OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 2. Use this form to submit a statement to support a claim. For more information you can contact us through Ask VA: **https://ask.va.gov/**, or call us toll-free at 800-827-1000 (TTY:711). VA forms are available at **www.va.gov/vaforms**. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444**.

SECTION I: VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, and insert one letter per box to help expedite processing of the form.

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

MELISSA CASHEW

2. VETERAN'S SOCIAL SECURITY NUMBER

123-45-6789

3. VA FILE NUMBER (If applicable)

123456789

4. VETERAN'S DATE OF BIRTH

Month ___ Day ___ Year ____

5. VETERAN'S SERVICE NUMBER (If applicable)

6. TELEPHONE NUMBER (Include Area Code)

Enter International Phone Number
(If applicable)

7. E-MAIL ADDRESS (Optional)

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

No. & Street: 4800 N NOBB HILL RD

Apt./Unit Number:

City: SUNRISE

State/Province: FL

Country:

ZIP Code/Postal Code: 33351-

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)

I am writing to inform you that I have moved to Sunrise Health & Rehab Center and have been approved for Medicaid, Please reduce my benefit to $90.00 Medicaid rate as I have no dependents and my income is used to pay the nursing home fees.

VETERAN'S SOCIAL SECURITY NO. [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

SECTION II: REMARKS *(Continued)*
(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary)

SECTION III: DECLARATION OF INTENT

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

9. SIGNATURE OF VETERAN/BENEFICIARY **(Required)**

10. DATE SIGNED

Month 0 4 – Day 1 2 – Year 2 0 2 2

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 to be false.

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, 58VA21/22/28, 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. 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. 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 obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). 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.