Sumner County Veterans Service Office
355 North Belvedere Drive
Room 114
Gallatin, TN 37066

Thank you for contacting us. Attached are the documents we need for an initial assessment:

- Veteran's DD214
- Marriage Certificate – spouse and veteran must have been married when the veteran died
- Veterans death certificate
- All income and net worth information on the Net worth, Income & expenses worksheet
    - The Pension Rate/Income Limits Document
- If the survivor seeks Homebound or Aid and Attendance portion of the benefit, the VA Form 21-2680 needs to be completed and signed by the survivor's examining physician.

Return these for an assessment, but keep all the paperwork you look at for the worksheet. We will need to file statements from every financial account the survivor has plus these forms for the VA's Wartime Veterans Pension:

- VA Form 21-0966 (Intent to File) and VA Form 21-22 - **completed ASAP**.
- VA Form 21-0845 (Third Party Disclosure) **only required if** you would like us to talk with someone, other than the claimant or veteran, about your claim.
- VA Form 21P-527EZ (Veteran) or 21P-534EZ (Widow) needs to be signed by the veteran/claimant. (Worksheets in back, **if applicable)**.
- The Medical Expense Report (VA Form 21P-8416) is used to list the out of pocket medical expenses for the veteran or claimant.
- Spouse information: Full name, Date of birth, Social Security Number,
- Previous marriage(s) information for BOTH vet and spouse:
    - Full name(s)
    - Date and location of marriage
    - Date and location of divorce or death (Plus copy of Divorce Degree preferred)
- All income and net worth information
    - Social Security award letter for veteran and spouse or widow
    - Bank statements (**Most recent** checking, CDs. and/or savings)
    - Retirement pay and/or annuities, 401k, IRAs
    - Stocks, bonds, money markets, business stake, rental properties, etc.
- All medical expenses since VA Form 21-0966 filed
- NOTE: If the gross household income is above the listed MAPR, often the listed income can be reduced by deducting from the gross income "out of pocket" medical expenses We can assist you with that when you come to your appointment.

When you are ready and have all the documents needed please contact us at (615) 451-6014 or VSO@SumnerCountyTN.gov

Sumner County Veteran Service Office

INCOME WORKSHEET

Gross Monthly Income	Veteran	Spouse	Monthly Expenses	
Wages/Bonuses:			Medicare Part B	
Social Security:			Medicare Part D	
Military Retirement:			Additional Insurance	
Pension:			Long Term Care Plan	
Civil Service or Railroad:			Home Health Care	
Interest Income:			Medical, Dental, Vision Co-Pays	
Dividend Income:			Travel for medical expenses	
Other income:				
Total Income:			Total Expenses:	

NET WORTH:	**Veteran**	**Spouse**
Cash in Checking Account		
Cash in Savings Account		
Certificate of Deposit		
IRA's		
Annuities		
Mutual Funds, Stocks		
Savings Bonds		
Total Assets:		

Veteran or claimant needs to sign all VA forms. VA does not recognize any civilian power of attorney

Veteran Pension Rate Table

From December 1, 2022 to November 30, 2023

The net worth limit to be eligible for Veterans Pension benefits is **$150,538**

Veteran

Maximum Annual Pension Rate (MAPR) **NO DEPENDENTS**	**Annual Amount**
Standard	$16,037
Housebound	$19,598
Aid and Attendance	$26,752
ONE DEPENDENT (Spouse or Child)	
Standard	$21,001
Housebound	$24,562
Aid and Attendance	$31,714

Surviving Spouse/ Child

Maximum Annual Pension Rate (MAPR) **NO DEPENDENTS**	**Annual Amount**
Standard	$10,757
Housebound	$13,147
Aid and Attendance	$17,192
ONE DEPENDENT (Spouse or Child)	
Standard	$14,078
Housebound	$16,462
Aid and Attendance	$20,509

OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 02/28/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

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

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 4. Use this form to determine eligibility for aid and attendance or housebound benefits. For more information, you can contact us online through Ask VA: **https://ask.va.gov/**. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at **www.va.gov/vaforms**.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable check box to help expedite processing of the form.

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

2. SOCIAL SECURITY NUMBER – –

3. VA FILE NUMBER (If applicable)

4. VETERAN'S SERVICE NUMBER (If applicable)

5. DATE OF BIRTH (MM/DD/YYYY) – –

SECTION II: CLAIMAINT'S IDENTIFICATION INFORMATION

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

7. CLAIMANT'S SOCIAL SECURITY NUMBER – –

8. RELATIONSHIP OF CLAIMANT TO VETERAN
☐ SELF ☐ PARENT
☐ SPOUSE ☐ CHILD

9. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY) – –

10. MAILING ADDRESS (Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

11. TELEPHONE NUMBER (Optional) (Include Area Code) – –

Enter International Phone Number (If applicable)

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

SECTION III: CLAIM INFORMATION

13. SELECT ONE OF THE FOLLOWING BENEFITS (Choose one)

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

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

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

14A. IS THE CLAIMANT HOSPITALIZED?

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

☐ NO (If "NO," skip to Section V)

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

☐☐ – ☐☐ – ☐☐☐☐

14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

SECTION V: CERTIFICATION AND SIGNATURE

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

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

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

☐☐ – ☐☐ – ☐☐☐☐

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

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

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

☐☐ – ☐☐ – ☐☐☐☐

NOTE: EXAMINER PLEASE READ CAREFULLY

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

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

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

A.		**D.**	
B.		**E.**	
C.		**F.**	

19A. AGE ☐☐☐

19B. WEIGHT — ACTUAL LBS. ☐☐☐ ESTIMATED LBS. ☐☐☐

19C. HEIGHT — FEET ☐ INCHES ☐☐

20. NUTRITION

21. GAIT

22. BLOOD PRESSURE ☐☐☐

23. PULSE RATE ☐☐☐

24. RESPIRATORY RATE ☐☐☐

25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

VETERAN'S SOCIAL SECURITY NUMBER [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

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

From 9 PM to 9 AM: [ ][ ] From 9 AM to 9 PM: [ ][ ]

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

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

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

- ☐ YES
- ☐ NO

28B. CORRECTED VISION

LEFT EYE	RIGHT EYE
[ ][ ][ ]	[ ][ ][ ]

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

- ☐ YES
- ☐ NO

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

- ☐ YES
- ☐ NO

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

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

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

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

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

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

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

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

☐ YES (If "YES," check the applicable box or specify distance) ☐ 1 BLOCK ☐ 5 OR 6 BLOCKS ☐ 1 MILE OTHER (Specify distance)_____

☐ NO

SECTION VII: EXAMINER'S SIGNATURE

38. PRINTED NAME OF EXAMINER	39. TITLE OF EXAMINER
40. SIGNATURE OF EXAMINER **(REQUIRED)**	41. DATE SIGNED (MM/DD/YYYY) ☐☐ – ☐☐ – ☐☐☐☐

SECTION VIII: EXAMINER'S INFORMATION

42. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER OF EXAMINER

☐☐☐☐☐☐☐☐☐☐

43. NAME OF MEDICAL FACILITY

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

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

☐☐☐ – ☐☐☐ – ☐☐☐☐ Enter International Phone Number (If applicable)

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

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

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