE                  ☐ CHILD

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[illegible][illegible]

State/Province   Country   ZIP Code/Postal Code     -

-  -  Enter International Phone Number (If applicable)

[illegible]

## SECTION III: CLAIM INFORMATION

☐☐

VA FORM  
FEB 2023

VETERAN'S SOCIAL SECURITY NUMBER    -   -

**SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?**

14A. IS THE CLAIMANT HOSPITALIZED?

☐ YES (If "YES," complete Items 14B, 14C & 14D)

☐ NO (If "NO," skip to Section V)

14B. DATE ADMITTED (MM/DD/YYYY)

-    -

14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

**SECTION V: CERTIFICATION AND SIGNATURE**

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

15A. VETERAN/CLAIMANT'S SIGNATURE (Required)

15B. DATE SIGNED (MM/DD/YYYY)

-    -

**SECTION VI: EXAMINATION INFORMATION**  
(IMPORTANT: Remainder of form **MUST** be filled out by Examiner)

**NOTE:** Examiner **must be** a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.

16. DATE OF EXAMINATION (MM/DD/YYYY)

-    -

**NOTE: EXAMINER PLEASE READ CAREFULLY**

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veteran/claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. Please provide as much description as needed for each question as this will assist VA to determine if the disease(s) or injury(ies) listed may lead to physical or mental impairment, loss of coordination or enfeeblement that require assistance with daily living. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well they ambulate, where they go, and what they are able to do during a typical day.

17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR EACH CONDITION (Diagnosis needs to equate to the level of assistance described in Items 26 through 37) (Describe below)

18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)

A.

D.

B.

E.

C.

F.

19A. AGE

19B. WEIGHT

ACTUAL LBS.

ESTIMATED LBS.

19C. HEIGHT

FEET

INCHES

20. NUTRITION

21. GAIT

22. BLOOD PRESSURE

23. PULSE RATE

24. RESPIRATORY RATE

25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

VETERAN'S SOCIAL SECURITY NUMBER    -   -

26. IF THE PATIENT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

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

27. DOES THE PATIENT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply)

- ☐ BATHING/SHOWERING ☐ TENDING TO HYGIENE NEEDS ☐ ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below)
- ☐ EATING OR SELF-FEEDING ☐ TRANSFERRING IN OR OUT OF BED/CHAIR
- ☐ DRESSING ☐ TOILETING
- ☐ AMBULATING WITHIN THE HOME OR LIVING AREA ☐ MEDICATION MANAGEMENT

28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)

☐ YES

☐ NO

28B. CORRECTED VISION

LEFT EYE

RIGHT EYE

29. DOES THE PATIENT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

☐ YES

☐ NO

30. IN YOUR JUDGMENT, DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYMENTS, OR ARE THEY ABLE TO DIRECT SOMEONE TO DO SO?

☐ YES

☐ NO

(If "NO," provide the disability(ies) that prevent them from performing this function and any rationale to support your conclusion in the space provided)

31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE

33. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. (NOTE: If indicated, comment specifically on weight bearing, balance and propulsion of each lower extremity)

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK



VETERAN'S SOCIAL SECURITY NUMBER  -  -

35. DESCRIBE ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE; SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS PATIENT'S ABILITY TO PERFORM SELF-CARE, OR IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA

36. HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES (to include the level of assistance required) IS THE PATIENT ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES (Describe)

37. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION?

☐ YES (If "YES," check the applicable box or specify distance)

☐ 1 BLOCK

☐ 5 OR 6 BLOCKS

☐ 1 MILE

OTHER

(Specify distance) \_\_\_\_\_

☐ NO

#### SECTION VII: EXAMINER'S SIGNATURE

38. PRINTED NAME OF EXAMINER

39. TITLE OF EXAMINER

40. SIGNATURE OF EXAMINER (REQUIRED)

41. DATE SIGNED (MM/DD/YYYY)

-  -

#### SECTION VIII: EXAMINER'S INFORMATION

42. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER OF EXAMINER

43. NAME OF MEDICAL FACILITY

44. ADDRESS OF MEDICAL FACILITY (Number and street or rural route, city, state, ZIP Code and Country)

45. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)

-  -

Enter International Phone Number (If applicable)

**PENALTY:** The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

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

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

# Facility Forms

These forms need to be filled out by the facility the claimant is living in. It is important to recognize that the VA does NOT distinguish between Assisted Livings and Nursing home. This means for the purpose of the program, they are the same thing.

## Forms

VA FORM 21-0779

VA FORM 21-4138

VA FORM 21P-8416 Facility Worksheet

**VA DATE STAMP**  
(Do Not Write In This Space)

**SECTION I - VETERAN'S IDENTIFICATION INFORMATION**

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

2. SOCIAL SECURITY NUMBER    -   -

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

[illegible]

6. SOCIAL SECURITY NUMBER	7. VA FILE NUMBER (If applicable)	8. DATE OF BIRTH (MM/DD/YYYY)
<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

## 9. NAME OF NURSING HOME

10. ADDRESS OF NURSING HOME (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																		

**NOTE:** Your state's Medicaid program may use a different name.

11. DATE ADMITTED TO NURSING HOME (MM/DD/YYYY)	12. IS THE NURSING HOME A MEDICAID APPROVED FACILITY?
<div> <div></div> <div></div> <div>-</div> <div></div> <div></div> <div>-</div> <div></div> <div></div> <div></div> <div></div> </div>	<div> <input type="checkbox"/> YES           <input type="checkbox"/> NO         </div>

<p>13. HAS THE PATIENT APPLIED FOR MEDICAID?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>	<p>14A. IS THE PATIENT COVERED BY MEDICAID?</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO (If "YES," complete Item 14B)</p>	<p>14B. DATE MEDICAID PLAN BEGAN (MM/DD/YYYY)</p> <p><input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
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15. MONTHLY AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET \$

16. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: (Check one)

☐ SKILLED NURSING CARE    ☐ INTERMEDIATE NURSING CARE

17. NURSING HOME OFFICIAL'S NAME (First and Last)

18. NURSING HOME OFFICIAL'S TITLE

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19. NURSING HOME OFFICIAL'S OFFICE TELEPHONE  
NUMBER (Include Area Code)

Enter International Phone  
Number (If applicable)

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

20. SIGNATURE OF NURSING HOME OFFICIAL (REQUIRED)

21. DATE SIGNED (MM/DD/YYYY)

$$\begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

VA FORM 21-0779  
SEP 2023



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

**RESPONDENT BURDEN:** VA needs this information to determine eligibility for pension and aid and attendance benefits based on nursing home status. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at [www.reginfo.gov/public/do/PRAMain](http://www.reginfo.gov/public/do/PRAMain). If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.





# Reporting Assets

For speedy processing of your pension claim, it is important to disclose all income and assets to the VA. It is also in addition important to provide documentation to support all income and asset. This can save the VA valuable time in processing your claim.

Forms

VA FORM 21P-0969

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## INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

This form should be used to report or verify income and/or net worth. Changes to income and net worth over multiple years must be reported on a separate VA Form 21P-0969 for each year. Changes to dependents and medical expenses may impact your benefits. Submit the following forms if you need to update dependent or medical expense information.

- To update dependents, submit VA Form 21-686c, *Application Request to Add and/or Remove Dependents*.
- To update medical expenses, submit VA Form 21P-8416, *Medical Expense Report*.

### INFORMATION FOR CLAIMANTS

**NOTE: The term assets** means the fair market value of all property that an individual owns, including all real and personal property (excluding the value of your or your dependents' primary residence including the residential lot area, not to exceed 2 acres); less the amount of mortgages or other (specify) encumbrances specific to the mortgages or encumbered property. Personal property means the value of personal effects that are in excess of being suitable consistent with a reasonable mode of life. There is a space on your initial application form to provide the value of the portion of your primary residence that exceeds 2 acres.

If you are a **Veteran**, you must report assets for:

- Yourself
- Your spouse (**unless** you live apart, **and** you are estranged, **and** you do not contribute to your spouse's support)
- Your child or children (**unless** you do not have custody, \* **and** you do not contribute to your child's or children's support)

If you are a **Surviving Spouse**, you must report income and assets for:

- Yourself
- Your child or children (**unless** you do not have custody, \* **and** you do not contribute to your child's or children's support)

If you are a **Surviving Child** or the **Custodian of a Surviving Child**, you must report income and assets for:

- Yourself and/or the surviving child
- Child's custodian (unless the child's custodian is an institution)
- Custodian's spouse

If you are a **Parent**, you must report income for:

- Yourself
- Your spouse (even if your spouse is the veteran's other parent. If your spouse is the veteran's other parent, you should file separate claims.)

\* Child custody for pension purposes is defined in 38 C.F.R. § 3.57(d). A natural or adoptive parent has custody of a child unless custody is legally removed. For pension purposes, a child who has attained age 18 remains in the custody of the person who had custody before the child turned 18 unless custody is legally removed.

\*\* Parents' D.I.C. claimants do **not** need to report or provide documentation of their assets.

### THIS FORM IS COMPRISED OF 14 SECTIONS.

**BE SURE TO ANSWER THE QUESTION(S) IN EACH SECTION AS REQUIRED.**

**SECTION I:** VETERAN'S IDENTIFICATION INFORMATION  
**SECTION II:** CLAIMANT'S IDENTIFICATION INFORMATION  
**SECTION III:** RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS  
**SECTION IV:** INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS  
**SECTION V:** INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS  
**SECTION VI:** INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES

**SECTION VII:** ASSET TRANSFERS  
**SECTION VIII:** TRUSTS  
**SECTION IX:** ANNUITIES  
**SECTION X:** ASSETS PREVIOUSLY NOT REPORTED  
**SECTION XI:** DISCONTINUED OR IRREGULAR INCOME  
**SECTION XII:** WAIVER OF RECEIPT INCOME  
**SECTION XIII:** CERTIFICATION AND SIGNATURE  
**SECTION XIV:** WITNESS TO SIGNATURE



## INSTRUCTIONS FOR INDIVIDUAL SECTIONS

### SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS

This section is for reporting all income not attached to a physical asset, financial account or other type of net worth. Income generated from assets will be captured in other sections of this form. Examples of income not associated with accounts or assets may include:

- Pensions
- Military Retirement
- Private Retirement
- Social Security Income
- Civil Service Retirement
- Black Lung Benefits
- Railroad Retirement Benefits
- Wages
- Unemployment Benefits

**NOTE:** If submitting this form with an initial application, do not report income(s) previously reported on your application (VA Form 21P-527EZ or VA Form 21P-534EZ.)

### SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS

This section is for reporting assets not related to property that generates income. Examples of income and net worth associated with accounts may include:

- Savings Bonds
- Stocks and Dividends
- Annuities
- Interest Earning Accounts (Checking, Savings, etc)
- Individual Retirement Account (IRA) Distributions (Including RMDs)
- Pension Plans with Cash Value (Employee, SEP, etc)

### SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS

This section is for reporting physical assets that generate income. These assets may be partially owned by third parties. Only report the portion of the asset that you own. When reporting the asset value of your portion of the property within this section, you may subtract from the reported value any mortgage or other encumbrance that you still owe for each, if applicable. Examples of current income and net worth associated with owned assets may include:

- Rental Property
- Farm Earnings
- Business Earnings

**Additional documentation may be required** for each of the following income sources:

- Property assets may require submission of a statement showing the fair market value (not an evaluation for property taxes, as appraisal from a licensed appraiser, realtor or an established online estimation tool is preferred).
- If you are in receipt of income from a:
  - Farm - You must submit VA Form 21P-4165, *Pension Claim Questionnaire for Farm Income*.
  - Business or a rental property - You must submit VA Form 21P-4185, *Report of Income from Property or Business*.

### SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES

This section is for reporting income generated from royalties and other owned assets. For these types of assets, you may submit any documentation you have demonstrating the sell-ability, value and income of the asset. Examples of income generated from royalties and other properties include:

- Intellectual Property Royalties (i.e., Acting, Written Works, Invention)
- Mineral Royalties
- Other Land Use

### SECTION VII: ASSETS TRANSFERS

This section is for clarifying the specific details of any applicable asset transfers. If income is received from the sale of a asset, in addition to reporting the details of the transfer in this section, ensure the remaining proceeds (if any) are reported as part of your assets within the other appropriate sections of this form.

- Sold - Exchange of property ownership for monetary benefit
- Gave Away - Exchange of property ownership without benefit
- Traded - Exchange of property ownership for alternative property
- Conveyed - Exchange of property ownership through a legal process

**NOTE:** A transfer for less than fair market value means you disposed of an asset for less than the asset was worth.

### SECTION VIII: TRUSTS

This section is for reporting aspects of trusts to include possible income(s), value and controlling interest. Trusts may be countable as an asset and may generate income depending on the terms of the trust. If you have more than one trust to report, submit the information on a separate VA Form 21P-0969 or provide the information on VA Form 21-4138 for each additional trust established. Provide the following additional evidence for each trust:

- Initial contract from your financial institution establishing the trust
- Schedule of Assets must be included
- Current statement showing surrender value and monthly payments

### SECTION IX: ANNUITIES

This section is for reporting annuity benefits. If additional space is needed due to ownership of multiple annuities, submit VA Form 21-4138, *Statement in Support of Claim*, with the information requested in this section for each additional annuity. You may need to submit the following evidence for each annuity:

- Initial contract from your financial institution establishing the trust
- Current statement showing surrender value and monthly payments

### SECTION X: ASSETS PREVIOUSLY NOT REPORTED

This section is for reporting any assets that have not been reported previously. For proceeds from asset transfers identified in Section VI, only include assets that you still have access to (not spent). Examples of assets that may not have been reported previously include:

- Non-Interest-Bearing Accounts
- Collectible Valuables
- Real Estate
- Cash

### SECTION XI: DISCONTINUED OR IRREGULAR INCOME

This section is for reporting all discontinued or irregular income received during the period reported in question 2E. If this form is submitted with your initial claim, submit information pertaining to the previous calendar years. You may need to submit copies of closed account documents, or current statements showing non-receipt of income such as a bank statement with no generated interest. Examples of discontinued or irregular income include:

- Discontinued Wages
- Unemployment Income
- Interest or Dividends from Depleted Accounts
- Lottery or Gambling Winnings

These incomes are typically classified as:

- Recurring - Income that occurred at a regular interval
- One-Time - Income that only occurred once
- Irregular - Income received several times during the reporting period at irregular intervals or irregular amounts



**SECTION XII: WAIVER OF RECEIPT OF INCOME**

Waived income, or income you are entitled to receive but have chosen not to accept at this time is considered countable income for VA pension purposes. It is unlawful to waive of entitlement of any income to create a need for pension. Examples include:

- Deferred Compensation
- Life Insurance
- Legal Settlements

**EXCEPTION:** Waiving income from the Social Security Administration done so to get a higher amount of SSA by waiting longer is allowed.

**NOTICE**

**FEES FOR CLAIMS:** Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed, or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the Department. Generally, a VA-accredited attorney or agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

**IMPORTANT:** VA will compare the information you report on this form to Internal Revenue Service (IRS) and Social Security Administration (SSA) records to verify your income for the past three tax years for which information is available. Information from the IRS or SSA that conflicts with the income information you provide with your application may delay your claim and/or reduce your benefit amount.

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your response is required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

**RESPONDENT BURDEN:** We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at: [www.reginfo.gov/public/do/PRAMain](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.



## INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (D.I.C.)

### SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME (First, Middle Initial (M.I.), Last)

First:

MI:

Last:

1B. VETERAN'S SOCIAL SECURITY NUMBER

1C. VETERAN'S FILE NUMBER (If known)

### SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION

(If you are the Veteran, skip questions 2A and 2B)

2A. CLAIMANT'S NAME (First, Middle Initial (M.I.), Last)

First:

MI:

Last:

2B. CLAIMANT'S SOCIAL SECURITY NUMBER

2C. CLAIMANT'S TELEPHONE NUMBER (If known)

2D. TYPE OF CLAIMANT (Check only one box)

☐ VETERAN

☐ SURVIVING SPOUSE

☐ SURVIVING CHILD

☐ PARENT

☐ CUSTODIAN OF CHILD BENEFICIARY

This form is designed to provide VA with your income and net worth during a specific date range to determine your eligibility or adjust your benefits. If you are submitting an initial application, report current information. Your effective date is typically the earliest of the following dates:

- Date VA receives your application
- Date VA receives your intent to file
- Date of Veteran's death (Survivor's Benefits only)

If you are submitting this form as a response to VA correspondence, report your income and net worth information during the date range specified in that correspondence. If you are reporting an income change, report changes from the date the change took effect.

**NOTE:** Submit a separate VA Form 21P-0969 if reporting income and net worth information for additional date ranges.

2E. THE INFORMATION ON THIS FORM REPRESENTS INCOME AND NET WORTH FOR THE FOLLOWING PERIOD:

THROUGH

-OR-

☐ DATE RECEIVED BY VA (For initial claims only.)

### SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS

(See instructions on Page 2)

3A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS FROM SOURCES NOT RELATED TO AN ACCOUNT OR YOUR ASSETS?

☐ YES

☐ NO (If NO, skip to Section IV)

3B. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN

☐ SPOUSE

☐ CUSTODIAN OF CHILD

☐ CHILD

☐ PARENT

☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME

☐ SOCIAL SECURITY

☐ RETIREMENT/PENSION

☐ WAGES

☐ UNEMPLOYMENT

☐ CIVIL SERVICE

☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

\$    .    .

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)

3C. (1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN

☐ VETERAN

☐ SPOUSE

☐ CUSTODIAN OF CHILD

☐ CHILD

☐ PARENT

☐ OTHER (Specify):

(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)

(3). SPECIFY THE TYPE OF INCOME

☐ SOCIAL SECURITY

☐ RETIREMENT/PENSION

☐ WAGES

☐ UNEMPLOYMENT

☐ CIVIL SERVICE

☐ OTHER (Specify):

(4). GROSS MONTHLY INCOME

\$    .    .

(5). SPECIFY INCOME PAYER (Name of business, financial institution, or program, etc.)



**SECTION III: RECURRING INCOME NOT ASSOCIATED WITH ACCOUNTS OR ASSETS (Continued)****(See instructions on Page 2)**

<b>3D.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):		<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)
	<b>(3). SPECIFY THE TYPE OF INCOME</b> <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):		<b>(4). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(5). SPECIFY INCOME PAYER</b> (Name of business, financial institution, or program, etc.)		
<b>3E.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):		<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)
	<b>(3). SPECIFY THE TYPE OF INCOME</b> <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):		<b>(4). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(5). SPECIFY INCOME PAYER</b> (Name of business, financial institution, or program, etc.)		
<b>3F.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):		<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)
	<b>(3). SPECIFY THE TYPE OF INCOME</b> <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> RETIREMENT/PENSION <input type="checkbox"/> WAGES <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/> CIVIL SERVICE <input type="checkbox"/> OTHER (Specify):		<b>(4). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(5). SPECIFY INCOME PAYER</b> (Name of business, financial institution, or program, etc.)		

**SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS****(See instructions on Page 2)**

<b>4A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS THAT IS RELATED TO FINANCIAL ACCOUNTS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, skip to Section V)			
<b>4B.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):		<b>(4). SPECIFY THE TYPE OF INCOME EARNED</b> <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)		<b>(5). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(3). SPECIFY INCOME PAYER</b> (Name of business, financial institution, or program, etc.)		<b>(6). VALUE OF ACCOUNT</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
<b>4C.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):		<b>(4). SPECIFY THE TYPE OF INCOME EARNED</b> <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)		<b>(5). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(3). SPECIFY INCOME PAYER</b> (Name of business, financial institution, or program, etc.)		<b>(6). VALUE OF ACCOUNT</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
<b>4D.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):		<b>(4). SPECIFY THE TYPE OF INCOME EARNED</b> <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)		<b>(5). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(3). SPECIFY INCOME PAYER</b> (Name of business, financial institution, or program, etc.)		<b>(6). VALUE OF ACCOUNT</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>



**SECTION IV: INCOME AND NET WORTH ASSOCIATED WITH FINANCIAL ACCOUNTS (Continued)****(See instructions on Page 2)**

<b>4E.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	<b>(4). SPECIFY THE TYPE OF INCOME EARNED</b> <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)	<b>(5). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(3). SPECIFY INCOME PAYER</b> (Name of business, financial institution, or program, etc.)	<b>(6). VALUE OF ACCOUNT</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>

<b>4F.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	<b>(4). SPECIFY THE TYPE OF INCOME EARNED</b> <input type="checkbox"/> INTEREST <input type="checkbox"/> DIVIDENDS <input type="checkbox"/> OTHER (Specify):
	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)	<b>(5). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(3). SPECIFY INCOME PAYER</b> (Name of business, financial institution, or program, etc.)	<b>(6). VALUE OF ACCOUNT</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>

**SECTION V: INCOME AND NET WORTH ASSOCIATED WITH OWNED ASSETS****(See instructions on Page 2)**

<b>5A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS GENERATED BY OWNED PROPERTY OR OTHER PHYSICAL ASSETS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, skip to Section VI)	
--	--

<b>5B.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	<b>(4). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)	<b>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED</b> <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185	

<b>5C.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	<b>(4). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other only)	<b>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED</b> <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185	

<b>5D.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	<b>(4). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other only)	<b>(5). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY</b> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	<b>(3). IDENTIFY THE TYPE OF ASSET AND SUBMIT THE REQUIRED FORM ASSOCIATED</b> <input type="checkbox"/> FARM - VA FORM 21P-4165 <input type="checkbox"/> BUSINESS - VA FORM 21P-4185 <input type="checkbox"/> RENTAL PROPERTY - VA FORM 21P-4185	

**SECTION VI: INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES****(See instructions on Page 2)****6A. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME AND NET WORTH ASSOCIATED WITH ROYALTIES AND OTHER PROPERTIES?**☐ YES ☐ NO (If NO, skip to Section VII)

<b>6B.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)
<b>(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET</b> <input type="checkbox"/> BENEFITS FROM INTELLECTUAL PROPERTY <input type="checkbox"/> EXTRACTION OF MINERALS/LUMBER <input type="checkbox"/> USE OF LAND <input type="checkbox"/> OTHER (Specify):		
<b>(4). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<b>(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET</b> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>(6). CAN THE ASSET BE SOLD?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET</b>		

  

<b>6C.</b>	<b>(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	<b>(2). SPECIFY NAME OF INCOME RECIPIENT</b> (Only needed if Custodian of child, child, parent, or other)
<b>(3). SPECIFY HOW INCOME IS GENERATED FROM THIS ASSET</b> <input type="checkbox"/> BENEFITS FROM INTELLECTUAL PROPERTY <input type="checkbox"/> EXTRACTION OF MINERALS/LUMBER <input type="checkbox"/> USE OF LAND <input type="checkbox"/> OTHER (Specify):		
<b>(4). GROSS MONTHLY INCOME</b> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<b>(5). SPECIFY FAIR MARKET VALUE OF THIS ASSET</b> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>(6). CAN THE ASSET BE SOLD?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>(7). EXPLAIN ANY MITIGATING CIRCUMSTANCES THAT PREVENT THE SALE OF THIS ASSET</b>		

**SECTION VII: ASSET TRANSFERS****(See instructions on Page 2)****7A. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ANY ASSETS?**☐ YES ☐ NO (If NO, skip to Section VIII)

<b>7B.</b>	<b>(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN</b> <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	<b>(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY)</b> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>(2). SPECIFY HOW THE ASSET WAS TRANSFERRED</b> <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify):		<b>(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>(3). WHAT ASSET WAS TRANSFERRED?</b>		<b>(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED?</b> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>(4). WHO RECEIVED THE ASSET?</b>		<b>(10). WHAT WAS THE SALE PRICE? (If applicable)</b> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>(5). RELATIONSHIP TO NEW OWNER</b>		<b>(11). WHAT WAS THE GAIN? (Capital gain, etc.)</b> \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		

**SECTION VII: ASSET TRANSFERS (Continued)**  
(See instructions on Page 2)

7C.	(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify): _____	(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) <div style="border: 1px solid black; padding: 2px; display: inline-block;">           ____ - ____ - ____         </div>
	(2). SPECIFY HOW THE ASSET WAS TRANSFERRED <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify): _____	(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE? <input type="checkbox"/> YES <input type="checkbox"/> NO
	(3). WHAT ASSET WAS TRANSFERRED?	(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED? \$ ____ . ____ . ____ . ____
	(4). WHO RECEIVED THE ASSET?	(10). WHAT WAS THE SALE PRICE? (If applicable) \$ ____ . ____ . ____ . ____
	(5). RELATIONSHIP TO NEW OWNER	(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ ____ . ____ . ____ . ____
	(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

  

7D.	(1). SPECIFY ASSET'S ORIGINAL OWNER'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify): _____	(7). SPECIFY DATE OF TRANSFER (MM/DD/YYYY) <div style="border: 1px solid black; padding: 2px; display: inline-block;">           ____ - ____ - ____         </div>
	(2). SPECIFY HOW THE ASSET WAS TRANSFERRED <input type="checkbox"/> SOLD <input type="checkbox"/> GAVE AWAY <input type="checkbox"/> CONVEYED <input type="checkbox"/> TRADED <input type="checkbox"/> OTHER (Specify): _____	(8). WAS THE ASSET TRANSFERRED FOR LESS THAN FAIR MARKET VALUE? <input type="checkbox"/> YES <input type="checkbox"/> NO
	(3). WHAT ASSET WAS TRANSFERRED?	(9). WHAT WAS THE FAIR MARKET VALUE WHEN TRANSFERRED? \$ ____ . ____ . ____ . ____
	(4). WHO RECEIVED THE ASSET?	(10). WHAT WAS THE SALE PRICE? (If applicable) \$ ____ . ____ . ____ . ____
	(5). RELATIONSHIP TO NEW OWNER	(11). WHAT WAS THE GAIN? (Capital gain, etc.) \$ ____ . ____ . ____ . ____
	(6). WAS THE SALE OF THE ASSET REPORTED TO THE IRS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**SECTION VIII: TRUSTS**  
(See instructions on Page 2)

8A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED A TRUST OR DO YOU OR YOUR DEPENDENTS HAVE ACCESS TO A TRUST? (If you have more than one trust to report, submit the information on a separate VA Form 21P-0969 or provide the information on VA Form 21-4138 for each trust established.) <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, skip to Section IX)		
8B. DATE TRUST ESTABLISHED (MM/DD/YYYY)  <div style="border: 1px solid black; padding: 2px; display: inline-block;">           ____ - ____ - ____         </div>	8C. SPECIFY MARKET VALUE OF ALL ASSETS WITHIN THE TRUST AT TIME OF ESTABLISHMENT  \$ ____ . ____ . ____ . ____	8D. SPECIFY TYPE OF TRUST ESTABLISHED <input type="checkbox"/> REVOCABLE <input type="checkbox"/> IRREVOCABLE <input type="checkbox"/> BURIAL TRUST
8E. HAVE YOU ADDED FUNDS TO THE TRUST AFTER IT WAS ESTABLISHED?  <input type="checkbox"/> YES <input type="checkbox"/> NO	8F. WHEN DID YOU ADD FUNDS? (MM/DD/YYYY) (If more than one date, submit a VA Form 21-4138 with all dates and amounts)  <div style="border: 1px solid black; padding: 2px; display: inline-block;">           ____ - ____ - ____         </div>	8G. HOW MUCH DID YOU ADD?  \$ ____ . ____ . ____ . ____
8H. ARE YOU RECEIVING INCOME FROM THE TRUST?  <input type="checkbox"/> YES <input type="checkbox"/> NO		8I. HOW MUCH DO YOU RECEIVE ANNUALLY?  \$ ____ . ____ . ____ . ____
8J. IS THE TRUST BEING USED TO PAY FOR OR TO REIMBURSE SOMEONE ELSE FOR YOUR MEDICAL EXPENSES? (Such as a guardian, family member or other service provider)  <input type="checkbox"/> YES <input type="checkbox"/> NO		8K. HOW MUCH IS BEING REIMBURSED MONTHLY?  \$ ____ . ____ . ____ . ____
8L. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?  <input type="checkbox"/> YES <input type="checkbox"/> NO		8M. DO YOU HAVE ANY ADDITIONAL AUTHORITY OR CONTROL OF THE TRUST?  <input type="checkbox"/> YES <input type="checkbox"/> NO



**SECTION IX: ANNUITIES**  
(See instructions on Page 2)

9A. HAVE YOU OR YOUR DEPENDENTS ESTABLISHED AN ANNUITY? (If you have more than one annuity to report, submit the information below on a separate VA Form 21P-0969, or provide the below information on VA Form 21-4138 for each annuity established.)

☐ YES ☐ NO (If NO, skip to Section X)

9B. SPECIFY DATE ANNUITY WAS ESTABLISHED  
(MM/DD/YYYY)

-  -

9C. SPECIFY MARKET VALUE OF ASSET AT TIME OF  
ANNUITY PURCHASE

\$  ,  ,  .

9D. HAVE YOU ADDED FUNDS TO THE  
ANNUITY IN THE CURRENT OR PRIOR  
THREE YEARS?

☐ YES ☐ NO

9E. WHEN DID YOU ADD FUNDS? (MM/DD/YYYY)

-  -

9F. HOW MUCH DID YOU ADD?

\$  ,  ,  .

9G. IS THE ANNUITY REVOCABLE OR  
IRREVOCABLE?

☐ REVOCABLE ☐ IRREVOCABLE

9H. DO YOU RECEIVE INCOME FROM THE  
ANNUITY?

☐ YES ☐ NO

9I. IF YES IN 9H, PROVIDE ANNUAL AMOUNT RECEIVED (If NO, skip to 9J)

\$  ,  ,  .

9J. CAN THE ANNUITY BE LIQUIDATED?

☐ YES ☐ NO

9K. IF YES IN 9J, PROVIDE THE SURRENDER VALUE (If NO, skip to Section X)

\$  ,  ,  .

**SECTION X: ASSETS PREVIOUSLY NOT REPORTED**  
(See instructions on Page 2)

10A. DO YOU OR YOUR DEPENDENTS HAVE ASSETS NOT ALREADY REPORTED?

☐ YES ☐ NO (If NO, skip to Section XI)

<p>10B. (1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN  <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD  <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p> <p>(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)</p>	<p>(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY            \$ <input type="text"/> , <input type="text"/> , <input type="text"/> . <input type="text"/></p> <p>(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)</p>
<p>10C. (1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN  <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD  <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p> <p>(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)</p>	<p>(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY            \$ <input type="text"/> , <input type="text"/> , <input type="text"/> . <input type="text"/></p> <p>(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)</p>
<p>10D. (1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN  <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD  <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p> <p>(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)</p>	<p>(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY            \$ <input type="text"/> , <input type="text"/> , <input type="text"/> . <input type="text"/></p> <p>(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)</p>
<p>10E. (1). SPECIFY ASSET OWNER'S RELATIONSHIP TO THE VETERAN  <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD  <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):</p> <p>(2). SPECIFY TYPE OF ASSET (Cash, art, etc.)</p>	<p>(3). SPECIFY VALUE OF YOUR PORTION OF THE PROPERTY            \$ <input type="text"/> , <input type="text"/> , <input type="text"/> . <input type="text"/></p> <p>(4). SPECIFY ASSET LOCATION (Financial institution, property address, etc.)</p>

**SECTION XI: DISCONTINUED OR IRREGULAR INCOME**

(See instructions on Page 2)

11A. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME THAT HAS STOPPED OR IS NO LONGER BEING RECEIVED WITHIN:  
THE REPORTING PERIOD (From question 2E)? - **OR** - LAST FULL CALENDAR YEAR (For initial claim)?

☐ YES ☐ NO (If NO, skip to Section XII)

11B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(5). SPECIFY FREQUENCY OF INCOME RECEIVED <input type="checkbox"/> RECURRING <input type="checkbox"/> IRREGULAR <input type="checkbox"/> ONE TIME PAYMENT
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(6). DATE INCOME LAST PAID (MM/DD/YYYY) [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS? \$ [ ] [ ] [ ] . [ ] [ ] [ ] . [ ] [ ]
	(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)	
11C.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(5). SPECIFY FREQUENCY OF INCOME RECEIVED <input type="checkbox"/> RECURRING <input type="checkbox"/> IRREGULAR <input type="checkbox"/> ONE TIME PAYMENT
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(6). DATE INCOME LAST RECEIVED (MM/DD/YYYY) [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(7). WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS? \$ [ ] [ ] [ ] . [ ] [ ] [ ] . [ ] [ ]
	(4). SPECIFY TYPE OF INCOME RECEIVED (Interest, dividends, etc.)	

**SECTION XII: WAIVER OF RECEIPT OF INCOME**

(See instructions on Page 2)

12A. DID YOU OR YOUR DEPENDENTS WAIVE OR EXPECT TO WAIVE ANY RECEIPT OF INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ NO (If NO, skip to Section XIII Certification and Signature)

12B.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE? \$ [ ] [ ] [ ] . [ ] [ ] [ ] . [ ] [ ]
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY) [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ] <input type="checkbox"/> This income will not resume
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(6). WAIVED GROSS MONTHLY INCOME \$ [ ] [ ] [ ] . [ ] [ ] [ ] . [ ] [ ]
12C.	(1). SPECIFY INCOME RECIPIENT'S RELATIONSHIP TO VETERAN <input type="checkbox"/> VETERAN <input type="checkbox"/> SPOUSE <input type="checkbox"/> CUSTODIAN OF CHILD <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER (Specify):	(4). IF THE INCOME RESUMES, WHAT AMOUNT DO YOU EXPECT TO RECEIVE? \$ [ ] [ ] [ ] . [ ] [ ] [ ] . [ ] [ ]
	(2). SPECIFY NAME OF INCOME RECIPIENT (Only needed if Custodian of child, child, parent, or other)	(5). DATE PAYMENTS WILL RESUME (MM/DD/YYYY) [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ] <input type="checkbox"/> This income will not resume
	(3). SPECIFY INCOME PAYER (Name of business, financial institution, etc.)	(6). WAIVED GROSS MONTHLY INCOME \$ [ ] [ ] [ ] . [ ] [ ] [ ] . [ ] [ ]

**SECTION XIII: CERTIFICATION AND SIGNATURE**

**I CERTIFY THAT** the statements on the form are true and correct to the best of my knowledge and belief. **I UNDERSTAND THAT** without consent, the Department of Veterans Affairs (VA) may disclose information that I provide to entities under a published "routine use." Under such a routine use, the VA may disclose information to third party entities that participate in VA claims processing and are authorized to assist the VA in administering benefits; to other federal agencies under computer matching programs, such as those with the Internal Revenue Service, Social Security Administration, Selective Service System, Department of Homeland Security, Department of Justice; and to members of Congress if they are assisting to help with Veteran's benefit questions.

13A. SIGNATURE

13B. DATE SIGNED (MM/DD/YYYY)

[ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ]

**SECTION XIV: WITNESS TO SIGNATURE**  
**(Two witness signatures are required if the claimant signed item 13A with an "X")**

14A. SIGNATURE OF FIRST WITNESS (If claimant signed above using an "X")

14B. PRINTED NAME OF FIRST WITNESS

FIRST: MI: LAST:

14C. ADDRESS OF FIRST WITNESS

No. & Street Apt./Unit Number

City

State/Province   Country   ZIP Code/Postal Code       -

14D. SIGNATURE OF SECOND WITNESS (If claimant signed above using an "X")

14E. PRINTED NAME OF SECOND WITNESS

FIRST: MI: LAST:

14F. ADDRESS OF SECOND WITNESS

No. & Street Apt./Unit Number

City

State/Province   Country   ZIP Code/Postal Code       -

**Where to Send Correspondence** - After completing the form, mail to:  
Department of Veterans Affairs  
Pension Intake Center  
P.O. Box 5365  
Janesville, WI 53547-5365

**PENALTY:** The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.