PENSION AND FIDUCIARY SERVICE

PMC VSR Core Course
Phase 5, Part 1(c): Income Eligibility Knowledge Check Preparation

Appendix C: Example Claim 2

12/20/2016

Version 1.0

OMB Control No. 2900-0004
Respondent Burden: 25 minutes
Expiration Date: 07/31/2018

VAROIC PHILADELPHIA 31
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2015 MAY 29 P 12:01

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

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 11 before completing the form.

SECTION I: PERSONAL INFORMATION *(MUST COMPLETE)*

1. VETERAN'S NAME (Last, first, middle)

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)

4. VETERAN'S SEX

☐ MALE ☐ FEMALE

5. HAS THE VETERAN, SURVIVING SPOUSE, CHILD, OR PARENT EVER FILED A CLAIM WITH VA?

☐ YES ☐ NO (If "Yes," provide the file number in Item 6)

6. VA FILE NUMBER

7. DID THE VETERAN DIE WHILE ON ACTIVE DUTY?

☐ YES ☐ NO

8. WHAT IS THE VETERAN'S DATE OF DEATH? (MM,DD,YYYY)

9. WHAT IS YOUR NAME? (First, middle, last name)

10. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? (Check one)

☐ SURVIVING SPOUSE ☐ PARENT ☐ CHILD ☐ CUSTODIAN FILING FOR CHILD

11. WHAT IS YOUR SOCIAL SECURITY NUMBER?

12. WHAT IS YOUR DATE OF BIRTH? (MM,DD,YYYY)

13. ARE YOU A VETERAN?

☐ YES ☐ NO

14A. WHAT IS YOUR ADDRESS?

Street address, rural route, or P.O. Box Apt. number

City State ZIP Code Country

14B. YOUR TELEPHONE NUMBER(S) (include Area Code)

DAYTIME ( )

EVENING ( )

CELL PHONE ( )

15A. YOUR PREFERRED E-MAIL ADDRESS (If applicable)

15B. YOUR ALTERNATE E-MAIL ADDRESS (If applicable)

16. WHAT ARE YOU CLAIMING? (Check all that apply)

☐ DEPENDENCY AND INDEMNITY COMPENSATION (DIC) ☐ DEATH PENSION ☐ ACCRUED BENEFITS

SECTION II: VETERAN'S SERVICE INFORMATION *(COMPLETE ONLY IF THE VETERAN WAS NOT RECEIVING VA COMPENSATION OR PENSION BENEFITS AT THE TIME OF DEATH)*

(Skip to Section III if the veteran was receiving VA compensation or pension benefits at the time of his or her death)

17A. DID THE VETERAN SERVE UNDER ANOTHER NAME?

☐ YES ☐ NO (If "Yes," complete Item 17B)

(If "No," skip to Item 18A)

17B. PLEASE LIST OTHER NAME(S) THE VETERAN SERVED UNDER:

18A. VETERAN ENTERED ACTIVE SERVICE ON (MM,DD,YYYY)

18B. BRANCH OF SERVICE

18C. RELEASE DATE FROM ACTIVE SERVICE (MM,DD,YYYY)

18D. DID THE VETERAN SERVE IN A COMBAT ZONE SINCE 9-11-2001?

☐ YES ☐ NO

18E. PLACE OF LAST SEPARATION

19A. WAS THE VETERAN ACTIVATED TO FEDERAL ACTIVE DUTY UNDER AUTHORITY OF TITLE 10, U.S.C. *(National Guard)*?

☐ YES ☐ NO (If "Yes," answer Items 19B, 19C and 19D)

19B. DATE OF ACTIVATION (MM,DD,YYYY)

19C. WHAT IS THE NAME AND ADDRESS OF THE VETERAN'S RESERVE/NATIONAL GUARD UNIT?

19D. WHAT IS THE TELEPHONE NUMBER OF THE RESERVE/NATIONAL GUARD UNIT? (Include Area Code)

( )

20A. WAS THE VETERAN EVER A PRISONER OF WAR?

☐ YES ☐ NO (If "Yes," complete Item 20B) (If "No," skip to Section III)

20B. DATES OF CONFINEMENT

FROM: TO:

SECTION III- MARITAL INFORMATION *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE SURVIVING SPOUSE OF THE VETERAN)*

*(Skip to Section IV if you are **NOT** claiming benefits as the surviving spouse of the veteran)*

TELL US ABOUT THE VETERAN'S MARRIAGES

21A. HOW MANY TIMES WAS THE VETERAN MARRIED (including marriage to you)?

21B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country)	21C. TO WHOM MARRIED (first, middle, last name)	21D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	21E. HOW MARRIAGE TERMINATED (death, divorce)	21F. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)

21G. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 21D, PLEASE EXPLAIN:

TELL US ABOUT YOUR MARRIAGES

22A. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?

☐ YES ☐ NO

22B. HOW MANY TIMES HAVE YOU BEEN MARRIED? (including your marriage to the veteran)

22C. DATE (month, day, year) and PLACE OF MARRIAGE (city/state or country)	22D. TO WHOM MARRIED (first, middle, last name)	22E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	22F. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	22G. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)

22H. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22E, PLEASE EXPLAIN:

23. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

☐ YES ☐ NO

24. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

☐ YES ☐ NO

25. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?

☐ YES ☐ NO (If "No," complete Item 26)

26. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)*

27. 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):

SECTION IV: DEPENDENT CHILDREN *(COMPLETE ONLY IF CLAIMING BENEFITS FOR A CHILD(REN) OF THE VETERAN)*

*(Skip to Section V if you are **NOT** claiming benefits for a child(ren) of the veteran)*

28A. NAME OF CHILD (First, middle initial, last name)	28B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	28C. SOCIAL SECURITY NUMBER	*(Check all that apply)* 28D. BIOLOGICAL	28E. ADOPTED	28F. STEPCHILD	28G. 18-23 YEARS OLD (in school)	28H. SERIOUSLY DISABLED	28I. CHILD MARRIED	28J. CHILD PREVIOUSLY MARRIED
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

If claiming benefits as the surviving spouse or custodian filing for a child, in items 29A through 29D tell us about the children listed in Item 28A who ***do not*** live with you.

29A. NAME OF CHILD (First, middle initial, last name)	29B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	29C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	29D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

SECTION V: VETERAN'S PARENT *(COMPLETE ONLY IF CLAIMING BENEFITS AS THE PARENT OF VETERAN)*

*(Skip to Section VI if you are **NOT** claiming benefits as the parent of a veteran)*

30A. WHAT IS YOUR MARITAL STATUS? (Check one)

☐ MARRIED AND LIVE WITH OTHER PARENT OF VETERAN ☐ MARRIED AND LIVE WITH SPOUSE WHO IS NOT THE OTHER PARENT OF THE VETERAN ☐ SEPARATED, MARRIED BUT NOT LIVING WITH SPOUSE

☐ DIVORCED ☐ WIDOWED ☐ NEVER MARRIED

30B. IF YOUR MARRIAGE HAS ENDED, PLEASE SPECIFY THE DATE (month, day, year) AND HOW MARRIAGE ENDED (death, divorce)

30C. IF YOU ARE SEPARATED, WHAT WAS THE CAUSE OF THE SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION ***(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)***

31A. WHAT IS YOUR SPOUSE'S NAME? (First, middle initial, last name) (Skip to Item 32A if never married or no longer married)	31B. WHAT IS YOUR SPOUSE'S DATE OF BIRTH? (MM,DD,YYYY)	31C. WHAT IS YOUR SPOUSE'S SOCIAL SECURITY NUMBER?

31D. IS YOUR SPOUSE ALSO A VETERAN?

☐ YES ☐ NO (If "Yes," complete Item 31E)

31E. WHAT IS YOUR SPOUSE'S VA FILE NUMBER? (If applicable)

32A. WAS THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF *MAJORITY* (AGE 18 IN MOST STATES)?

☐ YES ☐ NO (If "Yes," skip to Item 34)

32B. DATE(S) OF PARENTAL CONTROL (If veteran did not live in your household continuously before age 18 provide the time period (dates) when he/she was under your parental control)

(MM DD YYYY) *to* (MM DD YYYY) (MM DD YYYY) *to* (MM DD YYYY)

32C. WHY WASN'T THE VETERAN A MEMBER OF YOUR HOUSEHOLD OR UNDER YOUR PARENTAL CONTROL AT ALL TIMES BEFORE HE/SHE REACHED THE AGE OF MAJORITY? (Explain fully)

33. NAME AND ADDRESS OF EACH PERSON WHO ASSUMED PARENTAL CONTROL OVER THE VETERAN OUTSIDE THE DATE(S) SHOWN IN ITEM 32B

A. NAME (FIRST, MIDDLE, LAST)	B. ADDRESS
	Street address, rural route, or P.O. Box / Apt. number City / State / ZIP Code / Country
	Street address, rural route, or P.O. Box / Apt. number City / State / ZIP Code / Country

34. IF YOU ARE NOT THE BIOLOGICAL PARENT OF THE VETERAN, PROVIDE THE NAMES OF THE BIOLOGICAL PARENTS, IF DECEASED, PROVIDE THE DATE OF DEATH.

A. NAME (FIRST, MIDDLE, LAST)	B. DATE OF DEATH (MM,DD,YYYY)

SECTION VI: DIC *(COMPLETE ONLY IF CLAIMING DEPENDENCY AND INDEMNITY COMPENSATION (DIC))*

*(Skip to Section VII if you are **NOT** claiming DIC)*

35. WHAT BENEFIT ARE YOU CLAIMING?

☐ DIC ☐ DIC under 38 U.S.C. 1151 (RARE)

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

A. NAME AND LOCATION OF VA MEDICAL CENTER	B. DATE(S) OF TREATMENT

SECTION VII: NET WORTH *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

37. **NET WORTH** (DO NOT LEAVE ANY ITEMS BLANK. If your household has no net worth in a particular source, write "0" or "none")

Report total net worth for your household. Identify the ***specific*** owner for each net worth source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your net worth and the child's net worth, if any.

SOURCE	AMOUNT	OWNER	SOURCE	AMOUNT	OWNER
CASH/NON-INTEREST BEARING BANK ACCOUNTS	$		REAL PROPERTY *(Not your home, vehicle, furniture, or clothing)*	$	
INTEREST-BEARING BANK ACCOUNTS	$		OTHER PROPERTY *(Provide source)*	$	
IRA'S, KEOGH PLANS, ETC.	$		OTHER PROPERTY *(Provide source)*	$	
STOCKS, BONDS, MUTUAL FUNDS, ETC.	$		OTHER *(Provide source)*	$	

SECTION VIII: GROSS MONTHLY INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

38. **GROSS MONTHLY INCOME** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report total monthly income for your household. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report your income and the child's income, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
SOCIAL SECURITY	$		SERVICE RETIREMENT/ SURVIVOR BENEFIT PLAN (SBP) ANNUITY	$	
SOCIAL SECURITY	$		SUPPLEMENTAL SECURITY INCOME (SSI)/PUBLIC ASSISTANCE	$	
U.S. CIVIL SERVICE	$		OTHER *(Provide source)*	$	
U.S. RAILROAD RETIREMENT	$		OTHER *(Provide source)*	$	
BLACK LUNG BENEFITS	$		OTHER *(Provide source)*	$	

SECTION IX: EXPECTED INCOME *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension benefits or parents DIC)*

39. **EXPECTED INCOME - NEXT 12 MONTHS** (DO NOT LEAVE ANY ITEMS BLANK. If no income was received from a particular source, write "0" or "none")

Report expected total household income for the 12 month period following the veteran's death. If the claim is filed more than one year after the veteran died, report the expected total household income for the 12 month period from the date you sign this application. Identify the ***specific*** income recipient for each income source, yourself or another person in your household, as applicable. If you are the custodian filing for a child of the veteran, you must report ***your expected income*** and the ***child's expected income***, if any.

SOURCE	AMOUNT	RECIPIENT	SOURCE	AMOUNT	RECIPIENT
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
GROSS WAGES AND SALARY	$		OTHER INCOME EXPECTED *(Provide source)*	$	
TOTAL DIVIDENDS AND INTEREST	Annual $		OTHER INCOME EXPECTED *(Provide source)*	$	

SECTION X: MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES *(COMPLETE ONLY IF CLAIMING DEATH PENSION OR PARENTS DIC)*

*(Skip to Section XI if you are **NOT** claiming death pension or parents DIC)*

40. MEDICAL, LAST ILLNESS, BURIAL, OR OTHER UNREIMBURSED EXPENSES

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of any continuing family medical expenses such as the monthly Medicare deduction or nursing home costs you pay. Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the veteran's or his/her child's last illness and burial and the veteran's just debts. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. Do not include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim.

AMOUNT PAID BY YOU	DATE PAID (mm/dd/yyyy)	PURPOSE (Medicare deduction, nursing home costs, burial expenses, etc.)	PAID TO (Name of nursing home, hospital, funeral home, etc.)	RELATIONSHIP OF PERSON FOR WHOM EXPENSES PAID (Spouse, child, etc.)
$				
$				
$				
$				
$				

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. Please attach a voided personal check or deposit slip or provide the information requested below in Items 41, 42, and 43 to enroll in direct deposit. If you ***do not*** have a bank account, you must receive your payment through Direct Express Debit MasterCard. To request a Direct Express Debit MasterCard you must apply at www.usdirectexpress.com or by telephone at 1-800-333-1795. 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.

41. 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.: ________________ Account No.: ________________

42. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)	43. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

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 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 44, 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.

44. 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 box below **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.

45A. CLAIMANT'S SIGNATURE **(REQUIRED)**	45B. DATE SIGNED
Edith Mae Cohen	

SECTION XIII: WITNESSES TO SIGNATURE *(COMPLETE ONLY IF CLAIMANT SIGNED ITEM 45A WITH AN "X")*

46A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	46B. PRINTED NAME AND ADDRESS OF WITNESS
47A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	47B. PRINTED NAME AND ADDRESS OF WITNESS

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation and/or 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 Vocational Rehabilitation 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 obligation to respond 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 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. 2900-0161
Respondent Burden: 30 minutes
Expiration Date: 09/30/2017

Department of Veterans Affairs

FOR VA USE ONLY

VAROIC PHILADELPHIA 31
RECEIVED IN MAILROOM
2015 MAY 29 P 12:01

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
Edith Mae Cohen	

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.

21. ITEMIZATION OF MEDICAL EXPENSES

Report medical expenses that you paid between the dates 01/01/2014 and 02/28/2015. 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				
Medicare Part D	29.10	09/01/2014	Social Security	Self
Medicare Part D	29.10	10/01/2014	Social Security	Self
Medicare Part D	29.10	11/01/2014	Social Security	Self
Medicare Part D	29.10	12/01/2014	Social Security	Self
Medicare Part D	29.10	1/01/2015	Social Security	Self
Medicare Part D	29.10	02/01/2015	Social Security	Self
Private Medical Insurance	170.50	02/01/2014	United healthcare	Self
Private Medical Insurance	170.50	03/01/2014	United healthcare	Self
Private Medical Insurance	177.25	04/01/2014	United healthcare	Self
Private Medical Insurance	177.25	05/01/2014	United healthcare	Self
Private Medical Insurance	177.25	06/01/2014	United healthcare	Self
Private Medical Insurance	177.25	07/01/2014	United healthcare	Self
Private Medical Insurance	177.25	08/01/2014	United healthcare	Self
Private Medical Insurance	177.25	09/01/2014	United healthcare	Self
Private Medical Insurance	177.25	10/01/2014	United healthcare	Self
Private Medical Insurance	177.25	11/01/2014	United healthcare	Self
Private Medical Insurance	177.25	12/01/2014	United healthcare	Self
Private Medical Insurance	177.25	1/01/2015	United healthcare	Self
Private Medical Insurance	177.25	2/01/2015	United healthcare	Self

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
Edith Mae Cohen	5/20/2015

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.

Care Expense Statement from Facility

VAROIC PHILADELPHIA 31
RECEIVED IN MAILROOM
2015 MAY 29 P 12:01

Claimant's or Resident's Name: Edith Mae Cohen

Veteran's Name: Joseph Peter Cohen

VA File Number: TRA-22-2223

Veteran Social Security Number: TRA-22-2223

Claimant's or Resident's Social Security Number: TRA-24-1965

FACILITY'S INFORMATION

What is facility Name: Parker Place Assisted Living Facility

What Services Do You Provide to the Claimant or Other Resident:

(Check all that apply)

_X_ **A Protective Environment**

_X_ **Monitoring by Caregivers Multiples Times Per Day**

___ **A Medic Alert System with 24 Hour on-site Emergency Response System**

_X_ **Assistance with Bathing and/or Dressing**

_X_ **Assisting with Incontinence Care**

___ **Assistance with Feeding**

___ **Assisting with Ambulation**

_X_ **Assistance with Medication Administration and Monitoring**

___ **Physical or Mental Therapy**

_X_ **Assistance with Other; e.g. Oxygen Equipment, Blood Pressure Monitoring, Blood Sugar Monitoring, Weight Monitoring, etc.**

_X_ **Assistance with Meal Preparation, Laundry, and/or Housekeeping**

___ **Preparation of Special Diet as Orde4 Hour On-site**

_X_ **Transportation to/from Doctors**

___ **Other (Please explain)** ______________________________________

Are any of the above services provided or supervised by a licensed professional; i.e., registered nurse, licensed practical nurse, or licenses vocational nurse)? (Yes)_X_ (No)___

When did you first start providing services: 3/14/2001

What do you charge on a regular month basis to the claimant: $4380.00

Is Medicaid paying any portion of your facility costs? (Yes)____ (No) _X_

To your knowledge, has the claimant's or resident's doctor stated that he/she requires care such as given by your facility? (Yes) _X_ (No) ___ (Don't Know) ___

What is your address: 9856 Parker Place Toledo, OH 43608

What is your phone number: (567) 345-6387

What is your fax number: (567) 345-6321

CERTIFICATION BY FACILITY AND CLAIMANT

I certify that the above statements are true and correct to the best of my knowledge and belief and that Parker Place Assisted Living Facility **is being paid** $4380.00 **monthly personally by the claimant or resident for the stated care with no expectation of reimbursement from any source.**

Signature of Authorized Facility Representative: **Date:** 3/5/2015

Alan Woolworth

Signature of Claimant or Resident Receiving Care: **Date:** 3/5/2015

Edith Mae Cohen

Signature of Witness:

Barbara Wheaten

Printed Name and Address of Witness:

Barbara Wheaten
2134 Oak Leaf Drive
Toledo, OH 43608

OMB Approved No. 2900-0138
Respondent Burden: 15 minutes
Expiration Date: 9/30/2019

Department of Veterans Affairs

REQUEST FOR DETAILS OF EXPENSES

INSTRUCTIONS - We need additional information to determine whether you are entitled to benefits. Please complete all items. If an answer is "none" or "0" write that. For additional space, use Item 12, "Remarks," or attach a separate sheet indicating the item number to which the answers apply. If you have any questions or need assistance, please call 1-877-294-6380 (Hearing Impaired TDD line 711).

1. NAME AND ADDRESS OF CLAIMANT

VAROIC PHILADELPHIA 31
RECEIVED IN MAILROOM
2015 MAY 29 P 12:01

2. NAME OF VETERAN *(First-middle-last)*	3. VA FILE NUMBER

SECTION I - DEPENDENTS NOT LIVING WITH YOU

(List ONLY persons you support who DO NOT live with you)

4A. NAME	4B. AGE	4C. RELATIONSHIP	4D. AMOUNT YOU CONTRIBUTE TO SUPPORT
			$
			$
			$
			$
			$

SECTION II - DEPENDENTS LIVING WITH YOU

(List ONLY persons you support who DO live with you)

5A. NAME	5B. AGE	5C. RELATIONSHIP

SECTION III - MONTHLY EXPENSES *(EXCEPT MEDICAL)* FOR YOU AND THOSE LISTED ABOVE AS LIVING WITH YOU

6A. ITEM	6B. AMOUNT	6A. ITEM *(Cont'd)*	6B. AMOUNT *(Cont'd)*
HOUSING **Parker Place Assisted Living Facility**	$	UTILITIES	$
FOOD	$	EDUCATION OF CHILDREN	$
TAXES	$	OTHER *(Specify)*	$
INTEREST	$	Personal care	$ 75.00
CLOTHING	$		$

SECTION IV - HOSPITAL AND MEDICAL EXPENSES

7A. DO YOU HAVE OR EXPECT TO HAVE ANY LARGE OR UNUSUAL HOSPITAL OR MEDICAL EXPENSES FOR YOURSELF AND OTHERS YOU SUPPORT AND LIVE WITH?

☐ YES ☐ NO

7B. ESTIMATED COST PER YEAR

$

7C. EXPLANATION

SECTION V - EDUCATIONAL EXPENSES

8. DO YOU EXPECT TO MAKE PROVISIONS FOR YOUR CHILDREN'S EDUCATIONAL NEEDS, INCLUDING ADVANCED TECHNICAL OR COLLEGE EDUCATION?

☐ YES ☐ NO

SECTION VI - EXPENSES OF LAST ILLNESS AND BURIAL OF VETERAN, SPOUSE, OR CHILD AND JUST DEBTS OF DECEASED VETERAN OR PARENT'S SPOUSE

9A. NAME OF DECEASED PERSON *(First-middle-last)*

9B. RELATIONSHIP TO YOU

☐ SPOUSE ☐ CHILD ☐ PARENT

9C. DATE OF DEATH

EXPENDITURES FOR ABOVE-NAMED PERSON

NOTE - Furnish information concerning unreimbursed expense as follows:

A VETERAN - For his/her spouse's or child's last illness and burial.

A CHILD - For veteran's last illness, burial and just debts.

A PARENT - For his/her spouse's or veteran's last illness and burial and for his/her spouse's just debts.

A SPOUSE - For the last illness and burial of veteran's child.

A WIDOW(ER) - For veteran's last illness, (paid before or after the veteran's death), burial and just debts and for the last illness and burial of veteran's child.

10A. NAME AND ADDRESS OF PERSON TO WHOM PAID	10B. NATURE OF EXPENSES OR DEBT	10C. TOTAL AMOUNT OF EXPENSES OR DEBT	10D. AMOUNT PAID BY YOU	10E. DATE PAID
		$	$	
		$	$	
		$	$	
		$	$	

SECTION VII - COMMERCIAL LIFE INSURANCE PAYMENTS

NOTE: Under Public Law 108-454, VA may not count as income the lump sum proceeds of a life insurance policy on a veteran who dies after December 9, 2004. Proceeds from all other insurance payments may be countable.		AMOUNT
11A.	TOTAL RECEIVED OR EXPECTED BY CLAIMANT	$
11B.	EXPECTED OR ACTUAL DATE OF RECEIPT *(If paid by installments, explain payment schedule in Item 12, Remarks)* ▶	
11C.	NAME OF THE DECEASED FOR WHOM PAYMENT IS RECEIVED.	

12. REMARKS

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission or any statement or evidence of a material fact, knowing it to be false.

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

13. SIGNATURE OF CLAIMANT *(Do not print, sign in ink)*

Edith Mae Cohen

14. DATE

15. TELEPHONE NUMBER(S) *(Include Area Code)*

A. DAYTIME

B. EVENING

Privacy Act Information: 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, Compensation, Pension, Education and Rehabilitation 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 entitlement to benefits. 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. 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 entitlement to pension or parent's dependency and indemnity compensation (38 U.S.C. 1503 and 1315). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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.

Department of Veterans Affairs

CORPUS OF ESTATE DETERMINATION

1. FILE NO.
C/CSS-

2. NAME OF VETERAN

3. LOCATION OF OFFICE

ISSUE: Entitlement to Pension 38 U.S.C. 1522 OR 1543, Parent Death Companions, or Dependency of Parents

FACTS

4. NAME OF CLAIMANT *(If other than veteran)*	5. AGE	6. CLAIMANT'S LIFE EXPECTANCY

7. STATE OF HEALTH OF CLAIMANT AND HIS/HER DEPENDENTS

8. PERSONS DEPENDING ON CLAIMANT FOR SUPPORT

AGE	RELATIONSHIP	AGE	RELATIONSHIP	AGE	RELATIONSHIP

9. ASSETS

LINE NO.	TYPE OF PROPERTY	AMOUNT	LINE NO.	TYPE OF PROPERTY	AMOUNT
1	STOCK	$	4	OTHER PERSONAL PROPERTY - TOTAL	$
2	BONDS	$	5	REAL ESTATE *(Other than claimant's residence) - TOTAL*	$
3	BANK DEPOSIT	$	6	TOTAL AMOUNT OF ESTATE	$

10. MONTHLY INCOME

LINE NO.	INCOME	AMOUNT	LINE NO.	INCOME	AMOUNT
1	SOCIAL SECURITY	$	4	DIVIDENDS AND INTEREST	$
2	RAILROAD RETIREMENT	$	5	EMPLOYMENT	$
3	OTHER RETIREMENT	$	6	RENTS	$
			7	OTHER	$
			8	TOTAL INCOME	$

11. MONTHLY EXPENSE

1	SHELTER	$	5	MEDICAL EXPENSES	$
2	FOOD	$	6	EDUCATION	$
3	TAXES AND INTEREST	$	7	OTHER *(Itemize)*	$
4	CLOTHING	$	8	TOTAL EXPENSES	$

12. DISCUSSION

13. CONCLUSION

- ☐ NET WORTH IS A BAR
- ☐ NET WORTH IS NOT A BAR
- ☐ DEPENDENCY ESTABLISHED/CONTINUED
- ☐ DEPENDENCY DOES NOT EXIT

14A. SUBMITTED BY *(Signature of Adjudicator)*	14B. DATE	15A. APPROVED BY *(Signature of Authorizer)*	15B. DATE