PLACER COUNTY

RICK BUCKMAN
Veterans Service Officer

VETERANS SERVICE OFFICE
1000 SUNSET BLVD. SUITE 115 ROCKLIN, CA 95765 (916) 780-3290 FAX: (916) 780-3299

Thank you for your interest in the Veterans Aid & Attendance Program. Enclosed are the forms and information you will need to process a claim. Please take a moment to familiarize yourself with the forms before getting started.

To initiate a claim for Aid & Attendance, you will need to submit the following items to our office:

1. Application for Aid & Attendance (3 page form)
2. Care and Expense Statement (2 page form)
3. Physicians Report (Examination for Housebound Status) (2 page form)
4. Informal Claim (1 page form)
5. Military Discharge/Report of Separation Documentation

If you are filing a claim for a surviving spouse we will also require the veterans' Death Certificate and Marriage Certificate.

All documents requiring a signature MUST be signed by the veteran or spouse. The VA does not recognize Powers of Attorney; therefore an agent's signature is not acceptable.

Once you have the completed the attached forms return them to our office by US Mail, or Fax at 916-780-3299.You can also scan and email the initial claim forms to our office at Veterans@placer.ca.gov

If you have any questions please call 916-780-3290 for assistance.

PLACER COUNTY VETERANS SERVICES

APPLICATION FOR VETERANS AID & ATTENDANCE

(PLEASE COMPLETE ALL PERTINENT INFORMATION)

SECTION I: INFORMATION ON THE VETERAN

NAME (Last, First Middle)	SSN: VA CLAIM#
DATE OF BIRTH	PLACE OF BIRTH (City, State)
DATE OF DEATH	PLACE OF DEATH (City, State)

DOES THE VETERAN OR WIDOW CURRENTLY RECEIVE MONEY FROM THE VA? YES ☐ NO ☐

CURRENT MARRIAGE INFORMATION

NEVER MARRIED ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐	# TIMES VET MARRIED	# TIMES SPOUSE MARRIED
DATE OF MARRIAGE (Month, Year)	PLACE OF MARRIAGE (City, State)	

If either the Veteran or Spouse has been married more than once, please complete the information on page 3.

SECTION II: INFORMATION FOR SPOUSE/WIDOW

FULL MAIDEN NAME (First and Last)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

DOES SPOUSE LIVE WITH VETERAN YES ☐ NO ☐	IF NO, WHY SEPARATED
DOES CURRENT SPOUSE REQUIRE ASSISTANCE YES ☐ NO ☐	IF SPOUSE REQUIRES ASSISTANCE PLEASE PROVIDE A PHYSICIANS REPORT FOR SPOUSE

SECTION III: WHO TO CONTACT FOR INFORMATION AND MAIL

NAME	PHONE	RELATIONSHIP
ADDRESS	CITY/STATE/ZIP	
EMAIL ADDRESS:		

SECTION IV: MILITARY INFORMATION

DATE OF ENTRY	DATE OF SEPARATION

ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE ☐ COAST GUARD ☐ MERCHANT ☐ OTHER ☐

SERIAL NUMBER	IS ORIGINAL OR CERTIFIED COPY OF DISCHARGE AVAILABLE? YES ☐ NO ☐

REMARKS

SECTION V: ASSISTED LIVING/RESIDENTAL CARE/SKILLED NURSING INFORMATION

FACILITY NAME		ADDRESS
PHONE	DATE MOVED IN	AMOUNT PAID MONTHLY $

INDEPENDENT LIVING ☐ ASSISTED LIVING ☐ RESIDENTIAL CARE ☐ BOARD & CARE ☐ SKILLED ☐

SECTION VI: HOME CARE INFORMATION

NAME OF PROVIDER	PHONE NUMBER
AMOUNT PAID MONTHLY $	

THIS IS NOT A GUESSING GAME, PLEASE PROVIDE EXACT AMOUNTS ON THE DAY THAT YOU COMPLETE THIS FORM

GROSS MONTHLY INCOME (Before Deductions)

	SOURCE	VETERAN	SPOUSE
SOCIAL SECURITY (Before Medicare Deduction)	Social Security	$	$
PENSION		$	$
PENSION		$	$
CIVIL SERVICE RETIREMENT	Civil Service	$	$
MILITARY RET	DFAS	$	$
VA DISABILITY	VA	$	$
INTEREST/DIVIDENDS		$	$
RENTAL INCOME		$	$
OTHER		$	$

MEDICAL EXPENSES

	SOURCE	VETERAN	SPOUSE
MEDICARE (Normally $96.40)	Social Security	$	$
HEALTH INSURANCE		$	$
HEALTH INSURANCE		$	$
DENTAL/VISION INSURANCE		$	$

ASSETS

	VETERAN	SPOUSE
CHECKING	$	$
SAVINGS/CD'S	$	$
STOCKS/BONDS/MUTUAL FUNDS	$	$
IRA'S/ANNUITY	$	$
RENTAL PROPERTY	$	$
OTHER ASSETS	$	$

DO NOT RETURN THIS PAGE UNLESS YOU HAVE PRIOR MARRIAGES TO REPORT

In order to complete the claim we will need the appropriate documents indicated below.

DOCUMENTATION REQUIRED

DOCUMENT	VETERAN CLAIM	WIDOW CLAIM
MILITARY DISCHARGE/DD 214	YES	YES
MARRIAGE CERTIFICATE	NO	YES
VETERANS DEATH CERTIFICATE	NO	YES
*ASSISTED LIVING VERIFICATION	YES	YES
*HOME CARE INFORMATION	YES	YES
PHYSICIANS REPORT	YES	YES

PRIOR MARRIAGE INFORMATION FOR VETERAN

WHO MARRIED	NAME	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACED ENDED	
WHO MARRIED	NAME	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACED ENDED	

PRIOR MARRIAGE INFORMATION FOR SPOUSE/WIDOW

WHO MARRIED	NAME	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACED ENDED	
WHO MARRIED	NAME	WHY ENDED: DEATH ☐ DIVORCE ☐	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
DATE ENDED		PLACED ENDED	

COMPLETED FORMS SHOULD BE SUBMITTED TO

MAIL: Veterans Service Office
1000 Sunset Blvd, Ste 115,
Rocklin, CA 95765

FAX: (916) 780-3290

EMAIL: Veterans@placer.ca.gov

Care Expense Statement

Section 1: General Information (To be completed by the facility administrator. Please Print.)

VA Claim Number or SSN: ___________________________________

Veterans Name: ____

Patient's Name: ____

Check the box which describes the patient's care status:

- ☐ In Home Care
- ☐ Nursing Home Care
- ☐ Other Care Facility *(Foster Home, Adult Day Care, Rest Home, Group Home, Assisted Living)*

Name of Facility or Care Provider: _____________________________________

Phone Number of Facility or Care Provider: _____________________________________

Address of Facility or Care Provider: _____________________________________

____

Date Entered Facility or Care Began: _____________________________________

Will the patient need this care indefinitely ☐ Yes ☐ No

If No, when will the care end? ____

Total monthly charge for the patient $ ____________ per month:

Has the patient applied for Medi-Cal (Medicaid) ☐ Yes ☐ No

Is part of the patient's care covered by Medi-Cal Medicare, Insurance or other source: ☐ Yes ☐ No

If Yes, please answer the following:

What is the source of payment? _______________________

What is the monthly amount covered by this source? $ ____________ per month:

When did coverage begin? _______________________

What monthly amount does the veteran or patient pay from his/her own funds which is not reimbursed by one of the sources listed above? $ ____________ per month:

(*If the patient is receiving Medicaid, what amount does Medicaid take from the patient*)

Continue on page 2

Be sure to sign and date

Section 2: In-Home Care Information

(To be completed by the care provider only if patient is being provided In-Home Care)

Do You provide any medical or nursing services for the patient? ☐ Yes ☐ No
(i.e. administering medication, physical or mental therapy, assisting with personal hygiene, dressing bathing; etc.)

Describe the services you provide:____

Are you a licensed health professional? (RN, LVN or LPN) ☐ Yes ☐ No
If Yes, provide your license number: ____

Section 3: Nursing Home Information

(To be completed by the facility administrator only if the patient is in a nursing home.)

Is your facility licensed by the State? ☐ Yes ☐ No

Is your facility Medicaid (Medi-Cal) approved? ☐ Yes ☐ No

Is the patient in your nursing home because of a physical or mental disability? ☐ Yes ☐ No

Do you provide either skilled or intermediate level nursing care to the patient? ☐ Yes ☐ No

What was the admitting diagnosis? ____

Section 4: Other Care Facility Information

(To be completed by the facility administrator only if the patient is in a foster home, adult day care, rest home, group home or assisted living)

Indicate type of facility ☐ Assisted Living ☐ Rest Home ☐ Foster Home
☐ Adult Day Care ☐ Group Home ☐ Other ______________

Do you provide any medical or nursing services for the patient? ☐ Yes ☐ No
(i.e. administering medication, physical or mental therapy, assisting with personal hygiene, dressing bathing; etc.)

Describe the services you provide: ____

If the patient receives medical or nursing services, are the services provided or supervised by a licensed health professional (RN, LVN, LPN) ☐ Yes ☐ No

We must have the monthly charge broken down into the following categories:

1. Base Rate (includes room, meals, laundry, housekeeping): $____________ per month:
2. Medical and Nursing Services: $____________ per month:

Section 5: Signatures *(To be completed by the facility administrator/care provider and veteran/widow)*

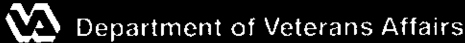
I certify that the above statements are true and correct to the best of my knowledge and belief.

____ _____________________________
Signature of facility administrator or care provider Date

I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying $_______ per month for my care from my own funds.

____ _____________________________
Signature of Veteran or Beneficiary Date

OMB Control No. 2900-0721
Respondent Burden: 30 minutes



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 *(If other than veteran)*	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?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*		

NOTE: EXAMINER PLEASE READ CAREFULLY
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 *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

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? *(If "No," provide explanation)*
☐ YES ☐ NO

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "Yes," provide explanation)*
☐ YES ☐ NO

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*
☐ YES ☐ NO

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*
☐ YES ☐ NO

26. DOES CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*
☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*
☐ YES ☐ 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 CONTRACTURESOR 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
☐ NO

(If "YES," give distance)(Check applicable box or specify distance) ☐ 1 BLOCK ☐ 5 or 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* ________________

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. 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. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The law authorizes us to request the information we are asking you to provide on this form (38 U.S.C. 501(a) and (b)). The responses you submit are considered confidential (38 U.S.C. 5701). They may be disclosed outside the Department of Veterans Affairs (VA) only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation 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.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO. C/CSS -

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

(CONTINUE ON REVERSE)

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

SIGNATURE	DATE SIGNED	
ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING

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