OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 02/29/2020

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

REQUEST FOR NURSING HOME INFORMATION IN CONNECTION WITH CLAIM FOR AID AND ATTENDANCE

INSTRUCTIONS: If you have any questions about completing this form, call VA toll-free at 1-800-827-1000 (Hearing Impaired TDD federal relay number is 711).

Section I - VETERAN/CLAIMANT'S IDENTIFICATION INFORMATION

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

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

2. VETERAN/CLAIMANT'S SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
Month — Day — Year

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

SECTION II - NURSING HOME INFORMATION

6. NAME OF NURSING HOME

7. ADDRESS OF NURSING HOME *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number City

State/Province Country ZIP Code/Postal Code —

SECTION III - GENERAL INFORMATION *(To be completed by a Nursing Home Official)*

8. DATE ADMITTED TO NURSING HOME *(MM/DD/YYYY)*
Month — Day — Year

9. IS THE NURSING HOME FACILITY MEDICAID OR EQUIVALENT APPROVED?
☐ YES ☐ NO

10. HAS THE PATIENT APPLIED FOR MEDICAID?
☐ YES ☐ NO

11A. IS THE PATIENT COVERED BY MEDICAID OR EQUIVALENT PLAN?
☐ YES ☐ NO *(If "YES," complete Item 11B)*

11B. DATE MEDICAID OR EQUIVALENT PLAN BEGAN
Month — Day — Year

12. MONTHLY AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET
$

13. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: *(Check one)*
☐ SKILLED NURSING CARE ☐ INTERMEDIATE NURSING CARE

14. NURSING HOME OFFICIAL'S NAME *(First and Last) (Please print)*

15. NURSING HOME OFFICIAL'S TITLE *(Please print)*

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

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.

17. SIGNATURE OF NURSING HOME OFFICIAL *(Sign in ink)*

18. DATE SIGNED *(MM,DD,YYYY)*

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

RESPONDENT BURDEN: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

CARE EXPENSE STATEMENT VA File Number: _____

Please note that both the Claimant and the administrator of the facility or care provider must sign and date the last section, or we will not be able to consider these expenses.

Veteran's name: _____

Patient's Name: _____

Name of facility or Care Provider: _____

Phone Number of facility or Care Provider: _____

Address of facility or Care Provider: _____

_____

_____

Date patient entered facility or In-Home care began: _____

Date patient left facility (if applicable): _____

Will the patient need this care indefinitely? Yes_____ No_____

If "NO", when will the care end? _____

Has the patient applied for Medicaid? Yes_____ No_____

Is part of the patient's cost covered by Medicaid, Medicare, or insurance? Yes_____ No_____

When did coverage begin? _____

What monthly amount does the veteran or patient pay from his/her own funds?

Effective date_____ $_____per month

(prior) Effective date_____ $_____per month

FOR NURSING HOME CARE:

Is your facility licensed by the State? Yes_____ No_____

Is your facility Medicaid approved? Yes_____ No_____

Is the patient in your nursing home because of physical or mental disability? Yes_____ No_____

Do you provide either skilled or intermediate level nursing care to the patient? Yes_____ No_____

What was the admitting diagnosis?

_____

_____

FOR OTHER TYPES OF CARE FACILITIES:

Indicate the type of facility in which the claimant resides:

_____Foster Home _____Adult Day Care _____Rest Home _____Group Home

_____Assisted Living _____Independent Living / Retirement Facility

Which of the following services do you provide:

_____Assistance with bathing and/or showering
_____Assistance with dressing
_____Assistance with eating and/or drinking (not including meal preparation)
_____Assistance with mobility (i.e. getting in or out of bed, a chair, etc.)
_____Assistance with personal hygiene needs (I.e. using the toilet, brushing teeth, etc.)

Describe additional medical or nursing services you provide:

_____

_____

_____

We must have the monthly charge broken down into the following two categories:

1. Base Rate $_____per month
   (includes room, meals, laundry, housekeeping, etc.)

2. Medical and Nursing Services: $_____per month

If a 3rd party provides the services listed above, please list their Name, Address, and Phone Number:

Name:_____

Address:_____

_____

Phone Number:_____

IMPORTANT: Please have the 3rd party complete the In-Home Section and sign and date the last section.

FOR IN-HOME CARE, ALSO ANSWER:

Which of the following services do you provide?

_____ Assistance with bathing and/or showering
_____Assistance with dressing
_____Assistance with eating and/or drinking (not including meal preparation)
_____Assistance with mobility (getting in or out of bed, chair, etc.)
_____Assistance with personal hygiene needs (using the toilet, brushing teeth, etc.)

Describe additional medical or nursing services you provide:

_____
_____
_____

Are you a licensed health professional? Yes_____ No_____
(Registered nurse, licensed vocational nurse, or licensed practical nurse)

If "yes" provide your license number: _____

If you charge by the hour, list your hourly rate and number of weekly hours worked:
Weekly Hours: _____ per Hour Rate $_____

SIGNATURES:

I certify that the above statements are true and correct to the best of my knowledge and belief.

_____
Signature of Facility Administrator or Care Provider **Date**

_____
Signature of 3rd Party Contractor (if applicable) **Date**

I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying $_____per month for my care from my own funds.

_____
Signature of Veteran or Beneficiary **Date**

How to complete the Medical Expense Report (VA form 21p-8416)

When itemizing health and medical expenses, you must have an entry in each box of the column. If this is a NEW Claim, you are giving a "snapshot" of ONE month's recurring, predictable, un-reimbursed health and medical expenses. Do not send the VA receipts. If needed, they will ask for them.

Un-reimbursed Medical Expenses(UME) used INITIALLY to qualify:

(1.) ***Medicare Part B and D Premiums*** **- For claimant, or, if married, for both claimant and spouse**

(2.) ***Private Medical Insurance Premiums*** **- For claimant, or, if married, for both claimant and spouse**

(3.) ***Any other health or medical premiums*****, such as Dental, Long Term Care, etc.**

(4.) ***Caregiver Services*** **- costs for in-home care or a care facility, such as assisted living, group home, and adult day care. PLEASE NOTE: if the care facility is an Independent Living Community, there must be paid caregiver services provided and the Doctor's form 21-2680 MUST STATE the Patient needs to live in (Name of Facility) and receive caregiver services. Please give to the Doctor the letter in our packet explaining this requirement. A family member, other than spouse, can be a caregiver. They do not have to be a licensed medical professional, but they do have to be paid. The rate of payment is based upon the normal rates for in-home care in the area. The family member can use the caregiver money to pay the non-medical bills for the claimant, if necessary, such as rent, utilities, phone, food, etc.**
All medical expenses need to be paid from the claimant's account.

(5.) ***Equipment rental cost*****, such as oxygen, insulin, wheelchairs, hospital beds, etc.**

(6.) ***Last Illness and Burial Expenses*** **for the Veteran or Spouse. You need to show the exact dates paid, as these would not be recurring expenses.**

(7.) ***Prescription Drug Co-Pays*** **- most prescriptions are considered to be Non-Recurring and will not be considered as an allowable deduction initially. However, if your monthly drugs are necessary, recurring, and expensive, your doctor can provide a statement indicating the prescriptions are necessary and recurring. You can provide the VA with a print-out from your pharmacy for the past year along with your doctor's statement that they are necessary and recurring.**

Example: 21p-8416 (Itemization of Expenses)

A. Medical Exp.	B. Amount Paid	C. Date Paid	D. Provider Name	For Whom Paid
Medicare Part B	107.90	Monthly	Social Security	Self
Medicare Part D	22.90	Monthly	Silver Script	Self
Private Med Insur	86.00	Monthly	United Health	Self
Assisted Living	3500	Monthly	The Bridges	Self & Spouse
Medicare Part B	104.90	Monthly	Social Security	Spouse

Department of Veterans Affairs

INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

VA may be able to pay you at a higher rate if you identify expenses VA considers allowable. Medical and dental expenses paid by you may be deductible from the income VA counts when determining your benefit entitlement.

In Items 20 and 21 below, identify any medical or dental expenses that you paid for a member of your household (self, spouse, child, etc.) for which you were not reimbursed. Below are examples of expenses you should include, if applicable:

- Hospital expenses
- Doctor's office fees
- Dental fees
- Prescription/non-prescription drug costs
- Vision care costs
- Medical insurance premiums
- Nursing home costs
- Hearing aid costs
- Home health service expenses
- Expenses related to transportation to a hospital, doctor, or other medical facility
- Monthly Medicare deduction

IMPORTANT NOTES

- Do not include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly notify the VA office handling your claim.
- If you are not sure whether a particular expense can be allowed, furnish a complete description of the purposes of the payment. We will let you know if an expense cannot be allowed.
- You may be asked to verify the amounts you actually paid, so keep all receipts or other documentation of payments for at lease 3 years after we make a decision on your medical expense claim. If you are unable to provide documentation of the claimed medical expenses when asked to do so by VA, your benefits may be retroactively reduced or terminated.
- If more space is needed to report expenses, attach a separate sheet of paper with columns corresponding to those on this form. Be sure to write your VA file number on any attachments.

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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits provided under law. 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. 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 whether medical expenses you paid may be used to reduce the amount of income we count in determining eligibility to benefits (38 U.S.C. 1503). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain.** 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. 2900-0161
Respondent Burden: 30 minutes
Expiration Date: 09/30/2017

Department of Veterans Affairs

FOR VA USE ONLY

MEDICAL EXPENSE REPORT

1. FIRST NAME OF VETERAN	2. MIDDLE NAME OF VETERAN	3. LAST NAME OF VETERAN	4. SUFFIX NAME OF VETERAN
5. VETERAN'S SOCIAL SECURITY NO.			6. VA FILE NUMBER
7. FIRST NAME OF CLAIMANT	8. MIDDLE NAME OF CLAIMANT	9. LAST NAME OF CLAIMANT	10. SUFFIX NAME OF CLAIMANT
11. STREET ADDRESS OF CLAIMANT			12. APT. NO.
13. CITY		14. STATE	15. ZIP CODE
16. DAYTIME TELEPHONE NO. OF CLAIMANT *(Include Area Code)*		17. EVENING TELEPHONE NO. OF CLAIMANT *(Include Area Code)*	
18. CHANGE OF ADDRESS *(Check box if address in Items 11-15 is different from last address furnished to VA)* ☐		19. EMAIL ADDRESS OF CLAIMANT *(If applicable)*	

20. ITEMIZATION OF EXPENSES RELATED TO TRANSPORTATION FOR MEDICAL PURPOSES

Report expenses related to transportation to a hospital, doctor, or other medical facility that you paid between the dates _____ and _____. If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates you should report medical expenses.

NOTE: If you claim miles traveled to a medical facility in a personal conveyance (car, motorcycle, other), VA will calculate the allowable expense amount based on the current mileage rate (41.5 cents per mile).

A. MEDICAL FACILITY TO WHICH YOU TRAVELED	B. TOTAL ROUNDTRIP MILES TRAVELED *(Personal conveyance only)*	C. AMOUNT PAID BY YOU *(Taxi, public transportation fares, tolls, parking fees, etc.)*	D. DATE PAID *(Month/Day/Year)*	E. FOR WHOM PAID *(Self, spouse, child)*

IMPORTANT: Be sure to sign this form in Item 22A on the reverse side. Unsigned reports will be returned.

(Continued on Reverse)

21. ITEMIZATION OF MEDICAL EXPENSES

Report medical expenses that you paid between the dates _____ and _____. If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates you should report medical expenses.

A. MEDICAL EXPENSE *(Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)*	B. AMOUNT PAID BY YOU	C. DATE PAID *(Month/Day/Year)*	D. NAME OF PROVIDER *(Name of doctor, dentist, hospital, lab, etc.)*	E. FOR WHOM PAID *(Self, spouse, child)*
MEDICARE (PART B)				
MEDICARE (PART D)				
PRIVATE MEDICAL INSURANCE				

CERTIFICATION: I have not and will not receive reimbursement for these expenses. I certify that the above information is true.

22A. SIGNATURE OF CLAIMANT *(Do NOT print)*	22B. DATE

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