AID AND ATTENDANCE/HOUSEBOUND BENEFITS (1.01.14)

Must be a wartime veteran or eligible spouse. Be a resident in a Care Facility or under contract with a Home Care **first** prior applying for benefits. The claimant must require the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment.

DOCUMENTS REQUIRED

1. **DISCHARGE (WDAGO OR DD 214) FOUND ON LEFT HAND BOTTOM CORNER**
2. **MARRIAGE CERTIFICATE(S)**
3. **DEATH CERTIFICATE(S)**
4. **DIVORCE DECREE(S)**
5. **VETERAN'S AND/OR WIDOW'S – SOCIAL SECURITY NUMBERS/CARDS**
6. **PREVIOUS MARRIAGES- NAMES, PLACE AND DATE OF MARRIAGE**
   HOW ENDED: DIVORCE OR DEATH, DATE AND PLACE

7. **PROOF OF MONTHLY INCOME - SOCIAL SECURITY AND PENSION**
   - CURRENT ASSETS- STOCKS, BONDS, IRA'S, CD'S, INTEREST AND DIVIDENDS
   -- (Anything that can be turned into cash). NOT INCLUDING YOUR HOME
   (UNLESS YOU SELL THE HOME, IT IS THEN CONSIDERED AN ASSET AND WILL BE INCLUDED IN THE $80,000 IN ASSETS.)

   - **NO GREATER THAN $80,000.** ***Include statements.***
   - **INCOME LIMITATIONS MAY APPLY**

8. **FINANCIAL INSTITUTION INFORMATION (Bank Routing/Checking Account Number)** ***Bring voided check***

9. **PROOF OF MONTHLY UNREIMBURSED MEDICAL EXPENSES (examples):**
   - SOCIAL SECURITY BENEFIT STATEMENT (MEDICARE $96.40/month (2010)
   - HEALTH INSURANCE PREMIUM - MEDICATION PLAN PREMIUM

10. **LETTER FROM NURSING FACILITY or HOME HEALTHCARE ADMINISTRATOR/DIRECTOR STATING COST per YR AND LEVEL OF CARE**

11. **MEDICAL STATEMENT (VDVA FORM 10)** to be completed by primary physician, see page 2.

During the claim process we are unable to determine the amount of your award at our level. After we submit the claim on your behalf, **never** send any additional information directly to Philadelphia Regional Office without first contacting the York County VA office.

Any questions regarding this matter can be addressed to the undersigned. Once you have obtained this information please call to set up an appointment @ 771-9218.

Michelle Lutz — *Veteran Service Officer*

Kim Scott — *Veteran Service Officer*

Philip A. Palandro — *Director of Veterans Affairs*

York County Veteran Affairs, 100 West Market St, Suite 101, York, PA 17401
(Government Center, old Bon Ton building)

Veteran Outreach Program

- Hanover American Red Cross, 1st and 3rd Friday beginning @ 9:00 am

Medical Evidence (documented on VDVA Form 10 or Physician's medical statement)

All medical evidence from the claimant's physician must be within the last six months, include a *complete medical history/treatment over the last year* that must describe the claimant's health, a diagnosis, prognosis, severity and limitations, level of disability, and the anticipated timeframes for the disabilities.

For Pension:
Submitted medical evidence should adequately describe the claimant's health, provide a diagnosis, and provide enough information to evaluate their conditions. The medical evidence must provide the level of disability for all medical conditions, the severity of the medical conditions and the limitations of the medical conditions. The medical evidence must provide a diagnosis, prognosis, severity and limitations, and anticipated timeframes for the disabilities.

For Housebound Benefits:
For a Veteran: The submitted evidence must demonstrate that the veteran is confined to the home and is unable to leave without assistance due to a medical or mental condition.

For Surviving Spouse: The submitted evidence must demonstrate that the surviving spouse is confined to the home and is unable to leave without assistance due to a medical or mental condition.

For Aid and Attendance (documented on VDVA Form 10 or Physician's medical statement include a *complete medical history/treatment over the last year)*

For a Veteran: The submitted evidence must demonstrate that the veteran needs assistance with activities of daily living [ADLs] because of specific physical or mental impairments.

For Surviving Spouse: The submitted evidence must demonstrate that the surviving spouse needs assistance with the activities of daily living (ADLs) because of specific or mental impairments.

The evidence of record must show that the claimant is UNABLE to dress or undress themselves, or to keep them self ordinarily clean and presentable, has a frequent need to adjustment of special prosthetic or orthopeadic appliances which by reason of particular disability cannot be done without aid, is UNABLE to feed themselves through loss of coordination of upper extremities or through extreme weakness, is UNABLE to attend to the wants of nature, or has an incapacity, physical or mental, which requires care or assistance on a regular basis to protect them from hazards or dangers incident to their daily environment.

****** For a Mental Condition:** (Alzheimer's or dementia, for example) A mentally incompetent person is defines as one who, because of injury or disease, lacks the mental capacity to control or manage his or her own affairs, including disbursements of funds without limitation. Physician should annotate this on the VDVA Form 10 line #12

For Helpless Child: A child over 18 years of age must be shown to be permanently incapable of self-support by reason of mental or physical defect by age 18. Children who become incapable of self-support because of a disability before age 18 may be eligible for death pension as long as the condition exists, unless the child marries of the child's income exceeds the applicable limit. Submitted medical evidence needs to demonstrate a physical/mental condition showing disability existed prior to age 18.

MEDICAL STATEMENT FOR CONSIDERATION OF AID & ATTENDANCE

****(Please circle the appropriate answer and <u>explain each in detail</u>)****

<u>RETURN ADDRESS:</u> ***VA FILE/CLAIM #:*_____**

Address:_____

City/State/Zip _____

VETERAN'S NAME: _____

Last **First** **Middle Name**

CLAIMANT'S NAME:_____

Last **First** **Middle Name**

1. Complete Diagnosis**:**_____

_____

_____

2. Is the claimant able to walk unaided? Yes No

Explanation: _____

_____

3. Is the claimant able to feed his/herself? Yes No

Explanation: _____

_____

4. Does the claimant need assistance in bathing and tending to other hygiene needs? Yes No

5. Is the claimant able to care for the needs of nature? Yes No

Explanation: _____

_____

6. Is the claimant confined to bed? Yes No

Explanation: _____

_____

7. Is the claimant able to sit up? Yes No

Explanation: _____

8. Is the claimant blind? Yes No

Corrected Vision: L _____/_____ R _____/_____

Explanation:_____

_____

VDVA FORM 10 page 1 of 2

VDVA FORM 10 page 2 of 2

9. Is the claimant able to travel? Yes No
Explanation: _____
_____

10. Can the claimant leave home without assistance? Yes No
(If yes, how far can he/she go? (List distance)
Explanation: _____
_____

11. Does the claimant require nursing home care? Yes No

Explanation: _____
_____

12. In your opinion, are there other pertinent facts which would show the claimant's need for aid and attendance? _____
_____
_____

** **If possible, please attach copies of office or hospital records concerning the claimant's recent medical history.*****

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.
(Please type or print)

Physician's Name:_____ _____

Address: _____ **(Examining Physician's Signature)**

_____

Phone Number: _____

**Billing Information: All expenses incurred as a result of the exam are the responsibility of the veteran/claimant. Direct billing to this agency is not authorized.

-- Example Letter --

Your Letter Head (insert here)

DATE

York County Veteran Affairs
ATTN: Phil Palandro, Kim Scott or Michelle Lutz
100 West Market Street, Suite 101
York, PA 17401

Please be advised that Mr./Mrs. Wartime Veteran is a resident in the Nursing/Assisted Living Facility. His/Her present level of care is (skilled nursing/intermediate/personal care).

Mr./Mrs. Veteran entered this facility/entered into this contract for services on (date entered into contract). His/Her per day cost is $203.03 ($$. $$ hourly/monthly cost). He/She requires (amount of hours of care per month). He/She is private pay at the present time. (Include a statement whether this is/is not a Medicaid accepting facility and if it is state if Medicaid covers all of part of the costs).

Sincerely,

(Facility Administrator/Director)

-- Example Letter --