NON-SERVICE CONNECTED PENSION

VA FORM 21P-527EZ

ELIGIBILITY

2

U.S. Department of Veterans Affairs
Veterans Benefits Administration

VA Veteran Pension

What is Veteran Pension?

Pension is a needs-based benefit program for wartime Veterans, who are age 65 or older or have a permanent and total non-service-connected disability, and who have limited income and net worth. To learn more about VA Pension benefits, please visit https://www.va.gov/pension/. Veterans who are more seriously disabled may qualify for pension at the increased housebound or aid and attendance rates. To learn more about aid and attendance and housebound benefits, please visit https://www.va.gov/pension/aid-attendance-housebound/.

Who is eligible?

You may be eligible if you meet the following criteria:

- You were discharged from service under other than dishonorable conditions, AND
- You served 90 days of active duty with at least one day during wartime, *AND
- Your countable income is below the maximum annual pension rate (MAPR), AND
- You meet net worth limitations AND
- You meet one of the following criteria:
  - You are age 65 or older.
  - You have a permanent and total nonservice-connected disability.
  - You are a patient in a nursing home due to mental or physical incapacity.
  - You are receiving Social Security disability benefits.

*Veterans who entered active duty after September 7, 1980, must serve at least 24 months of active-duty service. If the length of service is less than 24 months, the Veteran must have completed their entire tour of active duty.

For the current net worth limit and MAPR, see the Veterans Pension Rate Table at http://www.benefits.va.gov/PENSION/current_rates_veteran_pen.asp.

How much does VA pay?

1. VA determines the Maximum Annual Pension Rate (MAPR) for your situation. This amount is set by Congress.
2. Next, VA determines your countable income. This is done by subtracting exclusions provided by law from your total annual income.
3. VA then subtracts your countable income from the MAPR. This difference is your yearly pension entitlement.
4. VA divides this amount by 12 and rounds to the nearest dollar. This is the approximate amount of your monthly pension payment.

   VA deducts certain expenses you pay, such as unreimbursed medical expenses, from your annual household income. This will decrease your countable income and increase your monthly pension payment. Find a complete list of eligible expenses in the Code of Federal Regulations, located at eCFR :: 38 CFR 3.278 -- Deductible medical expenses..

How can you apply?

You can apply for Veteran Pension benefit by filling out VA Form 21P-527EZ, "Application for Pension," located at http://www.vba.va.gov/pubs/forms/VBA-21P-527EZ-ARE.pdf.

Documents may be submitted by mail, in person at a VA regional office or electronically. However, VA recommends submitting correspondence electronically as this is the fastest method of receipt at www.va.gov/pension/application/527EZ/.

VA provides several tools to assist in electronic submission. To learn more about how to submit documents and claims electronically, visit www.va.gov/disability/upload-supporting-evidence. You can also go directly to access.va.gov to digitally upload any correspondence using Direct Upload.

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OMB Control No. 2900-0002
Respondent Burden: 30 minutes
Expiration Date: 8/31/2025

Department of Veterans Affairs

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

APPLICATION FOR VETERANS PENSION

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

1A. VETERAN'S NAME *(First, Middle Initial, Last)*: Joe Smith

1B. VETERAN'S SOCIAL SECURITY NUMBER: 123 – 45 – 6789

1C. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*: 01 / 01 / 1900

1D. HAVE YOU EVER FILED A CLAIM WITH VA? ○ YES ◉ NO *(If NO, skip question 1E.)*

1E. VA FILE NUMBER *(If applicable)*:

SECTION II: VETERAN'S CONTACT INFORMATION

2A. MAILING ADDRESS

No. & Street: 123456 Happy Lane

Apt./Unit Number: | City: Happy Town

State/Province: MI | Country: | ZIP Code/Postal Code: 12345 – 6789

2B. TELEPHONE NUMBERS *(Include Area Code)*: 123 – 456 – 7890 International Phone Number *(If applicable)*:

2C. VETERAN'S E-MAIL ADDRESS *(Optional)*: none

SECTION III: VETERAN'S SERVICE INFORMATION *(MUST COMPLETE)*

3A. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER *(If None, leave blank)*:

3B. DATE INITIALLY ENTERED ACTIVE DUTY *(MM/DD/YYYY)*: / /

3C. FINAL RELEASE DATE FROM ACTIVE DUTY *(MM/DD/YYYY)*: / /

3D. YOUR SERVICE NUMBER:

3E. BRANCH OF SERVICE
◉ ARMY ○ NAVY ○ AIR FORCE
○ COAST GUARD ○ MARINE CORPS
○ SPACE FORCE ○ USPHS ○ NOAA

3F. PLACE OF YOUR LAST SEPARATION: Fort McHappy

3G. HAVE YOU EVER BEEN A PRISONER OF WAR? ○ YES ◉ NO *(If NO, skip to question 4A)*

3H. DATES CONFINEMENT STARTED *(MM/DD/YYYY)*: / /

3I. DATES CONFINEMENT ENDED *(MM/DD/YYYY)*: / /

SECTION IV: PENSION INFORMATION

4A. ARE YOU OVER THE AGE OF 65 OR HAVE YOU BEEN DETERMINED TO BE DISABLED BY SOCIAL SECURITY ADMINISTRATION? ◉ YES ○ NO *(If YES, skip question 4B)*

4B. ARE YOU MEDICALLY INCAPABLE OF WORKING? ◉ YES ○ NO *(If YES, you must submit medical evidence with this application)*

4C. DO YOU LIVE IN A NURSING HOME? ○ YES ◉ NO *(If "NO, skip question 4D)*

4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS OR HAVE YOU APPLIED FOR MEDICAID? ○ YES ○ NO *(If YES, please have an official from your nursing home complete VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance)*

4E. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL IMPAIRMENT OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES? ◉ YES ○ NO *(If YES, complete and attach with this application, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS.))*

4F. HAVE YOU RECEIVED TREATMENT FROM A VA MEDICAL CENTER? ○ YES ○ NO Specify Facility:

4G. HAVE YOU RECENTLY RECEIVED TREATMENT FROM ANY FEDERAL MEDICAL FACILITIES *(Military base, etc.)*? ○ YES ○ NO Specify Facility:

SECTION V: EMPLOYMENT HISTORY

5A. ARE YOU CURRENTLY EMPLOYED? ○ YES ◉ NO *(If NO, skip questions 5B and 5C)*

5B. WHAT KIND OF WORK ARE YOU CURRENTLY DOING?

5C. HOW MANY HOURS PER WEEK DO YOU AVERAGE?

5D. WHEN DID YOU LAST WORK? *(MM/DD/YYYY)*: / /

5E. HOW MANY HOURS PER WEEK DID YOU AVERAGE?

5F. WHAT WAS YOUR JOB TITLE?

5G. WHAT KIND OF WORK DID YOU DO?

SECTION VI: MARITAL STATUS *(MUST COMPLETE)*

6A. WHAT IS YOUR MARITAL STATUS? *(Check one)*
◉ MARRIED ○ SEPARATED ○ NOT MARRIED *(Widowed or Never Married - Skip to Section VIII)*

6B. SPOUSE'S CURRENT LEGAL NAME *(First, Middle Initial, Last)*: Betty Smith

6C. SPOUSE'S BIRTH DATE *(MM/DD/YYYY)*: 01 / 01 / 1900

6D. SPOUSE'S SOCIAL SECURITY NUMBER: 123 – 45 – 6789

6E. DATE AND PLACE OF MARRIAGE *(MM/DD/YYYY)*: 01 / 01 / 1901

CITY AND STATE OR COUNTRY: Happy Town MI

6F. TYPE OF MARRIAGE *(Ceremonial, Common-Law, Proxy, Tribal, etc.)*
◉ CEREMONIAL ○ OTHER *(Specify)*

6G. IS YOUR SPOUSE ALSO A VETERAN? ○ YES ◉ NO *(If NO, skip question 6H)*

6H. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? *(If any)*

6I. IF YOU ARE SEPARATED, PLEASE TELL US THE REASON YOU ARE SEPARATED *(Illness, work, etc.)*
○ MEDICAL REASON ○ MARITAL DISCORD ○ WORK ○ OTHER *(Specify)*

6J. SPOUSE'S MAILING ADDRESS *(If separated)*

No. & Street:

Apt./Unit Number: | City:

State/Province: | Country: | ZIP Code/Postal Code: –

6K. HOW MUCH DO YOU CONTRIBUTE MONTHLY TO YOUR SPOUSE'S SUPPORT? *(If separated)*
$, .

SECTION VII: PRIOR MARITAL HISTORY

Tell us about your and your spouse's previous marriages. If you have never been married or your current marriage is yours and your spouse's only marriage skip to Section VIII.

VETERAN'S PRIOR MARRIAGES *(If None, skip to question 7I)*

7A. WHO WERE YOU MARRIED TO? *(First, Middle Initial, Last)*: Mary Jane

7B. HOW DID YOUR PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
○ DEATH ◉ DIVORCE ○ OTHER *(Specify)*:

7C. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START: 01 / 01 / 1900
END: 01 / 01 / 1901

7D. PLACE OF MARRIAGE *(City and State or Country)*: Sad Town, MI

7E. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*: Happy Town, MI

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VETERAN'S PRIOR MARRIAGES - CONTINUED *(If None, skip to question 7L)*

7F. WHO WERE YOU MARRIED TO? *(First, Middle Initial, Last)*

7G. HOW DID YOUR PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
○ DEATH ○ DIVORCE ○ OTHER *(Specify)*

7H. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START: / /
END: / /

7I. PLACE OF MARRIAGE *(City and State or Country)*

7J. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?
○ YES ○ NO *(If "YES," please submit a VA Form 21-686c, Declaration of Status of Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history.)*

SPOUSE'S PRIOR MARRIAGES *(If "None," skip to Section VIII)*

7L. WHO WAS YOUR SPOUSE MARRIED TO? *(First, Middle Initial, Last)*

7M. HOW DID THE PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
○ DEATH ○ DIVORCE ○ OTHER *(Specify)*

7N. WHAT ARE THE DATES OF THE PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START: / /
END: / /

7O. PLACE OF MARRIAGE *(City and State or Country)*

7P. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7Q. WHO WAS YOUR SPOUSE MARRIED TO? *(First, Middle Initial, Last)*

7R. HOW DID THE PREVIOUS MARRIAGE END? *(Death, divorce, etc.)*
○ DEATH ○ DIVORCE ○ OTHER *(Specify)*

7S. WHAT ARE THE DATES OF THE PREVIOUS MARRIAGE? *(MM/DD/YYYY)*
START: / /
END: / /

7T. PLACE OF MARRIAGE *(City and State or Country)*

7U. PLACE OF MARRIAGE TERMINATION *(City and State or Country)*

7V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR YOUR SPOUSE?
○ YES ○ NO *(If "YES", please submit a VA Form 21-686c, Declaration of Status of Dependents, or a VA Form 21-4138, Statement in Support of Claim, as needed to provide the information for additional marital history.)*

SECTION VIII: DEPENDENT CHILDREN

NOTE: Please refer to the Special Circumstances on the instructions page for information regarding dependents and the necessary forms if additional space is required to list all dependents. If None, skip to Section IX. **In most circumstances, children over the age of 23 are not considered dependent for VA purposes.**

8A. HOW MANY DEPENDENT CHILDREN LIVE WITH YOU? *(Please complete a VA Form 21-686c, Application Request to Add and/or Remove Dependents, if you need more space for additional dependents.)*

8B. CHILD'S NAME *(First, Middle Initial, Last)*

8C. CHILD'S BIRTH DATE *(MM/DD/YYYY)*
/ /

8D. CHILD'S SOCIAL SECURITY NUMBER
– –

8E. PLACE OF BIRTH *(City and State or Country)*

8F. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*
○ BIOLOGICAL ○ STEPCHILD ○ SERIOUSLY DISABLED ○ 18-23 YEARS OLD *(in school)* ○ PREVIOUSLY MARRIED ○ ADOPTED
○ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $, .

8G. CHILD'S NAME *(First, Middle Initial, Last)*

8H. CHILD'S BIRTH DATE *(MM/DD/YYYY)*
/ /

8I. CHILD'S SOCIAL SECURITY NUMBER
– –

8J. PLACE OF BIRTH *(City and State or Country)*

SECTION VIII: DEPENDENT CHILDREN *(CONTINUED)*

8K. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*
○ BIOLOGICAL ○ STEPCHILD ○ SERIOUSLY DISABLED ○ 18-23 YEARS OLD *(in school)* ○ PREVIOUSLY MARRIED ○ ADOPTED
○ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $, .

8L. CHILD'S NAME *(First, Middle Initial, Last)*

8M. CHILD'S BIRTH DATE *(MM/DD/YYYY)*
/ /

8N. CHILD'S SOCIAL SECURITY NUMBER
– –

8O. PLACE OF BIRTH *(City and State or Country)*

8P. WHAT IS THE CHILD'S STATUS? *(Select all that apply)*
○ BIOLOGICAL ○ STEPCHILD ○ SERIOUSLY DISABLED ○ 18-23 YEARS OLD *(in school)* ○ PREVIOUSLY MARRIED ○ ADOPTED
○ DOES NOT LIVE WITH YOU BUT CONTRIBUTES $, .

8Q. DO ALL OF YOUR CHILDREN THAT ARE NOT LIVING WITH YOU AS ANSWERED ABOVE RESIDE AT THE SAME ADDRESS?
○ YES ○ NO *(If "NO," Please submit a VA Form 21-4138, Statement in Support of Claim, with the following information: Who the child is currently living with, and the full address of where the child resides.)*

8R. PLEASE PROVIDE THE NAME OF THE CUSTODIAN AND THE ADDRESS OF CHILDREN NOT LIVING WITH YOU

NAME OF CUSTODIAN *(First, Middle Initial, Last)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code –

SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS

NOTE: Assets are all the money and property you or your dependents own. Assets do not include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

9A. DO YOU AND YOUR DEPENDENTS HAVE OVER $25,000.00 IN ASSETS (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)?
○ YES ● NO *(If "YES," please submit VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' Dependency and Indemnity Compensation (D.I.C.))*

$, .00 *(If "NO," please estimate the total value of your assets)*

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? *(Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust.)*
○ YES ● NO *(If "YES," please submit VA Form 21P-0969)*

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?
● YES ○ NO *(If "NO," skip to Item 9G)*

9D. IS THE SIZE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?
○ YES ● NO *(If "NO," skip to Item 9G)*

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF LAND OVER 2 ACRES? *(Do not include the value of the residence or the first 2 acres.)*
$, , .00

9F. IS THE LAND OVER 2 ACRES (87, 120 SQ FT) REPORTED IN QUESTION 9E MARKETABLE?
○ YES ○ NO *(If "YES," please submit VA Form 21P-0969)*

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?
○ YES ● NO *(If "YES," please submit VA Form 21P-0969 and **ONLY** report your Social Security Income below)*

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, Income and Asset Statement in Support of Claim for Pension or Parents' D.I.C., by questions 9A through 9G, we only require Social Security income reported below. All other income should be reported on VA Form 21P-0969. Income will be counted as reported, do not duplicate.

NOTE: If reporting income in 9H through 9K, any items skipped or left blank will be considered as an unspecified income and could require a request for further information, potentially delaying your claim. If you leave the entire question blank, we will assume you have no income to report.

9H(1) WHO IS THE INCOME RECIPIENT? *(Select one)*
● VETERAN
○ SPOUSE
○ CHILD *(Specify)*

9H(2) PLEASE SPECIFY THE SOURCE OF INCOME *(Specify name of institution)*
● SOCIAL SECURITY ○ INTEREST/DIVIDENDS
○ CIVIL SERVICE ○ PENSION/RETIREMENT
○ SPECIFY SOURCE *(i.e., inheritance, etc.)*

9H(3) CURRENT GROSS MONTHLY INCOME?
$, 0 0 1 . 0 0

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SECTION IX: QUESTIONS REGARDING INCOME AND ASSETS *(Continued)*

9I(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9I(2) PLEASE SPECIFY THE SOURCE OF INCOME *(Specify name of institution)*	9I(3) CURRENT GROSS MONTHLY INCOME?
○ VETERAN ● SPOUSE ○ CHILD *(Specify)*	● SOCIAL SECURITY ○ INTEREST/DIVIDENDS ○ CIVIL SERVICE ○ PENSION/RETIREMENT ○ SPECIFY SOURCE *(i.e., inheritance, etc.)*	$ 0 0 1 . 0 0
9J(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9J(2) PLEASE SPECIFY THE SOURCE OF INCOME *(Specify name of institution)*	9J(3) CURRENT GROSS MONTHLY INCOME?
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	○ SOCIAL SECURITY ○ INTEREST/DIVIDENDS ○ CIVIL SERVICE ○ PENSION/RETIREMENT ○ SPECIFY SOURCE *(i.e., inheritance, etc.)*	$
9K(1) WHO IS THE INCOME RECIPIENT? *(Select one)*	9K(2) PLEASE SPECIFY THE SOURCE OF INCOME *(Specify name of institution)*	9K(3) CURRENT GROSS MONTHLY INCOME?
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	○ SOCIAL SECURITY ○ INTEREST/DIVIDENDS ○ CIVIL SERVICE ○ PENSION/RETIREMENT ○ SPECIFY SOURCE *(i.e., inheritance, etc.)*	$

SECTION X: INFORMATION ABOUT YOUR UNREIMBURSED MEDICAL EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses that you expect to pay indefinitely (including the Medicare deduction) for yourself, any claimed dependents who are under your obligation for support, or any relatives who are members of your household. In some circumstances we can consider medical expenses up to one year prior to your initial date of entitlement. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse at any time prior to the end of the year following the year of death. Educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you or your dependents were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If more space is needed, complete and attach a separate VA Form 21P-8416, *Medical Expense Report.*

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES?

● YES ○ NO *(If "NO," skip to Section XI.)*

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed in questions 10B through 10J. Do not include expenses paid by other family members, insurance, etc.

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or residential care, adult daycare, or similar care facility, you must complete the applicable worksheet(s) on **pages 16 and 17** for each provider.

10B(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10B(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10B(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
● VETERAN ○ SPOUSE ○ CHILD *(Specify)*	○ CARE FACILITY ● IN-HOME CARE ATTENDANT	$ 0 2 5 . 0 0 PER HOUR 0 1 5 HOURS WORKED PER WEEK

10B(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10B(5). PAYMENT FREQUENCY	10B(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: 0 1 / 0 1 / 1 9 0 2 END: / / ● NO END DATE	● MONTHLY ○ ANNUALLY	$

10C(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10C(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10C(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	○ CARE FACILITY ○ IN-HOME CARE ATTENDANT	$ PER HOUR HOURS WORKED PER WEEK

10C(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10C(5). PAYMENT FREQUENCY	10C(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: 0 1 / 0 1 / 1 9 0 2 END: / / ● NO END DATE	● MONTHLY ○ ANNUALLY	$ 9 0 0 . 0 0

IN-HOME CARE OR CARE FACILITY *(Continued)*

10D(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10D(2). NAME OF PROVIDER AND TYPE OF CARE *(Select one)*	10D(3). IF THIS IS AN IN-HOME CARE PROVIDER, WHAT IS THE RATE PER HOUR?
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	○ CARE FACILITY ○ IN-HOME CARE ATTENDANT	$ PER HOUR HOURS WORKED PER WEEK

10D(4). PROVIDER START AND END DATE *(MM/DD/YYYY)*	10D(5). PAYMENT FREQUENCY	10D(6). AMOUNT YOU PAY BASED ON FREQUENCY SELECTED
START: / / END: / / ○ NO END DATE	○ MONTHLY ○ ANNUALLY	$

OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES

10E(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10E(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10E(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	10E(3) PURPOSE *(Insurance premium, medical supplies, etc.)*	/ / 10E(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ○ ONE-TIME 10E(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

10F(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10F(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10F(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	10F(3) PURPOSE *(Insurance premium, medical supplies, etc.)*	/ / 10F(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ○ ONE-TIME 10F(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

10G(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10G(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10G(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	10G(3) PURPOSE *(Insurance premium, medical supplies, etc.)*	/ / 10G(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ○ ONE-TIME 10G(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

10H(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10H(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10H(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	10H(3) PURPOSE *(Insurance premium, medical supplies, etc.)*	/ / 10H(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ○ ONE-TIME 10H(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

10I(1). WHOSE EXPENSES WERE PAID? *(Select one)*	10I(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10I(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	10I(3) PURPOSE *(Insurance premium, medical supplies, etc.)*	/ / 10I(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ○ ONE-TIME 10I(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

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OTHER MEDICAL, LAST AND/OR BURIAL EXPENSES *(Continued)*

10J(1) WHOSE EXPENSES WERE PAID? *(Select one)*	10J(2) PAID TO *(Name of Provider, Insurance Company, etc.)*	10J(4) DATE COSTS INCURRED *(MM/DD/YYYY)*
○ VETERAN ○ SPOUSE ○ CHILD *(Specify)*	10J(3) PURPOSE *(Insurance premium, medical supplies, etc.)*	10J(5) PAYMENT FREQUENCY ○ MONTHLY ○ ANNUALLY ○ ONE-TIME 10J(6) AMOUNT YOU PAY *(Based on Frequency selected)* $

SECTION XI: DIRECT DEPOSIT INFORMATION *(MUST COMPLETE)*

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and attach either a voided personal check or a deposit slip**. If you **do not** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP) and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit sent)*

b a n k o f H a p p y D a y

11B. TYPE OF ACCOUNT *(Check the appropriate box and provide the account number or simply write "Established." if you have a direct deposit with VA.)*

○ CHECKING ○ SAVINGS ○ I CERTIFY I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

11C. ROUTING NUMBER	11D. ACCOUNT NO.
1 2 3 4 5 6 7 8 9	9 8 7 6 5 4 3 2 1 9 8 7 6 5 4

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE *(MUST COMPLETE)*

I CERTIFY THAT AND AUTHORIZE the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency to give the Department of Veterans Affairs any information about me and waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled Notice to Veteran of Evidence Necessary to Substantiate a Claim for Veterans Pension Benefits.

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA Medical Center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in item 12A indicating that I do not want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

12A. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will automatically consider a claim submitted on this form for rapid processing under the FDC program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

○ **I DO NOT want my claim considered for rapid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

12B. SIGNATURE OR MARK	12C. DATE SIGNED *(MM/DD/YYYY)*
	/ /

SECTION XIII: WITNESSES TO SIGNATURE
(TWO (2) WITNESS SIGNATURES ARE REQUIRED IF THE CLAIMANT SIGNED ITEM 12B WITH AN "X")

13A. SIGNATURE OF THE FIRST WITNESS *(If claimant signed above using an "X")*	13B. PRINTED NAME AND ADDRESS OF FIRST WITNESS Name: Address:
13C. SIGNATURE OF THE SECOND WITNESS *(If claimant signed above using an "X")*	13D. PRINTED NAME AND ADDRESS OF SECOND WITNESS Name: Address:

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, Medical Expense Report. In addition, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? *(Name of Care Recipient, either the Claimant or Dependent)*

2. WHO IS COMPLETING THIS WORKSHEET? *(Name of Provider, either an Administrator or Licensed Medical Professional)*

3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

4. WHAT IS THE NAME OF THE FACILITY? *(As shown on facility license or official website)*

5. WHAT IS THE FACILITY TELEPHONE NUMBER? – – International Phone Number *(If applicable)*

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

○ A. EATING ○ B. BATHING/SHOWERING ○ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
○ D. DRESSING ○ E. USING THE TOILET ○ F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT, PLEASE CHECK THE BOX IF THE STATEMENT IS TRUE FOR THE FACILITY.

○ THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
○ THE FACILITY IS LICENSED
○ THE FACILITY IS RESIDENTIAL
○ THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)

○ YES ○ NO, Care is being provided by a third-party provider. ○ NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each in-home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. *(MM/DD/YYYY)*	12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)* *(Select "Indefinite" if the care you provide is not temporary.)*
/ /	/ / ○ INDEFINITE

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

$ PER MONTH

FACILITY CERTIFICATION

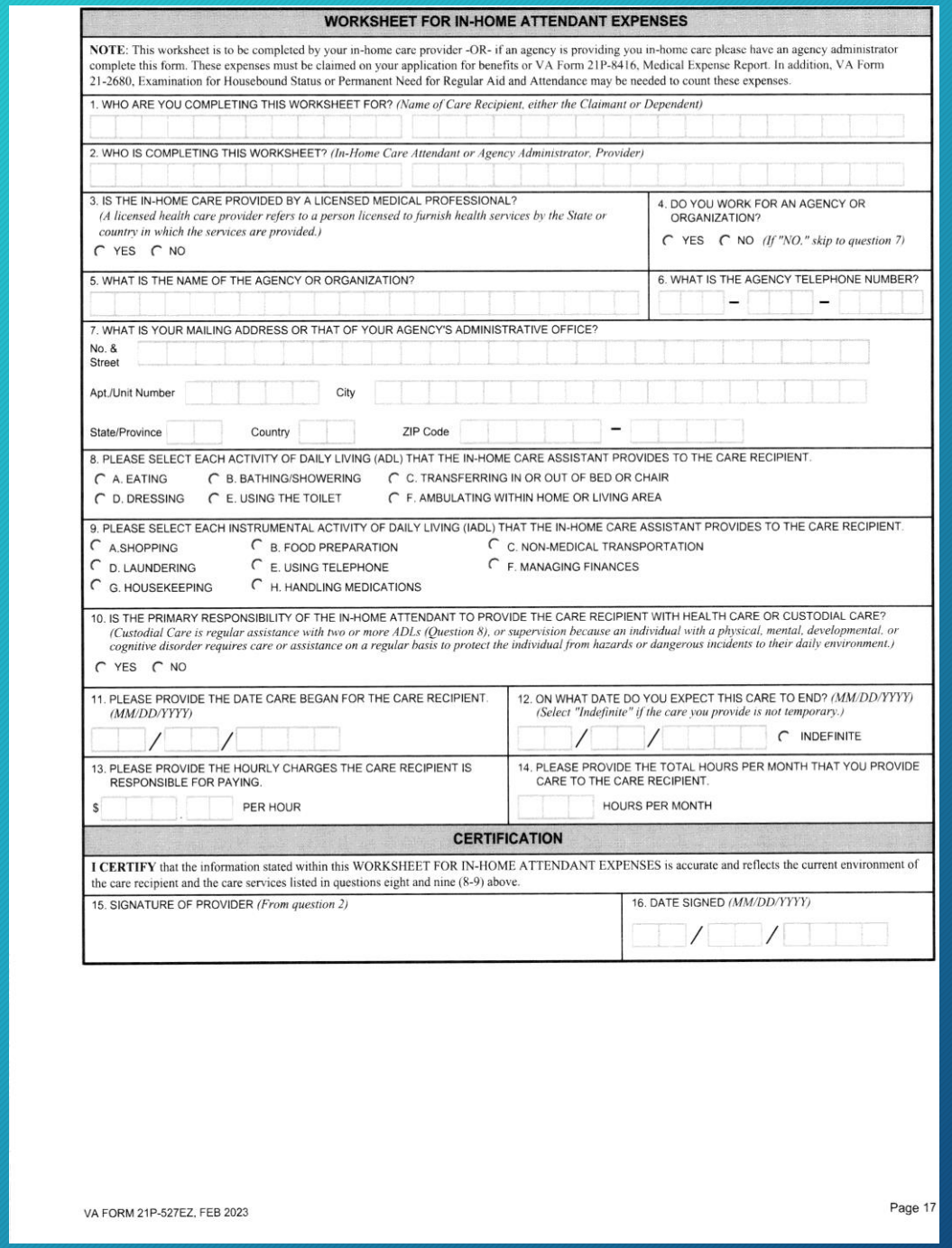
I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the care recipient and the facility.

14. SIGNATURE OF PROVIDER *(From question 2)*	15. DATE SIGNED *(MM/DD/YYYY)*
	/ /

VA FORM 21P-527EZ

APPLICTION FOR VETERANS PENSION

7



WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, Medical Expense Report. In addition, VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? *(Name of Care Recipient, either the Claimant or Dependent)*

2. WHO IS COMPLETING THIS WORKSHEET? *(In-Home Care Attendant or Agency Administrator, Provider)*

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)
○ YES ○ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?
○ YES ○ NO *(If "NO," skip to question 7)*

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

6. WHAT IS THE AGENCY TELEPHONE NUMBER?
– –

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code –

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
○ A. EATING ○ B. BATHING/SHOWERING ○ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
○ D. DRESSING ○ E. USING THE TOILET ○ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
○ A.SHOPPING ○ B. FOOD PREPARATION ○ C. NON-MEDICAL TRANSPORTATION
○ D. LAUNDERING ○ E. USING TELEPHONE ○ F. MANAGING FINANCES
○ G. HOUSEKEEPING ○ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE?
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangerous incidents to their daily environment.)
○ YES ○ NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. *(MM/DD/YYYY)*
/ /

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? *(MM/DD/YYYY)*
(Select "Indefinite" if the care you provide is not temporary.)
/ / ○ INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$. PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.
HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

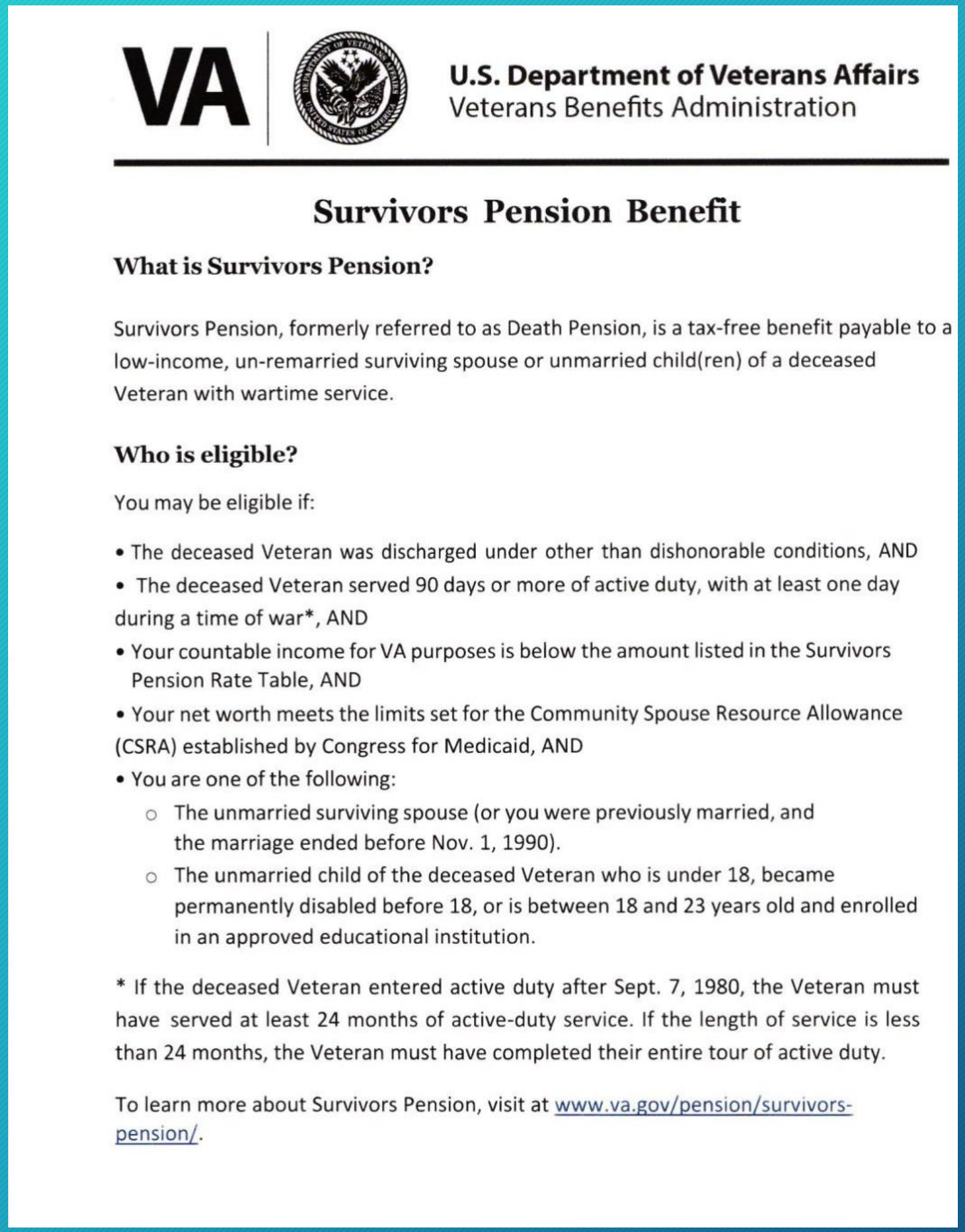
15. SIGNATURE OF PROVIDER *(From question 2)*

16. DATE SIGNED *(MM/DD/YYYY)*
/ /

SURVIVORS PENSION

VA FORM 21P-534EZ

APPLICTION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS



U.S. Department of Veterans Affairs
Veterans Benefits Administration

Survivors Pension Benefit

What is Survivors Pension?

Survivors Pension, formerly referred to as Death Pension, is a tax-free benefit payable to a low-income, un-remarried surviving spouse or unmarried child(ren) of a deceased Veteran with wartime service.

Who is eligible?

You may be eligible if:

- The deceased Veteran was discharged under other than dishonorable conditions, AND
- The deceased Veteran served 90 days or more of active duty, with at least one day during a time of war*, AND
- Your countable income for VA purposes is below the amount listed in the Survivors Pension Rate Table, AND
- Your net worth meets the limits set for the Community Spouse Resource Allowance (CSRA) established by Congress for Medicaid, AND
- You are one of the following:
  - The unmarried surviving spouse (or you were previously married, and the marriage ended before Nov. 1, 1990).
  - The unmarried child of the deceased Veteran who is under 18, became permanently disabled before 18, or is between 18 and 23 years old and enrolled in an approved educational institution.

* If the deceased Veteran entered active duty after Sept. 7, 1980, the Veteran must have served at least 24 months of active-duty service. If the length of service is less than 24 months, the Veteran must have completed their entire tour of active duty.

To learn more about Survivors Pension, visit at www.va.gov/pension/survivors-pension/.

CHECKLIST

APPLICTION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

Survivor's/Widow Pension

For:..... Phone#:.....

USE ONLY ORIGINAL SIGNATURES

The VA does not recognize Power of Attorney

21-527EZ NSC Veteran's Pension

21-534EZ Survivor's (Widow's) Pension, Accrued Benefits or DIC

21-22 Assignment of POA

21-0966 Intent to File (If claim can't be completed by the 29th of month)

DD-214 Military Discharge Papers. **War Time Vet** Yes No

Death Cert. Veteran's Death Certificate

___ Marriage Cert. If married more than once, might need cert for each marriage

Divorce Cert. If divorced, then might need documentation for each divorce

21-2680 Examination Aid & Attendance/ Homebound (Doctor completes)

21-0779 Nursing Home Information (Assisted Living Facility completes)

__ Work Sheet for an Assisted Living, Adult Day Care or Similar Facility.

Att Aff. Use if assistance is NOT provided by Assisted Living Facility

__ Work Sheet for In-Home attendant expenses

21P-0969 Statement of Assets and Income

__ Checking and Savings Statements

__ Annuity Statements

__ Stocks, bonds, dividends and/or interest -- if they have a Ck or Svs, they have interest.

__ Other retirement income (might be a direct deposit entry)

21-4138 Statement in Support of Claims

21-0845 3rd Party Authorization (if claimant wants a family member to talk to the VA.)

21-8416 Medical Expense Report (If requesting medical expense reimbursement

21-5655 Financial Status Report (lfrequesting an increase)

21-4185 Farm and Business (Rental) Income Report (If Needed)

21-0849 Use when the claimant has> $80,000 in assets (*)

(*)maybe needed for Veteran filing and/or widow(er) filing

CHECKLIST

APPLICTION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

Serving the Dickinson County Area 800 Crystal Lake Blvd., Suite 100
Iron Mountain, MI 49801
PH: (906) 774-2820 FAX: (906) 774-0051

What I need to complete your application:

___ 21-0799 (Completed by Assisted Living)

___ 21-2680 (Completed by Physician)

___ Attendant Affidavit (Completed by Assisted Living)

___ Recurring Medical Bills -- including insurance

___ Social Security and Income Statement

--- Power of Attorney

--- Copies of Checking/Saving Statements

__ DD-214

___ Marriage Certificate

- - - Award Letter

_____ Birth Certificate(s)

- - - Death Certificate

_____ Checking account Nr

_____ Bank Routing Number

_____ Other

_____

_____

_____

_____

Fax the documents to (906) 774-0051
Use your Last name and claim docs in the subject line.

VA FORM 21P-534EZ

APPLICTION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

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OMB Control No. 2900-0004
Respondent Burden: 40 minutes
Expiration Date: 07/31/2025

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 18. Use this form to submit a claim for DIC, Survivors Pension, and/or Accrued Benefits. For additional information or questions contact us online at https://www.va.gov/contact-us or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms. If submitting by mail, send completed form to: **Department of Veterans Affairs, Pension Intake Center, P.O. Box 5365, Janesville, WI 53547-5365**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

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

1A. VETERAN'S NAME (First, Middle Initial, Last): Joe Smith

1B. VETERAN'S SOCIAL SECURITY NUMBER: 123-45-6789

1C. VETERAN'S DATE OF BIRTH (MM/DD/YYYY): 01/01/1900

1D. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA? ○ YES ◉ NO (If "YES," provide the file number in Item 1E)

1E. VA FILE NUMBER (If known):

1F. DID THE VETERAN DIE WHILE ON ACTIVE DUTY? ○ YES ◉ NO

1G. VETERAN'S SERVICE NUMBER:

1H. VETERAN'S DATE OF DEATH? (MM/DD/YYYY): 01/01/2000

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION *(MUST COMPLETE)*

2A. YOUR NAME (First, Middle Initial, Last): Betty Smith

2B. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)
◉ SURVIVING SPOUSE ○ CHILD 18-23 IN SCHOOL ○ CUSTODIAN FILING FOR CHILD UNDER 18 ○ HELPLESS ADULT CHILD

2C. YOUR SOCIAL SECURITY NUMBER: 123-45-6789

2D. YOUR DATE OF BIRTH (MM/DD/YYYY): 01/01/1900

2E. ARE YOU A VETERAN? ○ YES ◉ NO

2F. MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)
No. & Street: 12345 Happy Lane
Apt./Unit Number:
City: Happy Town
State/Province: MI
Country:
ZIP Code/Postal Code: 12345

2G. YOUR TELEPHONE NUMBER (Include Area Code): 123-456-7890 Enter International Phone Number (If applicable):

2H. E-MAIL ADDRESS (Optional):

2I. WHAT ARE YOU CLAIMING? (Check all that apply)
○ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ○ SURVIVORS PENSION ○ ACCRUED BENEFITS

SECTION III: VETERAN'S SERVICE INFORMATION
(Skip to Section IV if the veteran was receiving VA compensation or pension benefits at the time of their death)

NOTE: Please refer to instructions page 4, Military Service Verification for more information pertaining to service information and relevant documents.

3A. DID THE VETERAN SERVE UNDER ANOTHER NAME? ○ YES ◉ NO (If "YES," list other names the veteran served under below)

SECTION III: VETERAN'S SERVICE INFORMATION (Continued)

3B. DATE VETERAN ENTERED ACTIVE DUTY (MM/DD/YYYY): 01/01/1920

3C. DATE VETERAN RELEASED FROM ACTIVE DUTY (MM/DD/YYYY): 01/01/1950

3D. BRANCH OF SERVICE
◉ ARMY ○ NAVY ○ AIR FORCE ○ MARINE CORPS
○ COAST GUARD ○ SPACE FORCE ○ NOAA ○ USPHS

3E. PLACE OF LAST SEPARATION:

3F. WAS THE VETERAN ACTIVATED TO FEDERAL/ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. (National Guard)
○ YES ◉ NO (If "NO," skip to Item 3J)

3G. DATE OF ACTIVATION (MM/DD/YYYY):

3H. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

3I. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

3J. WAS THE VETERAN EVER A PRISONER OF WAR? ○ YES ◉ NO (If "NO," skip to Section IV)

3K. DATES OF CONFINEMENT (MM/DD/YYYY)
START:
END:

SECTION IV: MARITAL INFORMATION
(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)
(Skip to Section VI if you are NOT claiming benefits as the surviving spouse of the veteran)

TELL US ABOUT YOUR MARRIAGE TO THE VETERAN

4A. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID? ○ YES ◉ NO (If "YES," provide explanation below)

4B. WERE YOU MARRIED TO THE VETERAN AT THE TIME OF THE VETERAN'S DEATH? ◉ YES ○ NO (If "NO," complete Item 4C)

4C. HOW DID YOUR MARRIAGE TO THE VETERAN END? ◉ DEATH ○ DIVORCE ○ OTHER (Explain)

4D. DATES OF YOUR MARRIAGE TO THE VETERAN (MM/DD/YYYY)
START: 01/01/1920
END: 01/01/2000

4E. PLACE OF MARRIAGE (City/State or Country): Happy Town, MI

4F. PLACE OF MARRIAGE TERMINATION (City/State or Country): Happy Town, MI

4G. TYPE OF MARRIAGE (Ceremonial, Common-Law, Proxy, Tribal, etc.)
◉ CEREMONIAL ○ OTHER (Explain):

4H. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE? ◉ YES ○ NO

4I. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD? ○ YES ◉ NO

4J. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF THE VETERAN'S DEATH? ◉ YES ○ NO (If "YES," skip to Item 4L)

4K. WAS THE SEPARATION DUE TO MARITAL DISCORD, MEDICAL, OR FINANCIAL REASONS? ○ YES ○ NO (If "YES," provide explanation in space provided)
NOTE: Give, the reason, date(s), and duration of the separation *(if the separation was by court order, attach a copy of the order)*

TELL US ABOUT YOUR REMARRIAGE AFTER THE VETERAN'S DEATH

4L. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN? ○ YES ◉ NO (If "NO," skip to Item 5A)

4M. WHAT ARE THE DATES OF YOUR REMARRIAGE? (MM/DD/YYYY)
START:
END:

4N. HOW DID YOUR REMARRIAGE END? ○ DEATH ○ DIVORCE ○ DID NOT END ○ OTHER (Explain)

4O. DID YOU HAVE ADDITIONAL MARRIAGES AFTER THE VETERAN'S DEATH? ○ YES ○ NO (If "YES," please submit a VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for each marriage)

VA FORM 21P-534EZ

APPLICTION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

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VETERAN'S SOCIAL SECURITY NUMBER 1 2 3 – 4 5 – 6 7 8 9

SECTION V: MARITAL HISTORY

TELL US ABOUT ANY OTHER MARRIAGES YOU AND/OR THE VETERAN HAD. IF YOU AND THE VETERAN DID NOT HAVE ANY ADDITIONAL MARRIAGES SKIP TO SECTION VI.

VETERAN'S PRIOR MARRIAGES (If none skip to Item 5L)

5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: / / END: / /

5D. PLACE OF MARRIAGE (City/State or Country)

5E. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: / / END: / /

5I. PLACE OF MARRIAGE (City/State or Country)

5J. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
○ YES ○ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN (If none skip to Section VI)

5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5M. HOW DID YOUR PREVIOUS MARRIAGE END?
○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: / / END: / /

5O. PLACE OF MARRIAGE (City/State or Country)

5P. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5R. HOW DID YOUR PREVIOUS MARRIAGE END?
○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: / / END: / /

5T. PLACE OF MARRIAGE (City/State or Country)

5U. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?
○ YES ○ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

VETERAN'S SOCIAL SECURITY NUMBER 1 2 3 – 4 5 – 6 7 8 9

SECTION V: MARITAL HISTORY

TELL US ABOUT ANY OTHER MARRIAGES YOU AND/OR THE VETERAN HAD. IF YOU AND THE VETERAN DID NOT HAVE ANY ADDITIONAL MARRIAGES SKIP TO SECTION VI.

VETERAN'S PRIOR MARRIAGES (If none skip to Item 5L)

5A. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5B. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5C. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: / / END: / /

5D. PLACE OF MARRIAGE (City/State or Country)

5E. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5F. NAME OF PERSON VETERAN WAS PREVIOUSLY MARRIED TO (First, Middle Initial, Last)

5G. HOW DID THE VETERAN'S PREVIOUS MARRIAGE END?
○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5H. WHAT ARE THE DATES OF THE VETERAN'S PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: / / END: / /

5I. PLACE OF MARRIAGE (City/State or Country)

5J. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5K. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT FOR THE VETERAN?
○ YES ○ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

TELL US ABOUT YOUR MARRIAGES PRIOR TO MARRYING THE VETERAN (If none skip to Section VI)

5L. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5M. HOW DID YOUR PREVIOUS MARRIAGE END?
○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5N. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: / / END: / /

5O. PLACE OF MARRIAGE (City/State or Country)

5P. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5Q. NAME OF PERSON YOU WERE MARRIED TO PRIOR TO MARRYING THE VETERAN (First, Middle Initial, Last)

5R. HOW DID YOUR PREVIOUS MARRIAGE END?
○ DEATH ○ DIVORCE ○ OTHER (Explain below)

5S. WHAT ARE THE DATES OF YOUR PREVIOUS MARRIAGE? (MM/DD/YYYY)
START: / / END: / /

5T. PLACE OF MARRIAGE (City/State or Country)

5U. PLACE OF MARRIAGE TERMINATION (City/State or Country)

5V. DO YOU HAVE ADDITIONAL MARRIAGES TO REPORT?
○ YES ○ NO (If "YES," please submit a VA Form 21-686c, *Application to Request to Add And/Or Remove Dependents*, or VA Form 21-4138, *Statement in Support of Claim*, as needed to provide the information for additional marital history)

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VA FORM 21P-534EZ

APPLICTION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

14

VETERAN'S SOCIAL SECURITY NUMBER 1 2 3 – 4 5 – 6 7 8 9

SECTION VII: DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Skip to Section VIII if you are NOT claiming DIC)

7A. WHAT BENEFIT ARE YOU CLAIMING? (Check one)

(•) DIC ( ) DIC under 38 U.S.C. 1151 (**Note**: DIC under 38 U.S.C. 1151 is a rare benefit. Please refer to Instructions page 5 for guidance on 38 U.S.C 1151) ( ) DIC due to claimant election of a re-evaluation of a previously denied claim based on expanded eligibility under PL 117-168 (PACT Act) (**Note**: Please refer to Instructions page 6 for guidance on PACT Act)

7B. LIST ANY VA MEDICAL CENTERS WHERE THE VETERAN RECEIVED TREATMENT PERTAINING TO YOUR CLAIM AND PROVIDE TREATMENT DATES.

NAME AND LOCATION OF VA MEDICAL CENTER	DATE(S) OF TREATMENT (MM/DD/YYYY)
VA Happy Day, Happy Town, MI	START: 01/01/1920 END: 01/01/2000
	START: END:
	START: END:

SECTION VIII: NURSING HOME OR INCREASED SURVIVORS ENTITLEMENT

8A. ARE YOU CLAIMING SPECIAL MONTHLY PENSION OR SPECIAL MONTHLY DIC BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE GENERALLY CONFINED TO YOUR IMMEDIATE PREMISES?

( ) YES (•) NO (If "YES," please complete a VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistant (PA)*, Certified Nurse Practitioner (CNP/CRNP), or Clinical Nurse Specialist (CNS))

8B. ARE YOU NOW IN A NURSING HOME?

( ) YES (•) NO (If "YES," complete VA Form 21-0779, *Request for Nursing Home Information in Connection with Claim for Aid and Attendance*. For additional information see Instructions, page 6 under "Increased Survivor Benefits Based on Special Monthly Pension or Special Monthly DIC") (If "NO," skip to Item 9A)

SECTION IX: INCOME AND ASSETS
(Skip to Section X if you are NOT claiming survivors pension benefits)

NOTE: **Assets** are all the money and property you or your dependents own. Assets **do not** include your/your family's primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation.

IMPORTANT:
- If you are a surviving spouse claimant, you must report income and assets for yourself and for any child of the veteran who lives with you or for whom you are responsible unless a court has decided you do not have custody of the child.
- If you are a surviving child claimant (which means the child is not in the custody of a surviving spouse), you must report income and assets for yourself, your custodian, and your custodian's spouse.

9A. DO YOU OR YOUR DEPENDENTS HAVE OVER $25,000.00 IN ASSETS? (NOT INCLUDING THE VALUE OF YOUR PRIMARY RESIDENCE)

( ) YES (•) NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC)*)

(If "No," provide an estimate of the total value of your assets below)

$, .

9B. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving assets away, selling assets, purchasing an annuity, or using assets to establish a trust)

( ) YES (•) NO (If "YES," please submit a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parent's Dependency and Indemnity Compensation (DIC)*)

9C. DO YOU OR YOUR DEPENDENTS OWN YOUR/YOUR FAMILY'S PRIMARY RESIDENCE?

(•) YES ( ) NO (If "NO," skip to Item 9G)

9D. IS THE VALUE OF THE LOT ON WHICH THE PRIMARY RESIDENCE SITS OVER 2 ACRES (87,120 SQ FT)?

( ) YES (•) NO (If "NO," skip to Item 9G)

9E. IF PRIMARY RESIDENCE SITS ON A LOT OVER 2 ACRES (87,120 SQ FT), WHAT IS THE VALUE OF THE LAND OVER 2 ACRES? (Do **NOT** include the value of the residence or the first 2 acres)

$, .

9F. IS THE LAND OVER 2 ACRES (87,120 SQ FT) MARKETABLE?

( ) YES ( ) NO (If "YES," please submit a VA Form 21P-0969)

9G. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN FOUR (4) SOURCES OF INCOME?

( ) YES (•) NO (If "YES," please submit a VA Form 21P-0969, and ONLY report your Social Security income in Item 9I)

9H. OTHER THAN SOCIAL SECURITY, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR THAT YOU NO LONGER RECEIVE?

( ) YES (•) NO (If "YES," please submit a VA Form 21P-0969)

VETERAN'S SOCIAL SECURITY NUMBER 1 2 3 – 4 5 – 6 7 8 9

SECTION IX: INCOME AND ASSETS (CONTINUED)
(Skip to Section X if you are not claiming survivors pension benefits)

Please use the space below to report any income you currently receive.

IMPORTANT: If you have been directed to complete a VA Form 21P-0969, *Income and Asset Statement in Support of Claim for Pension or Parents' DIC*, in previous Items 9A through 9H, VA only requires that Social Security income be reported below in Items 9I through 9L. All other income should be reported on the VA Form 21P-0969 and will be counted as reported, **do not** duplicate.

NOTE: Gross income is defined as any income you received prior to deductions. If reporting income in Items 9I through 9L, any items skipped or left blank will be considered as unspecified income and could require a request for additional information potentially delaying your claim. If you leave entire question blank we will assume you have no income to report.

NO.	(1) WHO IS THE INCOME RECIPIENT?	(2) WHAT IS THE TYPE/SOURCE OF INCOME?	(3) WHAT IS THE CURRENT GROSS MONTHLY INCOME?
9I	(•) SURVIVING SPOUSE ( ) CHILD (Provide name below)	(•) SOCIAL SECURITY ( ) PENSION/RETIREMENT ( ) CIVIL SERVICE ( ) INTEREST/DIVIDENDS ( ) OTHER (Specify Source i.e., inheritance, etc.)	$ 001,500.00
9J	( ) SURVIVING SPOUSE ( ) CHILD (Provide name below)	( ) SOCIAL SECURITY ( ) PENSION/RETIREMENT ( ) CIVIL SERVICE ( ) INTEREST/DIVIDENDS ( ) OTHER (Specify Source i.e., inheritance, etc.)	$, .
9K	( ) SURVIVING SPOUSE ( ) CHILD (Provide name below)	( ) SOCIAL SECURITY ( ) PENSION/RETIREMENT ( ) CIVIL SERVICE ( ) INTEREST/DIVIDENDS ( ) OTHER (Specify Source i.e., inheritance, etc.)	$, .
9L	( ) SURVIVING SPOUSE ( ) CHILD (Provide name below)	( ) SOCIAL SECURITY ( ) PENSION/RETIREMENT ( ) CIVIL SERVICE ( ) INTEREST/DIVIDENDS ( ) OTHER (Specify Source i.e., inheritance, etc.)	$, .

SECTION X: INFORMATION ABOUT YOUR MEDICAL OR OTHER EXPENSES

Family medical expenses and certain other expenses you actually paid may be deductible from your income. Show the amount of unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid.

Last illness and burial expenses are unreimbursed amounts you paid for the last illness and burial of a spouse or child, educational or vocational rehabilitation expenses are amounts you paid for courses of education including tuition, fees, and materials. Do not include any expenses for which you were/will be reimbursed. Please make sure to complete all criteria below (if applicable). If you need more space, complete and attach a separate VA Form 21P-8416, *Medical Expense Report*.

IMPORTANT: Out of pocket expenses paid by you or a VA-approved dependent may be claimed. Do **NOT** include expenses paid by other family members, insurance, etc.

10A. ARE YOU OR YOUR DEPENDENTS CLAIMING UNREIMBURSED MEDICAL EXPENSES OR OTHER EXPENSES?

(•) YES ( ) NO (If "NO," skip to Section XI)

IN-HOME CARE OR CARE FACILITY

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10B (1). WHOSE EXPENSES WERE PAID?
(•) SURVIVING SPOUSE
( ) OTHER (Specify below)

10B (2). NAME OF PROVIDER AND TYPE OF CARE
Happy In Home Care
CHECK ONE:
( ) CARE FACILITY (•) IN-HOME CARE ATTENDENT

10B (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
Payment Rate (Per Hour) $ 025 .00
Hours Worked (Per Week) 015

10B (4). PROVIDER START AND END DATE (MM/DD/YYYY)
START: 01/01/1950
END:
(•) NO END DATE

10B (5). PAYMENT FREQUENCY
(•) MONTHLY ( ) ANNUALLY

10B (6). AMOUNT YOU PAY (Based on frequency selected in Item 10B (5))
$ 001,500.00

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APPLICTION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS

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IN-HOME CARE OR CARE FACILITY (Continued)

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 19 and 20 for each provider.

10C (1). WHOSE EXPENSES WERE PAID?	10C (2). NAME OF PROVIDER AND TYPE OF CARE	10C (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
○ SURVIVING SPOUSE ○ OTHER (Specify below)	CHECK ONE: ○ CARE FACILITY ○ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $ .00 Hours Worked (Per Week)
10C (4). PROVIDER START AND END DATE (MM/DD/YYYY)	**10C (5). PAYMENT FREQUENCY**	**10C (6). AMOUNT YOU PAY (Based on frequency selected in Item 10C (5))**
START: / / END: / / ○ NO END DATE	○ MONTHLY ○ ANNUALLY	$, .

10D (1). WHOSE EXPENSES WERE PAID?	10D (2). NAME OF PROVIDER AND TYPE OF CARE	10D (3). IF THIS IS AN IN-HOME CARE PROVIDER WHAT IS THE:
○ SURVIVING SPOUSE ○ OTHER (Specify below)	CHECK ONE: ○ CARE FACILITY ○ IN-HOME CARE ATTENDENT	Payment Rate (Per Hour) $ .00 Hours Worked (Per Week)
10D (4). PROVIDER START AND END DATE (MM/DD/YYYY)	**10D (5). PAYMENT FREQUENCY**	**10D (6). AMOUNT YOU PAY (Based on frequency selected in Item 10D (5))**
START: / / END: / / ○ NO END DATE	○ MONTHLY ○ ANNUALLY	$, .

OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES

10E (1). WHOSE EXPENSES WERE PAID? (Check one)	10E (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
○ SURVIVING SPOUSE ○ CHILD (Specify below)	Provider: Purpose:
10E (3). DATE COSTS INCURRED (MM/DD/YYYY)	**10E (4). PAYMENT FREQUENCY**	**10E (5). AMOUNT YOU PAY (Based on frequency selected in Item 10E (4))**
/ /	○ MONTHLY ○ ANNUALLY ○ ONE-TIME	$, .

10F (1). WHOSE EXPENSES WERE PAID? (Check one)	10F (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
○ SURVIVING SPOUSE ○ CHILD (Specify below)	Provider: Purpose:
10F (3). DATE COSTS INCURRED (MM/DD/YYYY)	**10F (4). PAYMENT FREQUENCY**	**10F (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4))**
/ /	○ MONTHLY ○ ANNUALLY ○ ONE-TIME	$, .

10G (1). WHOSE EXPENSES WERE PAID? (Check one)	10G (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
○ SURVIVING SPOUSE ○ CHILD (Specify below)	Provider: Purpose:
10G (3). DATE COSTS INCURRED (MM/DD/YYYY)	**10G (4). PAYMENT FREQUENCY**	**10G (5). AMOUNT YOU PAY (Based on frequency selected in Item 10G (4))**
/ /	○ MONTHLY ○ ANNUALLY ○ ONE-TIME	$, .

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OTHER MEDICAL, LAST, AND/OR BURIAL EXPENSES (Continued)

10H (1). WHOSE EXPENSES WERE PAID? (Check one)	10H (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
○ SURVIVING SPOUSE ○ CHILD (Specify below)	Provider: Purpose:
10H (3). DATE COSTS INCURRED (MM/DD/YYYY)	**10H (4). PAYMENT FREQUENCY**	**10H (5). AMOUNT YOU PAY (Based on frequency selected in Item 10H (4))**
/ /	○ MONTHLY ○ ANNUALLY ○ ONE-TIME	$, .

10I (1). WHOSE EXPENSES WERE PAID? (Check one)	10I (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
○ SURVIVING SPOUSE ○ CHILD (Specify below)	Provider: Purpose:
10I (3). DATE COSTS INCURRED (MM/DD/YYYY)	**10I (4). PAYMENT FREQUENCY**	**10I (5). AMOUNT YOU PAY (Based on frequency selected in Item 10F (4))**
/ /	○ MONTHLY ○ ANNUALLY ○ ONE-TIME	$, .

10J (1). WHOSE EXPENSES WERE PAID? (Check one)	10J (2). PAID TO (Name of Provider, Insurance company, etc.) AND PURPOSE (Insurance premium, medical supplies, etc.)
○ SURVIVING SPOUSE ○ CHILD (Specify below)	Provider: Purpose:
10J (3). DATE COSTS INCURRED (MM/DD/YYYY)	**10J (4). PAYMENT FREQUENCY**	**10J (5). AMOUNT YOU PAY (Based on frequency selected in Item 10J (4))**
/ /	○ MONTHLY ○ ANNUALLY ○ ONE-TIME	$, .

SECTION XI: DIRECT DEPOSIT INFORMATION (MUST COMPLETE)

The Department of Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, **and** attach either a voided personal check **or** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

11A. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	11B. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)
H a p p y S a v i n g D a y	1 2 3 4 5 6 7 8 9

11C. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

● CHECKING ○ SAVINGS ○ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No.: 9 8 7 6 5 4 3 2 1 1 2 3 4 5 6

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE)

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me except protected health information, and I waive any privilege which makes the information confidential.

I certify I have received the notice attached to this application titled ***Notice to Survivor of Evidence Necessary to Substantiate a Claim for Dependency Indemnity Compensation, Death Pension, and/or Accrued Benefits.***

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility, such as a VA medical center; **OR,** I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 12A, indicating that I **DO NOT** want my claim considered for rapid processing in the Fully Developed Claim (FDC) Program because I plan to submit further evidence in support of my claim.

12A. The FDC Program is designed to rapidly process compensation or pension claims received with the evidence necessary to decide the claim. VA will *automatically* consider a claim submitted on this form for rapid processing under the FDC Program. Check the below box **ONLY if you DO NOT want your claim considered for rapid processing** under the FDC Program because you plan to submit further evidence in support of your claim.

○ **I DO NOT want my claim considered for paid processing** under the FDC Program because I plan to submit further evidence in support of my claim.

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VETERAN'S SOCIAL SECURITY NUMBER 1 2 3 – 4 5 – 6 7 8 9

SECTION XII: CLAIM CERTIFICATION AND SIGNATURE (MUST COMPLETE) (Continued)

12B. CLAIMANT'S SIGNATURE **OR** MARK WITH AN "X" IF UNABLE TO SIGN **(REQUIRED)**	12C. DATE SIGNED (MM/DD/YYYY)
	/ /

SECTION XIII: WITNESSES TO SIGNATURE
(TWO (2) WITNESS SIGNATURES ARE REQUIRED ONLY IF ITEM 12B IS SIGNED WITH AN "X")

13A. SIGNATURE OF WITNESS (Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12B using an "X")	13B. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:
13C. SIGNATURE OF WITNESS (Sign in **INK**) (**NOTE**: Only sign if claimant signed in Item 12B using an "X")	13D. PRINTED NAME AND ADDRESS OF WITNESS Name: Address:

SECTION XIV: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(NOTE: REQUIRED ONLY IF ITEM 12B IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

14A. ALTERNATE SIGNER SIGNATURE	14B. DATE SIGNED (MM/DD/YYYY)
	/ /

PRIVACY ACT NOTICE: The form will be used to determine allowance to pension benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. Your response is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for pension. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 40 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

5. WHAT IS THE FACILITY TELEPHONE NUMBER? – – International Phone Number (If applicable) _____

6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?
   No. & Street
   Apt./Unit Number City
   State/Province Country ZIP Code –

7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.
   ○ A. EATING ○ B. BATHING/SHOWERING ○ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
   ○ D. DRESSING ○ E. USING THE TOILET ○ F. AMBULATING WITHIN HOME OR LIVING AREA

9. FOR EACH STATEMENT BELOW PLEASE CHECK THE BOX IF THIS STATEMENT IS TRUE FOR THE FACILITY:
   ○ THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED
   ○ THE FACILITY IS LICENSED
   ○ THE FACILITY IS RESIDENTIAL
   ○ THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH.
(Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)
   ○ YES ○ NO, Care is being provided by a third-party provider. ○ NO, Care is not being provided to this claimant.
   If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY)	12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.)
/ /	/ / ○ INDEFINITE

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.
   $ . . PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)	15. DATE SIGNED (MM/DD/YYYY)
	/ /

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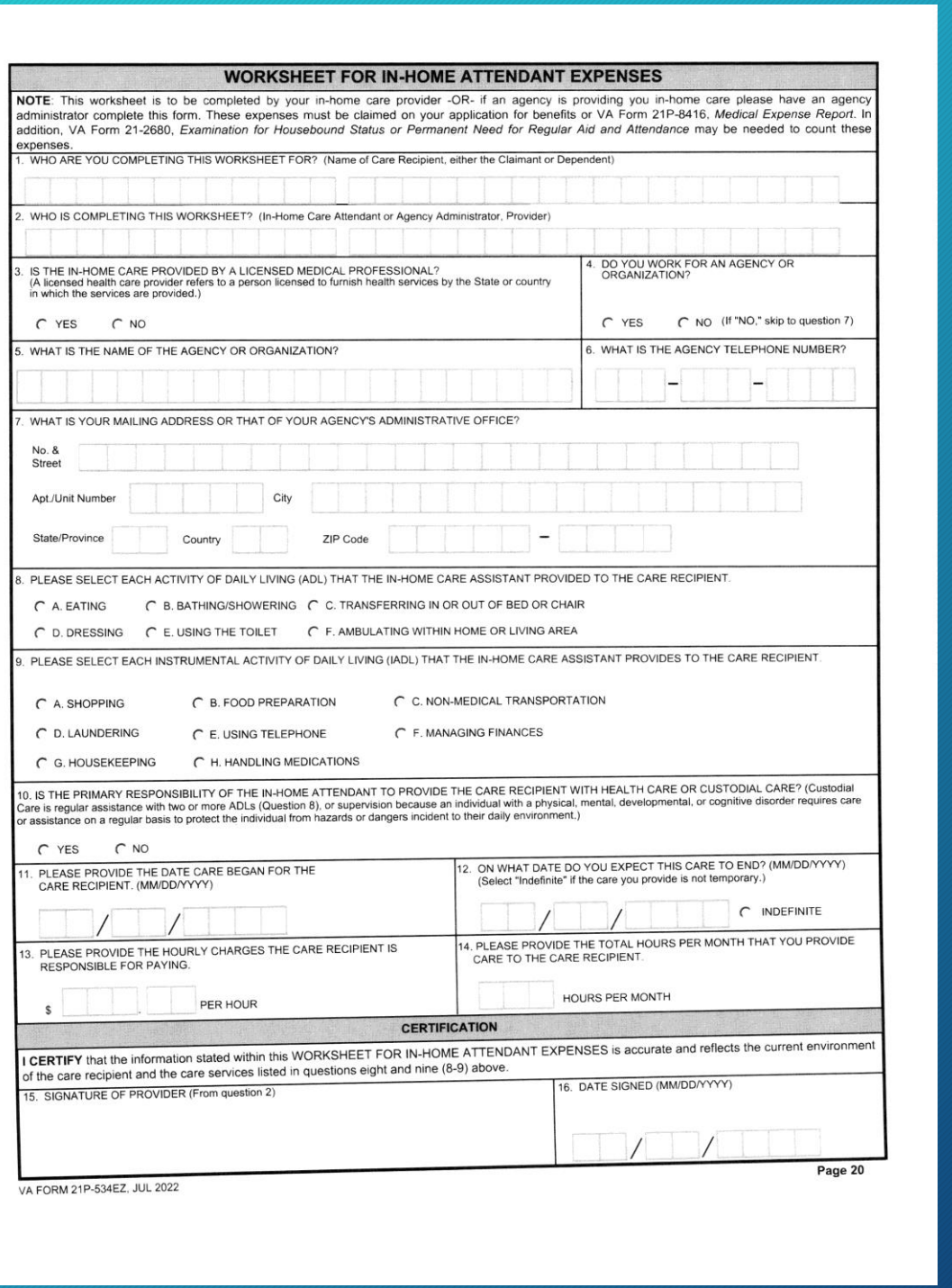
APPLICTION FOR DIC, SURVIVORS PENSION, AND/OR ACCRUED BENEFITS



WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency Administrator, Provider)

3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL? (A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)
○ YES ○ NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?
○ YES ○ NO (If "NO," skip to question 7)

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

6. WHAT IS THE AGENCY TELEPHONE NUMBER?
– –

7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?
No. & Street
Apt./Unit Number City
State/Province Country ZIP Code –

8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.
○ A. EATING ○ B. BATHING/SHOWERING ○ C. TRANSFERRING IN OR OUT OF BED OR CHAIR
○ D. DRESSING ○ E. USING THE TOILET ○ F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.
○ A. SHOPPING ○ B. FOOD PREPARATION ○ C. NON-MEDICAL TRANSPORTATION
○ D. LAUNDERING ○ E. USING TELEPHONE ○ F. MANAGING FINANCES
○ G. HOUSEKEEPING ○ H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)
○ YES ○ NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. (MM/DD/YYYY)
/ /

12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.)
/ / ○ INDEFINITE

13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.
$. PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.
HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)
/ /

VA FORM 21-0845

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

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OMB Approved No. 2900-0736
Respondent Burden: 5 minutes
Expiration Date: 02/28/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

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

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

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

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

2. VETERAN'S SOCIAL SECURITY NUMBER — 3. VA FILE NUMBER *(If known)* — 4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*

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

SECTION II - BENEFICIARY/CLAIMANT'S IDENTIFICATION INFORMATION

6. NAME OF BENEFICIARY/CLAIMANT WHO IS ***NOT*** THE VETERAN *(First, Middle Initial, Last)*

7. ADDRESS OF BENEFICIARY/CLAIMANT *(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

8. TELEPHONE NUMBER *(Include Area Code)* — Enter International Phone Number *(If applicable)*

9. EMAIL ADDRESS *(Optional)* ☐ I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III - CONTACT INFORMATION

10. VA IS AUTHORIZED TO DISCLOSE THE INFORMATION SPECIFIED BELOW TO ONE PERSON ***OR*** ONE ORGANIZATION LISTED BELOW. PROVIDE THE NAME AND ADDRESS OF THE PERSON YOU HAVE CHOSEN TO RECEIVE INFORMATION FROM VA IN ITEMS 10A AND 10B ***OR*** PROVIDE THE NAME AND ADDRESS OF THE ORGANIZATION YOU HAVE CHOSEN AND THE NAME OF THE ORGANIZATION'S REPRESENTATIVE IN ITEMS 10C AND 10D.

A. NAME OF PERSON *(First, Middle Initial, Last Name)*

B. ADDRESS OF PERSON

No. & Street

Apt./Unit Number — City

State/Province — Country — ZIP Code/Postal Code

NOTE: An organization may have more than one representative. Include the first and last name of any additional representatives.

C. NAME OF ORGANIZATION *(Include name of representative(s))*

D. ADDRESS OF ORGANIZATION

No. & Street

Apt./Unit Number — City

State/Province — Country — ZIP Code/Postal Code

VETERAN'S SSN

11. I, THE BENEFICIARY/CLAIMANT AUTHORIZE VA TO CONTACT THE PERSON ***OR*** ORGANIZATION LISTED IN ITEM 10A OR 10C FOR THE PURPOSE OF PROVIDING THE FOLLOWING INFORMATION PERTAINING TO MY VA RECORD *(Check only one box below to tell VA the specific benefit or claim information you want disclosed)*

☐ LIMITED INFORMATION *(Go to Item 12)* ☐ ANY INFORMATION *(Go to Item 13)*

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

☐ Status of pending claim or appeal ☐ Amount of money owed VA ☐ Current benefit and rate

☐ Request a benefit payment letter ☐ Payment history ☐ Change of address or direct deposit

☐ Other *(Specify below)*:

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

☐ One time only ☐ Ongoing until written notice is given to VA to terminate

☐ From the date of signing below until *(Specify Date (MM/DD/YYYY))*:

14. SPECIFY THE SECURITY QUESTION YOU WANT USED WHEN VERIFYING THE IDENTITY OF YOUR DESIGNATED THIRD PARTY. CHECK ONLY ***ONE*** SECURITY QUESTION BOX IN ITEM 14A AND PROVIDE THE ANSWER IN ITEM 14B.

A. SECURITY QUESTION	B. ANSWER
☐ The city and state your mother was born in	
☐ The name of the high school you attended	
☐ Your first pet's name	
☐ Your favorite teacher's name	
☐ Your father's middle name	

SECTION IV - DECLARATION OF INTENT

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

15. CLAIMANT/BENEFICIARY SIGNATURE *(REQUIRED)*

16. DATE SIGNED *(MM/DD/YYYY)*

PRIVACY ACT INFORMATION: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

RESPONDENT BURDEN: We need this information to release your private benefit and/or claim information to a designated third party(ies). The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form will authorize release of the information you specify. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.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.

VA FORM 21P-0969

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

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Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Attachment to VA Forms 21P-527, 21P-527EZ, 21P-534, and 21P-534EZ)

IMPORTANT: This *is not* a stand-alone form. Only complete this attachment if you are directed to do so when you complete *one* of the following:
(1) Section VI on VA Form 21P-527 or Section VIII on VA Form 21P-527EZ.
(2) Section VII on VA Form 21P-534 or Section VIII on VA Form 21P-534EZ.

VETERAN/CLAIMANT PERSONAL INFORMATION

1. VETERAN'S NAME *(Last, First, Middle)*	2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S FILE NUMBER *(If known)*
4. CLAIMANT'S NAME *(Last, First, Middle)*	5. CLAIMANT'S SOCIAL SECURITY NUMBER	6. CLAIMANT'S TELEPHONE NUMBER

7. TYPE OF CLAIMANT *(Check only one box)*
☐ VETERAN ☐ SURVIVING SPOUSE ☐ SURVIVING CHILD ☐ PARENT

IMPORTANT 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 dependent's primary residence including the residential lot area, not to exceed 2 acres) less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. Personal property means the value of personal effects that are in excess of being suitable and consistent with a reasonable mode of life.

If you are a **Veteran**, you must report income and 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
- any child of the veteran who is in your custody*

If you are a **Surviving Child** or the **Custodian of a Surviving Child**, you must report income and assets for the:
- 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 must *both* file 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 age 18 unless custody is legally removed.

** Parent's DIC claimants do *not* need to *report* or *provide* documentation of their assets.

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.

NOTICE

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 25 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at: www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Control No. 2900-0829
Respondent Burden: 25 minutes
Expiration Date: 12/31/2024

Department of Veterans Affairs

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENTS' DEPENDENCY AND INDEMNITY COMPENSATION (DIC)
(Attachment to VA Forms 21P- 527, 21P-527EZ, 21P-534, and 21P-534EZ)

SECTION I: RETIREMENT INCOME AND DISTRIBUTIONS ***(If additional space is needed attach a separate sheet)***

1. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE ANY INCOME IN THE NEXT 12 MONTHS INCLUDING, BUT NOT LIMITED TO, DISTRIBUTIONS FROM A RETIREMENT PLAN, SUCH AS:

- Military Retirement
- Civil Service Retirement
- IRA
- SEP
- Qualified Plans
- Pensions
- Annuities
- Black Lung

☐ YES ☐ NO *(If "No," skip to Section II)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHO IS THE INCOME PAYER? *(Name of business, financial institution, etc.)*	C. WHAT IS YOUR CURRENT AND/OR EXPECTED INCOME? *(Provide documentation of current income and expected income changes)*	D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME? *(Provide documentation of assets)*
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $	
		DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
		DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	

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INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

SECTION II - UNEMPLOYMENT INCOME *(If additional space is needed attach a separate sheet)*

2. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE UNEMPLOYMENT INCOME IN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section III)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED UNEMPLOYMENT INCOME? *(Provide documentation of current income and expected income changes)*
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $

SECTION III - SAVINGS BONDS *(If additional space is needed attach a separate sheet)*

3. DO YOU OR YOUR DEPENDENTS OWN A SAVINGS BOND OR RECEIVE OR EXPECT TO RECEIVE INTEREST FROM A SAVINGS BOND WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section IV)*

A. WHO OWNS THE SAVINGS BOND? *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED ANNUAL INCOME *(interest earned)*? *(Attach a copy of the savings bond)*	C. WHAT IS THE CURRENT FACE VALUE OF THE SAVINGS BOND?
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$
	CURRENT MONTHLY GROSS INCOME $	
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO	
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	$

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INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

SECTION IV - RENTAL PROPERTY, FARM OR BUSINESS INCOME *(If additional space is needed attach a separate sheet)*

4. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INCOME FROM RENTAL PROPERTY, FARM OR BUSINESS WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section V)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT OR EXPECTED INCOME FROM THIS SOURCE? *(Provide documentation of current income and expected income changes)*	C. WHAT KIND OF INCOME IS THIS? *(Check applicable box)*	D. WHAT IS THE VALUE OF YOUR PORTION OF THE PROPERTY, FARM, OR BUSINESS? *(**Note:** Subtract the amount of Mortgages or other encumbrances specific to the property. Provide available documentation)*
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$
	CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	☐ Farm - Submit a completed VA Form 21P-4165 with this application ☐ Rental Property - Submit a completed VA Form 21P-4185 with this application ☐ Business - Submit a completed VA Form 21P-4185 with this application	$

SECTION V - INTEREST, ROYALTIES, AND DIVIDENDS *(If additional space is needed attach a separate sheet)*

5. ARE YOU OR YOUR DEPENDENTS RECEIVING OR EXPECTING TO RECEIVE, INTEREST, DIVIDENDS, OR ROYALTIES WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section VI)*

IMPORTANT: Do ***not*** report income you have already reported in Section III (Savings Bonds) or Section IV (Rental Property, Farm or Business Income).

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHO IS THE INCOME PAYER? *(Name of business, financial institution, etc.)*	C. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED INCOME? *(Provide documentation of current income and expected income changes)*	D. WHAT IS THE TOTAL CASH VALUE OF THE ASSET ASSOCIATED WITH THIS INCOME? *(Provide documentation of assets)*
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	
		CURRENT MONTHLY GROSS INCOME $ DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $	

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INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

SECTION VI - WAGES - INCLUDING SELF-EMPLOYMENT *(If additional space is needed attach a separate sheet)*

6. ARE YOU OR YOUR DEPENDENTS RECEIVING WAGES OR EXPECTING TO RECEIVE WAGES WITHIN THE NEXT 12 MONTHS?

☐ YES ☐ NO *(If "No," skip to Section VII)*

A. WAGE RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHAT ARE YOUR OR YOUR DEPENDENTS CURRENT WAGES AND/OR EXPECTED WAGES? *(Provide documentation of current wages and expected wage changes)*
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $
	CURRENT MONTHLY GROSS INCOME $
	DO YOU EXPECT THIS INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED INCOME AMOUNT $

SECTION VII - DISCONTINUED INCOME IN THE PRIOR TAX YEAR *(If additional space is needed attach a separate sheet)*

7. DID YOU OR YOUR DEPENDENTS RECEIVE INCOME ***LAST YEAR*** THAT IS NO LONGER BEING RECEIVED OR WAS A ONE-TIME PAYMENT?

☐ YES ☐ NO *(If "No," skip to Section VIII)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHO WAS THE INCOME PAYER? *(Name of business, financial institution, etc.)*	C. WHAT WAS THE GROSS ANNUAL AMOUNT REPORTED TO THE IRS?	D. WHEN DID THE INCOME STOP? *(MM/DD/YYYY)*
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	

VA FORM 21P-0969

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

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NOTE: Parent's DIC Claimants Only - You ***do not*** have to complete Sections VIII thru XI. Return to the application form. Your certification, signature and date on the application form applies to this attachment.

Pension Claimants - Continue to complete the attachment.

SECTION VIII - ASSETS PREVIOUSLY NOT REPORTED *(If additional space is needed attach a separate sheet)*

8. DO YOU OR YOUR DEPENDENTS HAVE ASSETS ***NOT*** ALREADY REPORTED, SUCH AS NON-INTEREST-BEARING ACCOUNTS, CASH, STOCKS, BONDS, OR REAL ESTATE?

☐ YES ☐ NO *(If "No," skip to Section IX)*

A. ASSET OWNER *(Veteran, Spouse, Child, Parent, Custodial, etc.)*	B. WHAT IS THE CURRENT CASH VALUE OF THE ASSET? *(Provide a bank or other official statement showing the current value. Do not report assets you have already reported in Sections I through VII)*	C. AMOUNT OWED ON THE ASSET OR AMOUNT MORTGAGED OR OTHERWISE ENCUMBERED? *(Provide documentation of mortgages or other encumbrances)*
	$	$
	$	$
	$	$
	$	$

SECTION IX - ASSET TRANSFERS *(If additional space is needed attach a separate sheet)*

9. IN THE CURRENT YEAR AND/OR PRIOR 3 TAX YEARS, DID YOU OR YOUR DEPENDENTS SELL, CONVEY, TRADE, OR GIVE AWAY ASSETS?

☐ YES ☐ NO *(If "No," skip to Section X)*

A. WHO OWNED THE ASSET? *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER *(Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)*
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER *(Explain below)*	Name: Relationship:	Was the asset transferred for less than fair market value? ☐ YES ☐ NO Was an asset reported to the IRS sold? ☐ YES ☐ NO What was the original purchase price? What was the sale price? What date was the asset sold? *(MM/DD/YYYY)* What was the gain (capital gain, etc.)?
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER *(Explain below)*	Name: Relationship:	Was the asset transferred for less than fair market value? ☐ YES ☐ NO Was an asset reported to the IRS sold? ☐ YES ☐ NO What was the original purchase price? What was the sale price? What date was the asset sold? *(MM/DD/YYYY)* What was the gain (capital gain, etc.)?

SECTION IX: ASSET TRANSFERS *(Continued)*

A. WHO OWNED THE ASSET? *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. HOW WAS THE ASSET TRANSFERRED?	C. WHO DID YOU TRANSFER THE ASSET TO?	D. DETAILS OF THE ASSET TRANSFER *(Provide documentation of the transfer. A transfer for less than fair market value means you disposed of an asset for less than the asset was worth)*
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER *(Explain below)*	Name: Relationship:	Was the asset transferred for less than fair market value? ☐ YES ☐ NO Was an asset reported to the IRS sold? ☐ YES ☐ NO What was the original purchase price? What was the sale price? What date was the asset sold? *(MM/DD/YYYY)* What was the gain (capital gain, etc.)?
	☐ SOLD ☐ CONVEYED ☐ GAVE AWAY ☐ TRADED ☐ OTHER *(Explain below)*	Name: Relationship:	Was the asset transferred for less than fair market value? ☐ YES ☐ NO Was an asset reported to the IRS sold? ☐ YES ☐ NO What was the original purchase price? What was the sale price? What date was the asset sold? *(MM/DD/YYYY)* What was the gain (capital gain, etc.)?

SECTION X: ANNUITIES AND TRUSTS *(Attach a separate sheet if more than one annuity or trust is involved)*

10A. IN THE CURRENT YEAR OR THE PRIOR THREE TAX YEARS, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS TO A TRUST OR PURCHASE AN ANNUITY?

☐ YES ☐ NO *(If "No," skip to Section XI)*

10B. WHAT WAS THE MARKET VALUE OF THE ASSET AT THE TIME OF TRANSFER OR ANNUITY PURCHASE? $

10C. WHAT WAS THE DATE THE ASSET WAS TRANSFERRED? *(MM/DD/YYYY)*

10D. DID YOU PURCHASE AN ANNUITY WITH THE ASSETS?	10E. PROVIDE DATE OF PURCHASE *(MM/DD/YYYY)*	10F. PROVIDE NAME OF PERSON THE ASSET WAS PURCHASED FROM *(First-Middle-Last)*
☐ YES ☐ NO *(If "Yes," complete Items 10E through 10G)*		

10G. PROVIDE TYPE OF ANNUITY PURCHASED *(Give details and attach documentation)*

10H. WERE THE ASSETS USED TO ESTABLISH A TRUST?	10I. PROVIDE TAX NUMBER	10J. PROVIDE DETAILS AND ATTACH DOCUMENTATION
☐ YES ☐ NO *(If "Yes," complete Items 10I through 10J)*		

10K. WAS THE TRUST ESTABLISHED FOR A CHILD OF THE VETERAN WHO WAS INCAPABLE OF SELF-SUPPORT PRIOR TO REACHING AGE 18?

☐ YES ☐ NO

VA FORM 21P-0969

INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

SECTION XI - WAIVER OF RECEIPT OF INCOME *(If additional space is needed attach a separate sheet)*

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

☐ YES ☐ NO *(If "NO," skip this section. This attachment is complete. Return to the application. Your certification, signature and date on the application form applies to this attachment)*

A. INCOME RECIPIENT *(Veteran, Spouse, Child, Parent, Custodian, etc.)*	B. WHAT IS YOUR OR YOUR DEPENDENTS CURRENT AND/OR EXPECTED WAIVED INCOME? *(Provide documentation of income and expected income changes)*
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $
	CURRENT MONTHLY GROSS WAIVED INCOME $
	DO YOU EXPECT THIS WAIVED INCOME TO CHANGE IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
	DATE WAIVED INCOME WILL CHANGE *(MM/DD/YYYY)* AND EXPECTED WAIVED INCOME AMOUNT $

THIS *ATTACHMENT FORM* IS COMPLETE. RETURN TO THE *APPLICATION FORM*. YOUR CERTIFICATION, SIGNATURE AND DATE ON THE APPLICATION FORM APPLIES TO THIS ATTACHMENT.

ANY QUESTIONS

DICKINSON COUNTY OFFICE OF VETERAN AFFAIRS

ACCREDITED COUNTY VETERAN SERVICE OFFICERS

DENISE FORMOLO AND LACEY ELLISON