PENSION AND FIDUCIARY SERVICE

PMC VSR Advanced Core Course
Phase 5: Stages of a Claim Part 5: Award Adjustments

# Phase 5, Part 5a: Knowledge Check Preparation

## Appendix B: Example Claim

May 18, 2017

Version 1.0

OMB Control No. 2900-0101
Respondent Burden: 30 minutes
Expiration Date: 04/30/2018

| FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN | Department o<br>IMPROVED PE<br>VERIFIC/<br>(VETERAN W |
|---|---|
| Sean P. Jacobson | |



| YOUR COMPLETE MAILING ADDRESS | VA FILE NUMBER |
|---|---|
| 2551 East Warner Road<br>Gilbert, AK 85233 (US) | TRA-68-2833 |
| | VA REGIONAL OFFICE RETURN ADDRESS |

IMPORTANT - Please read the enclosed EVR Instructions (VA Form 21P-0510) prior to completing this form.

| 1A. YOUR SOCIAL SECURITY NUMBER | 1B. YOUR SPOUSE'S SOCIAL SECURITY NUMBER |
|---|---|
| TRA-68-2833 | |
| 1C. FIRST, MIDDLE, LAST NAME OF SPOUSE | 1D. SPOUSE'S DATE OF BIRTH *(Mo., day, yr.)* |
| | |

2. MARITAL STATUS *(Check only one box)*

(1) ☐ MARRIED-LIVING WITH SPOUSE (You are legally married and you live with your spouse or are separated for medical reasons.)

(2) ☐ MARRIED-NOT LIVING WITH SPOUSE (You are legally married but estranged from your spouse.) Show the amount you contributed to your spouse's support during the last 12 months $ _____

If you separated within the last 12 months, show the date of separation _____

(3) ☒ NOT MARRIED (You have never married or are now divorced or widowed.) If your marriage ended within the last 12 months, show the date of divorce or death _____

3. NUMBER OF UNMARRIED, DEPENDENT CHILDREN *(See Paragraph 1 of the EVR Instructions, VA Form 21-0510)*

IN YOUR CUSTODY _____ NOT IN YOUR CUSTODY _____

AMOUNT CONTRIBUTED DURING PAST 12 MONTHS TO CHILDREN NOT IN YOUR CUSTODY $ _____

| 4A. ARE YOU A PATIENT IN A NURSING HOME? | 4C. ENTER THE NAME, COMPLETE ADDRESS, AND TELEPHONE NUMBER OF NURSING HOME *(Please include Zip Code)* |
|---|---|
| ☐ YES ☒ NO *(If "Yes," Complete Items 4B thru 4D. If "No," go to Item 5.)* | |
| 4B. SHOW THE DATE YOU ENTERED THE NURSING HOME | |
| 4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME FEES?<br>☐ YES ☐ NO | |
| 4E. SHOW THE DATE YOUR MEDICAID COVERAGE STARTED | |

5. DID EITHER YOU OR YOUR SPOUSE RECEIVE ANY WAGES OR WERE EITHER OF YOU EMPLOYED AT ANY TIME DURING THE PAST 12 MONTHS?

☐ YES ☒ NO

6. DO YOU RECEIVE ANY OTHER VA BENEFITS AS A VETERAN, PARENT, OR SURVIVING SPOUSE?

☐ YES ☒ NO *(If "Yes," write in the VA file number of the other benefit)* _____

7A. MONTHLY INCOME *(Read Paragraphs 2 and 3 of the EVR Instructions)*

GROSS MONTHLY AMOUNTS *(If no income was received from a particular source, write "0" or "none." VA WILL INTERPRET A BLANK SPACE AS "NONE" or "0.")*

| SOURCE | VETERAN | SPOUSE |
|---|---|---|
| SOCIAL SECURITY | $ 600.00 | $ |
| U.S. CIVIL SERVICE | 0.00 | |
| U.S. RAILROAD RETIREMENT | 0.00 | |
| BLACK LUNG BENEFITS | 0.00 | |
| MILITARY RETIREMENT | 0.00 | |
| OTHER *(Show Source)* | 0.00 | |
| OTHER *(Show Source)* | 0.00 | |

7B. ANNUAL INCOME *(Read Paragraphs 2 and 4 of the EVR Instructions)*

If no income was received from a particular source, write "0" or "none." VA WILL INTERPRET A BLANK SPACE AS "NONE" OR "0."

NOTE: Report annual income for the dates indicated. If no dates are shown above the columns that follow, then report last calendar year (January through December) income in the left-hand column and current calendar year income in the right-hand column.

| SOURCE | VETERAN | | SPOUSE | |
|---|---|---|---|---|
| | FROM: 01-01-2016<br>THRU: 12-31-2016 | FROM: 01-01-2017<br>THRU: 12-31-2017 | FROM:<br>THRU: | FROM:<br>THRU: |
| GROSS WAGES FROM ALL EMPLOYMENT | $ 0 | $ 0 | $ | $ |
| TOTAL INTEREST AND DIVIDENDS | 0 | 0 | | |
| ALL OTHER *(Show Source)* | $950.00<br>State Lottery | 0 | | |
| ALL OTHER *(Show Source)* | 0 | 0 | | |

7C. DID ANY INCOME CHANGE (Increase/Decrease) DURING THE PAST 12 MONTHS? (Answer "NO" if there were no income changes or if the only change was a Social Security/VA cost-of-living adjustment. Answer "YES" if there were any other income changes or if you received any NEW source of income or any ONE-TIME income.)

☒ YES ☐ NO *(If "YES," complete Items 7D through 7F. If "NO," go to Item 7G.)*

| 7D. WHAT INCOME CHANGED? *(Show what income changed, for example, wages, city pension, etc.)* | 7E. WHEN DID THE INCOME CHANGE? *(Show the dates you received any new income or the date income changed)* | 7F. HOW DID INCOME CHANGE? *(Explain what happened; for example, quit work, got raise, received inheritance)* |
|---|---|---|
| Lottery Winnings - State Lottery | March 18, 2017 | Winnings from state lottery |

7G. NET WORTH *(Read Paragraph 5 of the EVR Instructions)*

| SOURCE | VETERAN | SPOUSE |
|---|---|---|
| CASH/NON- INTEREST-BEARING BANK ACCOUNTS | $ 37,000.00 | $ |
| INTEREST-BEARING BANK ACCOUNTS | 0 | |
| IRA'S, KEOGH PLANS, ETC. | 0 | |
| STOCKS, BONDS, MUTUAL FUNDS, ETC. | 0 | |
| REAL PROPERTY *(Not your home)* | 0 | |
| ALL OTHER PROPERTY | 0 | |

8. MEDICAL EXPENSES *(Read Paragraph 6 of the EVR Instructions)*

Normally, medical expenses are reported at the end of the year. If you are using this form as your annual Eligibility Verification Report and Paragraph 6 of the EVR Instructions indicates that you should report medical expenses, use VA Form 21P-8416, Medical Expense Report, to report your medical expenses. If you are using this form as a supplement to a pending claim, you do not need to report medical expenses. If entitlement is established, you will have an opportunity to report your medical expenses at the end of the year.

9. VETERAN'S EDUCATIONAL AND VOCATIONAL REHABILITATION EXPENSES *(Read Paragraph 7 of the EVR Instructions)*

| Show amounts paid by you during the last 12 months. DO NOT REPORT DEPENDENTS' EXPENSES. | $ |
|---|---|

| 10A. SIGNATURE OF VETERAN *(Read paragraph 9 of the EVR Instructions before signing)* | 10B. DATE SIGNED |
|---|---|
| *Sean P. Jacobson* | 04/17/2017 |

10C. TELEPHONE NUMBERS *(Include Area Code)*

| DAYTIME | EVENING |
|---|---|
| (555) 555-0162 | |

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.

VAROIC PHILADELPHIA 31
RECEIVED IN MAILROOM
2017 APR 21 P 12:01

**Department of Veterans Affairs**

# MEDICAL EXPENSE REPORT

| 1. FIRST NAME OF VETERAN | 2. MIDDLE NAME OF VETERAN | 3. LAST NAME OF VETERAN | 4. SUFFIX NAME OF VETERAN |
|---|---|---|---|
| Sean | P. | Jacobson | |

| 5. VETERAN'S SOCIAL SECURITY NO. | 6. VA FILE NUMBER |
|---|---|
| TRA-68-2833 | TRA-68-2833 |

| 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. |
|---|---|
| 2551 East Warner Road | |

| 13. CITY | 14. STATE | 15. ZIP CODE |
|---|---|---|
| Gilbert | Alaska | 85233 |

| 16. DAYTIME TELEPHONE NO. OF CLAIMANT *(Include Area Code)* | 17. EVENING TELEPHONE NO. OF CLAIMANT *(Include Area Code)* |
|---|---|
| (555) 555-0162 | |

| 18. CHANGE OF ADDRESS *(Check box if address in Items 11-15 is different from last address furnished to VA)* | 19. E-MAIL ADDRESS OF CLAIMANT *(If applicable)* |
|---|---|
| ☐ | sean2@my-case.com |

**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 01/01/2017 and 12/31/2017. 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)* |
|---|---|---|---|---|
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**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 01/01/2017 and 12/31/2017. 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) | 108.00 | monthly | Social Security | Self |
| MEDICARE (PART D) | | | | |
| PRIVATE MEDICAL INSURANCE | | | | |
| | | | | |
| Caregiver Expense | 750.00 | monthly | Debbie Williams | Self |
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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 |
|---|---|
| *Sean P. Jacobson* | 04/17/2017 |

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.

VA FORM 21P-8416, SEP 2014

# SSA Inquiry
# SSA Basic Info (S02)

Input Section

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| SSN | TRA-68-2833 | CAN | | BIC | | Vet Reference No | TRA-68-2833 | Reference | |
| Name | JACOBSON, SEAN P. | | | | | DOB | 09/04/1932 | | |

| | | | |
|---|---|---|---|
| Deferred Pmt Date | | SMI Option Code | |
| Payment Indicator | | | |
| Retro Pmt Date | | SMI Start Date | 03/1998 |
| Retro Pmt | | SMI Stop Date | |
| Current Pmt Amt | | SMI Premium Amt | 108.00 |
| Combined Check | | SMI Buy-In Option Code | |
| Date Of Initial Ent | 03/1998 | SMI Buy-In Start Date | |
| Date Of Current Ent | 03/1998 | SMI Buy-In Stop Date | |
| Date Of Susp Or Term | | Disability Onset Date | 03/1998 |
| LAF | | SSI Disability Payment Code | |
| | | Final Determination Allowance | |

Cross Reference Account Numbers

| Number | BIC | Code |
|---|---|---|
| | | |
| | | |
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| | | |

| Dual Entitlement | BIC |
|---|---|
| | |

Monthly Benefit Credited

| Date | Amount | Type |
|---|---|---|
| 12/2016 | 600.00 | Paid |
| 12/2014 | 597.90 | Paid |
| 12/2013 | 587.90 | Paid |
| 12/2012 | 578.90 | Paid |
| 12/2011 | 568.90 | Paid |
| 12/2008 | 548.90 | Paid |
| | | |
| | | |

# ATTENDANT AFFIDAVIT

_____Sean Jacobson_____
Veterans Name Last, First, Middle

_____TRA-68-2833_____
VA Claim or Social Security Number

_____Sean Jacobson_____
Claimants Name

_____2551 East Warner Road_____
Claimants Address (street)

_____Gilbert, AK 85233_____
Claimants State, Zip Code

My name is _____Debbie Williams_____, and I provide health care for the above named claimant.

X Yes ☐ No I am a Licensed Health Care Professional

The services which I provide are:

X Yes ☐ No Assistance with bathing

X Yes ☐ No Standing and sitting

X Yes ☐ No Getting in and out of bed

X Yes ☐ No Eating

X Yes ☐ No Walking

X Yes ☐ No Dressing and undressing

X Yes ☐ No Taking medication

☐ Other (Please describe)

_____
_____

For these services, I am paid by the claimant $600.00 per: Month___X___ Day_____ Year_____

I began employment on _____January 1, 2017_____

__*Debbie Williams*_____
Signature of provider
_____18 North State Street_____
Street Address
_____Gilbert, AK 85233_____
City, State, and Zip Code
_____(555) 555-1980_____
Phone number (including area code)

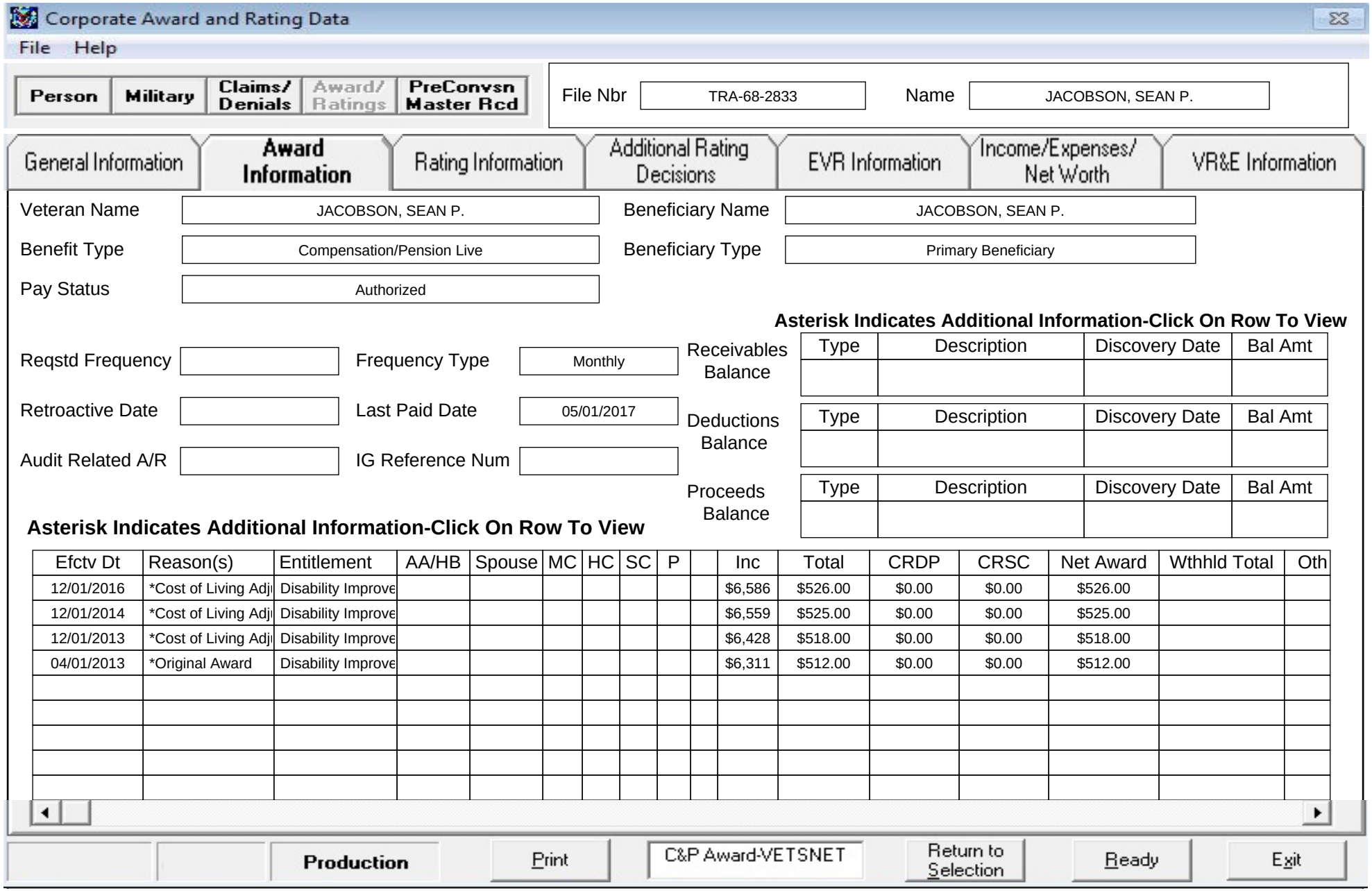
I CERTIFY, under the penalty of law, that the above information is true and correct, that I do pay the above referenced sitter the amount listed for the services listed. (If claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Signature:_____Sean Jacobson_____

Date:_____04/17/2017_____

Witness:_____ Date:_____

Witness:_____ Date:_____



Corporate Award and Rating Data

File Help

Person | Military | Claims/ Denials | Award/ Ratings | PreConvsn Master Rcd

File Nbr TRA-68-2833 Name JACOBSON, SEAN P.

General Information | **Award Information** | Rating Information | Additional Rating Decisions | EVR Information | Income/Expenses/ Net Worth | VR&E Information

Veteran Name: JACOBSON, SEAN P.
Beneficiary Name: JACOBSON, SEAN P.
Benefit Type: Compensation/Pension Live
Beneficiary Type: Primary Beneficiary
Pay Status: Authorized

**Asterisk Indicates Additional Information-Click On Row To View**

Reqstd Frequency:
Frequency Type: Monthly
Retroactive Date:
Last Paid Date: 05/01/2017
Audit Related A/R:
IG Reference Num:

Receivables Balance

| Type | Description | Discovery Date | Bal Amt |
|---|---|---|---|
| | | | |

Deductions Balance

| Type | Description | Discovery Date | Bal Amt |
|---|---|---|---|
| | | | |

Proceeds Balance

| Type | Description | Discovery Date | Bal Amt |
|---|---|---|---|
| | | | |

**Asterisk Indicates Additional Information-Click On Row To View**

| Efctv Dt | Reason(s) | Entitlement | AA/HB | Spouse | MC | HC | SC | P | | Inc | Total | CRDP | CRSC | Net Award | Wthhld Total | Oth |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/01/2016 | *Cost of Living Adj | Disability Improve | | | | | | | | $6,586 | $526.00 | $0.00 | $0.00 | $526.00 | | |
| 12/01/2014 | *Cost of Living Adj | Disability Improve | | | | | | | | $6,559 | $525.00 | $0.00 | $0.00 | $525.00 | | |
| 12/01/2013 | *Cost of Living Adj | Disability Improve | | | | | | | | $6,428 | $518.00 | $0.00 | $0.00 | $518.00 | | |
| 04/01/2013 | *Original Award | Disability Improve | | | | | | | | $6,311 | $512.00 | $0.00 | $0.00 | $512.00 | | |
| | | | | | | | | | | | | | | | | |
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Production | Print | C&P Award-VETSNET | Return to Selection | Ready | Exit

## Record Decisions - Financial

Main
Allotments
Award Adjustments
Basic Eligibility
Dependency
Elections
Financial
Institutionalizations
Military Eligibility
Military Payment Info
Rating
Fraud

Financial Decisions | Medical Expenses | Financial Interfaces

Financial Decision
Effective Date: 12/01/2014

☐ Post- Award Audit ☐ No Family Income
☐ Potential Fraud ☐ Net Worth is a Bar

Entitlement Date:

Improved Pension Family
Net Worth Amount: $35,000

| Select | Person | Award Status | Income/Expense Type | Other Income Description | Income/Expense Amount | Exclusion Type | Exclusion Amount | Decision Date |
|---|---|---|---|---|---|---|---|---|
| | SEAN JACOBSON | Primary Beneficiary | Social Security Monthly | | $597.90 | | | |
| | | | Medical | | $1,258.00 | | | |