

VA LONG TERM HEALTH CARE  
For  
War Time Veterans and their Survivors

**THIS IS NOT A VA APPLICATION**

**How to Apply for Financial Assistance from the U.S. Department of Veterans Affairs**

- Ensure criteria on TAB "A" is met before continuing.
- Obtain required documents and applicable information in TAB "B"
- Provide required information on TAB "C" Worksheet
- Complete **one** of the following:
  - TAB "D" for Assisted Living Facility (ALF)
  - TAB "E" for Home Care Assistance
- Have Medical Dr. complete the enclosed VA Form 21-2680
- Deliver / send the completed documents to Veterans Service Officer.

ESCAMBIA COUNTY  
VETERANS SERVICE OFFICE  
221 PALAFOX PLACE, SUITE 200  
PENSACOLA FLORIDA 32502  
(850) 595-1479 main  
(850) 595 -4966 fax

E-mail: [mrmerillat@myescambia.com](mailto:mrmerillat@myescambia.com)

**PENSION MAY BE AVAILABLE FOR VETERANS AND WIDOWS  
WHO MEET THE FOLLOWING CRITERIA**

- 90 DAYS OF ACTIVE DUTY MILITARY SERVICE WITH AT LEAST ONE DAY OF WAR TIME SERVICE.
- AT LEAST 65 YEARS OF AGE AND RECEIVING SOCIAL SECURITY BENEFITS, OR PERMANENT & TOTAL (P&T) DISABILITY.
- INCOME LIMITS MUST BE MET (USUALLY OVER \$80K WILL BE CONSIDERED OVER INCOME-PLEASE CONTACT A VETERAN SERVICE OFFICER FOR FURTHER GUIDANCE). MEDICAL EXPENSES PAID TO AN ALF OR HOMECARE GIVER MAY BE USED TO REDUCE OTHER INCOME IN ORDER TO QUALIFY FOR VA PENSION BENEFITS.
- CLAIMANT MUST BE RECEIVING CARE EITHER IN AN ASSISTED LIVING FACILITY OR THROUGH HOME HEALTH CARE PRIOR TO SUBMITTING A CLAIM FOR VA PENSION BENEFITS.
- IF THE VETERAN WAS ENTITLED TO PENSION BENEFITS, THE **UNREMARIED** SURVIVING SPOUSE MAY QUALIFY IF THE WIDOW'S INCOME LIMITS AND MEDICAL CONDITIONS ARE MET.
- **DIVORCE:** IF SPOUSE IS DIVORCED FROM THE VETERAN – NOT ELIGIBLE FOR VA PENSION BENEFITS.

**AID AND ATTENDANCE (A & A) MONTHLY BENEFIT**

- VETERAN OR **UNREMARIED** SPOUSE CONFINED TO RESIDENCE DUE TO DISABILITY
- NEEDS ASSISTANCE WITH **MOST** BASIC ACTIVITIES OF DAILY LIVING (ADL's)
- MUST BE DOCUMENTED ON VA FORM 21-2680 WITH MEDICAL DOCTOR STATEMENTS, DIAGNOSIS, AND PROGNOSIS

**HOUSEBOUND (HB) MONTHLY BENEFIT**

- VETERAN OR **UNREMARIED** SPOUSE CONFINED TO RESIDENCE DUE TO DISABILITY
- NEEDS ASSISTANCE WITH **SOME** BASIC ACTIVITIES OF DAILY LIVING (ADL's)
- MUST BE DOCUMENTED ON VA FORM 21-2680 WITH MEDICAL DOCTOR STATEMENTS, DIAGNOSIS, AND PROGNOSIS.

**WARTIME SERVICE PERIODS**

***World War II*** – December 7, 1941, through December 31, 1946, inclusive.

\*If the Veteran was in service on December 31, 1946 and has continuous service before July 26, 1947.\*

***Korean Conflict*** – June 27, 1950, through January 31, 1955, inclusive.

***Vietnam Era*** – February 28, 1961, through August 5, 1964, inclusive (served in Republic of Vietnam)

\*August 5, 1964, through May 7, 1975, inclusive in all other cases.\* (Authority: 38 U.S.C. 101 (29))

***Persian Gulf War*** – August 2, 1990, through a date to be prescribed by Presidential proclamation or law.  
(Authority: 38 U.S.C. 101 (33))

**REQUIRED DOCUMENTS TO APPLY FOR THE  
VA AID & ATTENDANCE OR HOUSEBOUND IMPROVED PENSION**

- **DISCHARGE / SEPARATION MILITARY PAPERS (DD-214):**
  - TO REQUEST MILITARY RECORDS: COMPLETE A SF-180 OR REFER TO THE FOLLOWING WEB SITE: [WWW.ARCHIVES.GOV](http://WWW.ARCHIVES.GOV)
  
- **COPY OF MARRIAGE CERTIFICATE:**
  - IF PREVIOUSLY MARRIED: WILL NEED INFORMATION FOR BOTH VETERAN AND SPOUSE (INCLUDE NAME, DATE/PLACE OF MARRIAGE, AND REASON TERMINATED)
  
- **COPY OF DEATH CERTIFICATE:**
  - MUST SHOW CAUSE OF DEATH
  
- **COPY OF CURRENT SOCIAL SECURITY AWARD LETTER:**
  - WILL NEED FOR BOTH VETERAN AND SPOUSE
  
- **PROOF OF ALL MONTHLY GROSS INCOME (LIQUID ASSETS):**
  - PENSIONS, RETIREMENT, INTEREST INCOME, ANNUITIES, ETC.
  - WILL NEED THE ABOVE FOR BOTH VETERAN AND SPOUSE
  
- **NET WORTH INFORMATION:**
  - CHECKING/SAVINGS, STOCKS, BONDS, IRAs, CDs, ANNUITIES, ETC.
  
- **BANKING INFORMATION FOR DIRECT DEPOSIT OF PENSION:**
  - INCLUDE VOIDED CHECK FOR SAVINGS OR CHECKING
  
- **PRIVATE INSURANCE PREMIUMS:**
  - NOT REIMBURSED BY INSURANCE, MEDICARE OR MEDICAID
  
- **WILL NEED ONE OF THE FOLLOWING:**
  - ASSISTED LIVING FACILITY EXPENSE FORM (TAB D) OR, MEMORANDUM CONCERNING IN HOME HEALTH CARE (TAB E)
  
- **PHYSICIAN'S FORM (VA FORM 21-2680):**
  - MUST SHOW COMPLETE DIAGNOSIS, INABILITY TO LIVE INDEPENDENTLY AND NEEDING ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADLs) REQUIRES PHYSICIAN'S SIGNATURE, ADDRESS AND TELEPHONE NUMBER (PA, RN OR FACILITY ADMINISTRATOR **NOT** ACCEPTABLE)

**WORKSHEET**

POINT OF CONTACT:	
ADDRESS:	
CITY, STATE, ZIP:	
TELEPHONE:	
EMAIL:	

**VETERAN INFORMATION**

NAME:		SSN:	
DATE OF BIRTH:		DATE ENTERED:	
PLACE OF BIRTH:		MIL/SERVICE NUMBER:	
DATE OF DEATH:		DATE LEFT MILITARY:	
PLACE OF DEATH:		BRANCH OF SERVICE:	

**SPOUSE INFORMATION**

NAME:	DATE OF BIRTH:	SSN:
DATE OF MARRIAGE:	PLACE OF MARRIAGE:	

**PROVIDE MONTHLY GROSS INCOME**

<b>VETERAN INCOME</b>		<b>SPOUSE INCOME</b>	
SOCIAL SECURITY		SOCIAL SECURITY	
OTHER PENSION		OTHER PENSION	
INTEREST		INTEREST	
OTHER SOURCES		OTHER SOURCES	

**TOTAL ASSETS**

<i>(DO NOT INCLUDE HOME OR AUTOMOBILE)</i>		
	<b>VETERAN</b>	<b>SPOUSE</b>
CHECKING		
SAVINGS		
STOCKS		
BONDS		
CDs		
ETC		

**TOTAL MONTHLY MEDICAL EXPENDITURES**

	<b>VETERAN</b>	<b>SPOUSE</b>
ASSISTED LIVING FACILITY		
IN HOME HEALTH CARE		
MEDICARE PART (B)		
MEDICARE PART (D)		
PRIVATE MEDICAL INS.		
OTHER		

**ASSISTED LIVING MONTHLY EXPENSE INFORMATION**

TO WHOM IT MAY CONCERN:

DATE: \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ (client) was admitted on \_\_\_/\_\_\_/\_\_\_ (date) to the personal care unit of \_\_\_\_\_ (facility name).

Total monthly expenses for services provided \$\_\_\_\_\_ (all inclusive).

- Meals – needs help or nutritional assistance.
- Hands on assist with shower/bathing, personal hygiene and dressing.
- Incontinence of urine and needs assistance for hygiene and assessment of skin.
- Supervision of ambulation for safety, as well as other interventions as needed.
- Supervision of medication which includes ordering, controlling and assistance with self-administration.
- Diminished dexterity needing additional help activities of daily living (ADL's).
- Frequent verbal direction and mental stimulation due to diminished mental status.
- Speech/communication of deficiency which inhibits resident's ability to convey needs.
- Within a 24 hour period, requires on an average of 2 hours of Certified Nursing Aid (CNA) and 30 minutes of Licensed Practical Nurse (LPN) monthly to manage activities of daily living (ADL's).

Assisted Living Administrator/ Representative

\_\_\_\_\_/\_\_\_\_\_  
 (Printed Name) (Signature)

\_\_\_\_\_  
 (Title)

Address of Facility:

\_\_\_\_\_  
 (Street) Telephone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
 (City, State, Zip) Fax: (\_\_\_\_) \_\_\_\_\_

Email (Optional): \_\_\_\_\_

Claimant's VA File Number: \_\_\_\_\_ (For Official Use Only)

**MEMORANDUM CONCERNING IN HOME HEALTH CARE SERVICE**

TO WHOM IT MAY CONCERN:

DATE: \_\_\_/\_\_\_/\_\_\_\_\_

This is a statement of home care services that I \_\_\_\_\_ (caregiver) provide to \_\_\_\_\_ (Veteran / Surviving Spouse) on a monthly basis. I charge \$\_\_\_\_\_ per month, based on \_\_\_\_\_ hours per day.

I began providing these services on \_\_\_/\_\_\_/\_\_\_\_\_ (date).

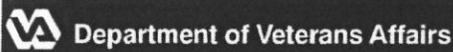
- Prepare meals and plan nutritional needs.
- Hands on assist with shower/bathing, personal hygiene and dressing.
- Incontinence of urine and needs assistance for hygiene and assessment of skin.
- Supervision of ambulation for safety, as well as other interventions as needed.
- Basic home up keep to include: making bed, laundry, dishes, etc.
- Transportation to and from: Medical facilities, Dentist, Grocery store, etc.
- Supervision of medication which includes ordering, controlling and assistance with self-administration
- Frequent verbal direction and mental stimulation due to diminished mental status.
- Speech/communication of deficiency which inhibits resident's ability to convey needs.
- Within a 24 hour period, requires on an average of two hours of Certified Nursing Aid (CNA) and 30 minutes of Licensed Practical Nurse (LPN) monthly to manage activities of daily living (ADLs).

**IN HOME HEALTH CARE PROVIDER CONTACT INFORMATION**

**I CERTIFY THE ABOVE TO BE TRUE AND CORRECT.**

\_\_\_\_\_/\_\_\_\_\_  
 Printed Name) (Signature)

Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_  
 (Street)  
 \_\_\_\_\_  
 (City, State, Zip)



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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN		2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT <i>(If other than veteran)</i>		3. RELATIONSHIP OF CLAIMANT TO VETERAN	
4A. VETERAN'S SOCIAL SECURITY NUMBER		4B. CLAIMANT'S SOCIAL SECURITY NUMBER		5. CLAIM NUMBER	
6. DATE OF EXAMINATION		7. HOME ADDRESS			
8A. IS CLAIMANT HOSPITALIZED?  <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "Yes," complete Items 8B and 9)</i>		8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL		
<b>NOTE: EXAMINER PLEASE READ CAREFULLY</b> The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. 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 he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.					
10. COMPLETE DIAGNOSIS <i>(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)</i>					
11A. AGE	11B. SEX	12. WEIGHT ACTUAL: LBS.                      ESTIMATED: LBS.		13. HEIGHT FEET:                      INCHES:	
14. NUTRITION				15. GAIT	
16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?		
20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED From 9 PM To 9 AM:                      From 9 AM To 9 PM:					
21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? <i>(If "No," provide explanation)</i>  <input type="checkbox"/> YES <input type="checkbox"/> NO					
22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? <i>(If "Yes," provide explanation)</i>  <input type="checkbox"/> YES <input type="checkbox"/> NO					
23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? <i>(If "Yes," provide explanation)</i>  <input type="checkbox"/> YES <input type="checkbox"/> NO					
24A. IS THE CLAIMANT LEGALLY BLIND? <i>(If "Yes," provide explanation)</i>  <input type="checkbox"/> YES <input type="checkbox"/> NO			24B. CORRECTED VISION		
			LEFT EYE	RIGHT EYE	
25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? <i>(If "Yes," provide explanation)</i>  <input type="checkbox"/> YES <input type="checkbox"/> NO					
26. DOES CLAIMANT REQUIRE MEDICATION MANAGEMENT? <i>(If "Yes," provide explanation)</i>  <input type="checkbox"/> YES <input type="checkbox"/> NO					
27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? <i>(If "No," provide explanation)</i>  <input type="checkbox"/> YES <input type="checkbox"/> NO					

28. POSTURE AND GENERAL APPEARANCE (Attach a separate sheet of paper if additional space is needed)

29. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE (Attach a separate sheet of paper if additional space is needed)

30. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK

32. SET FORTH 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 CLAIMANT'S ABILITY TO PERFORM SELF-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

33. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

34. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? (If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)

YES (If "YES," give distance) (Check applicable box or specify distance)  1 BLOCK  5 or 6 BLOCKS  1 MILE OTHER (Specify distance) \_\_\_\_\_  
 NO

35A. PRINTED NAME OF EXAMINING PHYSICIAN

35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN

35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY

36B. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)

**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 Vocational Rehabilitation Records - VA, and 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 of the SSN 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 page at [www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA](http://www.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA). If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

## MILITARY REQUIRED SERVICE DATES

WWII <12/07/1941 – 12/31/1946> \*

KOREA <06/27/1950 – 01/31/1955> \*

VIETNAM <08/05/1964 – 05/07/1975> \*

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\* \* VIETNAM-LAND ONLY 02/28/1961 – 08/05/1964 \* \*

GULF WAR <08/02/1990 – FUTURE DATE (TBD)> \*

\* *REQUIRED TO HAVE SERVED 1 DAY DURING WARTIME PERIOD AND 90 CONSECUTIVE DAYS IN SERVICE.* \*

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## 2015 VA PENSION RATES

### SOCIAL SECURITY PART B

\$104.90 x 12 months = \$1,258.80 x 2 = \$2,517.60

	<u>BASIC PENSION</u>	<u>AID &amp; ATTENDANCE</u>
MARRIED VET	\$1,404.00	\$2,120.00
SINGLE VET	\$1,072.00	\$ 1,788.00
WIDOW	\$ 719.00	\$ 1,149.00
VET + VET		\$2,790.00 (Both Vets)

### DIC

DIC: \$1,254.19

DIC + 8 (\$266.32): \$1,520.51

DIC + A/A (\$310.71): \$1,564.90

DIC + H/B (\$145.55): \$1,399.74

DIC + Helpless child (\$529.23): \$1,783.42

DIC + 2 YEARS (\$270.00): \$1,524.19 (*Transitional* \*not per child\*)

DIC + (\$310.71 **PER** Child **UNDER** age 18) = \$1,564.90 (1 child)

DIC + (\$263.23 **PER** Child **ages 18-23 in school**) = \$1,517.42 (1 child)