

INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

VA may be able to pay you a higher benefit rate if you report medical expenses for VA to deduct from your income. Your benefit rate is calculated based on your income. Your out-of-pocket payments for medical, optical and dental expenses may be deductible.

This form is used to report any medical expenses that you paid for yourself or for a relative who is a dependent member of your household (spouse, child, grandchild, parent, etc.), for which you were not reimbursed and do not expect to be reimbursed. Below are examples of expenses you may include, if applicable:

- · Hospital expenses
- Doctor's office fees
- Dental fees
- Prescription/non-prescription drug costs
- Vision care costs
- Medical insurance premiums
- Nursing home costs
- Hearing aid costs
- Home health service expenses
- Expenses related to transportation to a hospital, doctor or other medical facility
- · Monthly Medicare deduction

THE FORM IS COMPRISED OF 8 SECTIONS. BE SURE TO ANSWER THE QUESTION(S) IN EACH SECTION AS REQUIRED.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION	SECTION V: OTHER MEDICAL EXPENSES
SECTION II: CLAIMANT'S CONTACT INFORMATION	SECTION VI: MILEAGE
SECTION III: REPORTING PERIOD	SECTION VII: CERTIFICATION AND SIGNATURE
SECTION IV: IN-HOME CARE AND CARE FACILITY EXPENSES	SECTION VIII: WITNESS TO SIGNATURE

This form contains the following addendums and worksheets that may be required to support your application:

Addendum:

- A: In-Home Care or Care Facility Expenses
- B: Other Medical Expenses Continued
- C: Mileage Traveled for Medical Purposes Using Privately Owned Vehicle

Worksheet:

- Residential Care, Adult Daycare, or a Similar Facility
- In-Home Attendant Expenses

IMPORTANT INFORMATION

- All medical expenses must be reported on VA Form 21P-8416, *Medical Expense Report*. This form contains
 optional addendums that you may submit to supplement this form without the need to submit multiple copies of
 VA Form 21P-8416. You may submit as many copies of each addendum as you need. If you leave the questions on the
 addendum blank, VA will assume you are not submitting any additional medical expenses beyond the pages received.
- Do not include any expenses for which you were or will be reimbursed. If you receive reimbursement after you have filed this claim, promptly notify VA by submitting a completed VA Form 21-4138, *Statement in Support of Claim,* or by contacting our call center at 1-800-827-1000.
- VA can deduct allowable expenses paid by either you, your spouse (for veterans) or other relative that is a constructive member of the household.

NOTE: **Constructive member** means the expenses can be for a spouse in a nursing home, a child away at school, or a similar situation. The expenses were incurred on behalf of the claimant or a relative of the claimant (not necessarily a dependent for VA purposes) who is a member or constructive member of the claimant's household.

- If you are unsure whether VA can deduct a payment for a particular expense, furnish a complete description including the purpose of the payment. VA will inform you if an expense cannot be deducted.
- If you are claiming vitamins, food supplements and/or herbal remedies, VA may allow these expense deductions on a limited basis (per household member and calendar year). If the deductions are over the limit per household member, VA requires evidence from a healthcare provider instructing the claimant or other dependent member of the household to purchase vitamins, food supplements and/or herbal remedies. Please ensure these expenses are listed separately per household member.

IMPORTANT INFORMATION (Continued)

- DO NOT submit receipts for medical expenses you paid. VA may require you to verify the amounts you paid in some circumstances. Therefore, please keep all receipts or other documentation of payments for at least 3 years after receiving a decision on your medical expense claim. If you are unable to provide documentation of your claimed medical expenses when VA asks you to do so, your benefits may be retroactively reduced or discontinued.
- Submitting a new VA Form 21P-8416 without reporting a previously counted continuing medical expense may result in removal of the medical expense from the date of receipt of the form.
- If reporting expenses for a nursing home facility, please also submit VA Form 21-0779, Request for Nursing Home Information in Connection with Claim for Aid and Attendance. Important - This only applies if your care facility is found under the "Nursing homes including rehab services" section of the following website address: https://www.medicare.gove/care-compare.
- If you are claiming expenses for an in-home care provider or for assisted living or similar care, each care provider should complete the applicable worksheet for VA to determine whether all or some of your payments to the provider or facility are deductible. The applicable worksheets are:
 - o Residential Care, Adult Daycare, or a Similar Facility OR -
 - o In-Home Attendant Expenses

ASSISTANCE WITH COMPLETING YOUR CLAIM

Veteran Service Officer (VSO)

You may wish to contact an accredited Veterans Service Officer to assist you with your application. For a list of accredited Veterans service organizations go to <u>https://www.va.gov/vso/</u>. You may also contact your state office of Veterans Affairs at <u>https://www.va.gov/statedva.htm</u>, should you need further assistance with the application process. To assign a VSO as your power of attorney for the claims process, please submit a VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*.

Private Attorney and Claims Agents

Attorneys and claims agents are available to assist you in completing your application. To verify if your attorney or claims agent is accredited by the Department of Veteran Affairs, go to: <u>https://www.va.gov/ogc/apps/accreditation/index.asp</u>. To assign a private attorney or claims agent as your power of attorney for the claims process, please submit VA Form 21-22a, *Appointment of Individual as Claimant's Representative*.

Fees for Claims

Section 5904, Title 38, United States Code (codified in § 14.636, Title 38, Code of Federal Regulations) contains provisions regarding fees that may be charged, allowed or paid for services provided by a VA-accredited attorney or agent in connection with a proceeding before the Department of Veterans Affairs with respect to a claim for benefits under laws administered by the department. Generally, a VA-accredited attorney or claims agent can ONLY charge claimants a fee after the VA has issued an initial decision on a claim and the attorney or agent has complied with the applicable power-of-attorney and the fee agreement requirements.

PRIVACY ACT NOTICE: 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. The requested information is considered relevant and necessary to determine maximum benefits provided under law. 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. VA will not deny an individual benefits for refusing to provide their 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 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 determine whether medical expenses you paid may be used to reduce the amount of income we count in determining eligibility to benefits (38 U.S.C. 1503). Title 38, United States Code, 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.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.

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DO NOT report your monthly recurring expenses on multiple lines; rather, report recurring expenses on one line, For recurring expenses in advecting on your particular of a monthly recurring expenses in a weater lines. Prescription metalations are generally not conditient and your monthly incompare an only example. In the amount appendix from the date of recurring expenses in an incompare an only example. In the amount appendix from the date of recurring expenses in a provide the amount appendix from the date of recurring expenses in a provide the metal expense from the date of recurring expenses in an incompare an only example. In the monthly appendix from the date of recurring expenses in an incompare expense expense expense expense		SECTION V: OTHER MEDICAL EXPENSES					
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NOTE: If you have additional medical expenses to report, complete Addendum B: Other Medical Expenses on page 7.		iy, oto.j		ioo promium, moutou supplies, etc.)			
	NOTE: If you have additional medical expenses to	report, complete Addendum B: C	ther Medical Expenses on pa	age 7.			

VA FORM 21P-8416, OCT 2023

SECTIO	ON VI: MI	LEAGE				
Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in Section III of this form.						
6A. (1). WHO NEEDED TO TRAVEL? VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:		OTAL MILES RAVELED	6A. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year 6A. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)			
			\$,			
6B. (1). WHO NEEDED TO TRAVEL? VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:		OTAL MILES RAVELED	6B. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year			
6B. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)			6B. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$			
6C. (1). WHO NEEDED TO TRAVEL? VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	()	OTAL MILES RAVELED	6C. (4). DATE TRAVELED (MM/DD/YYYY) Month Day Year 6C. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)			
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6D. (1). WHO NEEDED TO TRAVEL?		OTAL MILES RAVELED	6D. (4). DATE TRAVELED (MM/DD/YYYY)			
6D. (2). PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)	1		6D. (5). AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.)			
NOTE : If you have additional mileage reimbursement to report, complete on page 8.	Addendur	m C: Mileage fo	r Privately Owned Vehicle Travel for Medical Purposes			
SECTION VII: CERT	IFICATIO	N AND SIGN	ATURE			
CERTIFICATION : I have not and will not receive reimbursement for these expenses. I certify the information contained on this form and the attached addendums is a true representation of expenses I have paid.						
7A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE		7B. DATE SIG	GNED (MM/DD/YYYY)			
		/	. /			
SECTION VIII: WITNESS TO SIGNATURE (Two witness signatures are required if claimant signed 7A with an "X")						
8A. PRINTED NAME OF FIRST WITNESS (NOTE: Only to be used if claimant signed in 7A using an "X")		8B. SIGNATU	JRE OF FIRST WITNESS (NOTE : Only to be used if claimant 7A using an "X")			
8C. MAILING ADDRESS OF FIRST WITNESS						
No. and Street			Apt./Unit Number			
City State/Province		Country	Zip Code/Postal Code			
8D. PRINTED NAME OF SECOND WITNESS (NOTE : Only to be used if claimant signed in 7A using an "X")			JRE OF SECOND WITNESS (NOTE : Only to be used if claimant 7A using an "X")			
8F. MAILING ADDRESS OF SECOND WITNESS						
No. and Street			Apt./Unit Number			
City State/Province		Country	Zip Code/Postal Code			
PENALTY : The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any payment to which you are not entitled.						

A	DDENDUM A: IN-HOME CARE OR CARE	FACILITY EXPENSES			
If you are not claiming expenses related	to a care facility or from an in-home care provider	, completion of Addendum A is not required.			
IMPORTANT: If you are claiming expenses for in-home care, residential care, adult daycare, or similar care facility; EACH provider must complete the applicable worksheet(s) on pages 9 and 10 , in addition to completion of this section. If you are reporting a nursing home, you must submit VA Form 21-0779, <i>Request for Nursing Home Information in Connection with Claim for Aid and Attendance</i> .					
1A. WHOSE EXPENSES WERE PAID?		1C. PROVIDER START AND END DATE (MM/DD/YYYY)			
	D (Specify) OTHER (Specify)	START:			
Specify Name of Child or Other:		NOTE: If care is ongoing leave end date blank.			
1B. NAME OF PROVIDER		END: / /			
1D. AMOUNT PAID MONTHLY	1E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE R				
\$,.		Hours Worked er Week)			
2A. WHOSE EXPENSES WERE PAID?		2C. PROVIDER START AND END DATE (MM/DD/YYYY)			
VETERAN SPOUSE CHILI	D (Specify) OTHER (Specify)	START: / /			
Specify Name of Child or Other:		NOTE: If care is ongoing leave end date blank.			
2B. NAME OF PROVIDER		END: / /			
2D. AMOUNT PAID MONTHLY	2E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE R				
\$,.		e Hours Worked 'er Week)			
3A. WHOSE EXPENSES WERE PAID?		3C. PROVIDER START AND END DATE (MM/DD/YYYY)			
VETERAN SPOUSE CHILI	D (Specify) OTHER (Specify)	START: / /			
Specify Name of Child or Other:		NOTE: If care is ongoing leave end date blank.			
3B. NAME OF PROVIDER		END: / /			
3D. AMOUNT PAID MONTHLY	3E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE F				
\$,.		e Hours Worked /er Week)			
4A. WHOSE EXPENSES WERE PAID?		4C. PROVIDER START AND END DATE (MM/DD/YYYY)			
VETERAN SPOUSE CHILI	D (Specify) OTHER (Specify)	START: / /			
Specify Name of Child or Other:		NOTE: If care is ongoing leave end date blank.			
4B. NAME OF PROVIDER		END: / /			
4D. AMOUNT PAID MONTHLY	4E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE R				
\$,.		e Hours Worked er Week)			
5A. WHOSE EXPENSES WERE PAID?		5C. PROVIDER START AND END DATE (MM/DD/YYYY)			
VETERAN SPOUSE CHILI	D (Specify) OTHER (Specify)	START: / /			
Specify Name of Child or Other:		NOTE: If care is ongoing leave end date blank.			
5B. NAME OF PROVIDER		END: / /			
5D. AMOUNT PAID MONTHLY	5E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE R				
\$,.		e Hours Worked er Week)			
6A. WHOSE EXPENSES WERE PAID?		6C. PROVIDER START AND END DATE (MM/DD/YYYY)			
VETERAN SPOUSE CHILI	D (Specify) OTHER (Specify)	START: / /			
Specify Name of Child or Other:		NOTE: If care is ongoing leave end date blank.			
6B. NAME OF PROVIDER		END: / /			
6D. AMOUNT PAID MONTHLY	6E. IF THIS IS AN IN-HOME PROVIDER, PROVIDE R				
\$,.		∋ Hours Worked Per Week)			

	ADDENDUM B: C	OTHER MEDICAL EXPENS	ES			
If you are not claiming additional expenses, complete	etion of Addendum B is no	ot required.				
calculated to either a monthly or annual rate. Com	Please report your monthly recurring expenses that are not reported in other sections on one line, including the specific dates the recurring expense started, and calculated to either a monthly or annual rate. Complete an additional line for any changes in the amount of a monthly recurring expense. Prescription medications are generally not considered recurring. If a recurring expense has already stopped, please treat the expense as non-recurring and report a total amount paid during the designated time period.					
the date of receipt of the form.	ut reporting a previously c	counted continuing medical expension	se may result in removal of the medical expense from			
1A. WHOSE EXPENSES WERE PAID?	ecify) 🔲 OTHER (Specify	y) Specify Name of Child or Other	•			
1B. DATE COSTS PAID (MM/DD/YYYY)	1C. FREQUENCY		1D. PAYMENT AMOUNT			
			\$,			
1E. PAID TO (Name of provider, insurance company	etc.)	1F. PURPOSE (Insurance premiu	m, medical supplies, etc.)			
2A. WHOSE EXPENSES WERE PAID?	ecify) 🔲 OTHER (Specify	y) Specify Name of Child or Other	·			
2B. DATE COSTS PAID (MM/DD/YYYY)	2C. FREQUENCY		2D. PAYMENT AMOUNT			
/ /			\$,.			
2E. PAID TO (Name of provider, insurance company,	etc.)	2F. PURPOSE (Insurance premiu	m, medical supplies, etc.)			
3A. WHOSE EXPENSES WERE PAID?	ecify) 🗌 OTHER (Specify	y) Specify Name of Child or Other	:			
3B. DATE COSTS PAID (MM/DD/YYYY)	3C. FREQUENCY		3D. PAYMENT AMOUNT			
/ /			\$,			
3E. PAID TO (Name of provider, insurance company	, etc.)	3F. PURPOSE (Insurance premiu	m, medical supplies, etc.)			
4A. WHOSE EXPENSES WERE PAID?	ecify) 🗌 OTHER (Specify	y) Specify Name of Child or Other				
4B. DATE COSTS PAID (MM/DD/YYYY)	4C. FREQUENCY		4D. PAYMENT AMOUNT			
		NNUALLY NOT RECURRING	\$,.			
4E. PAID TO (Name of provider, insurance company,	etc.)	4F. PURPOSE (Insurance premiu	m, medical supplies, etc.)			
5A. WHOSE EXPENSES WERE PAID?	ecify) 🗍 OTHER (Specify	y) Specify Name of Child or Other	·			
5B. DATE COSTS PAID (MM/DD/YYYY)	5C. FREQUENCY		5D. PAYMENT AMOUNT			
	MONTHLY AN		¢			
/ / 5E. PAID TO (Name of provider, insurance company,		5F. PURPOSE (Insurance premiu				
6A. WHOSE EXPENSES WERE PAID?]					
VETERAN SPOUSE CHILD (Sp	ecify) 🔲 OTHER (Specify	y) Specify Name of Child or Other	:			
6B. DATE COSTS PAID (MM/DD/YYYY) 6C. FREQUENCY 6D. PAYMENT AMOUNT						
			\$,			
6E. PAID TO (Name of provider, insurance company, etc.) 6F. PURPOSE (Insurance premium, medical supplies, etc.)						
7A. WHOSE EXPENSES WERE PAID? VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:						
7B. DATE COSTS PAID (MM/DD/YYYY) 7C. FREQUENCY 7D. PAYMENT AMOUNT						
/ /			\$,			
7E. PAID TO (Name of provider, insurance company,	etc.)	7F. PURPOSE (Insurance premiu	m, medical supplies, etc.)			

ADDENDUM C: MILEAGE FOR PRIVATELY OWNED VEHICLE TRAVEL FOR MEDICAL PURPOSES						
Report miles traveled for medical purposes (e.g. hospital, clinic, pharmacy, etc.) in a privately owned vehicle (POV) such as a car, truck or motorcycle. Only report travel that occurred between the dates reported in Section III of VA Form 21P-8416, Medical Expense Report submitted with this addendum.						
1A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	1C. TOTAL MILES TRAVELED	1D. DATE TRAVELED (MM/DD/YYYY) Month Day Year 1E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$				
		,				
2A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	2C. TOTAL MILES TRAVELED	2D. DATE TRAVELED (MM/DD/YYYY) Month Day Year				
2B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		2E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$				
3A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	3C. TOTAL MILES TRAVELED	3D. DATE TRAVELED (MM/DD/YYYY) Month Day Year 3E. AMOUNT REIMBURSED FROM ANY SOURCE				
3B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		(VA Medical Center, etc.) \$, .				
4A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) UETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	4C. TOTAL MILES TRAVELED	4D. DATE TRAVELED (MM/DD/YYYY) Month Day Year				
4B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		4E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$				
5A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	5C. TOTAL MILES TRAVELED	5D. DATE TRAVELED (MM/DD/YYYY) Month Day Year				
5B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		5E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$				
6A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) UETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	6C. TOTAL MILES TRAVELED	6D. DATE TRAVELED (MM/DD/YYYY) Month Day Year				
6B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		6E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$				
7A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	7C. TOTAL MILES TRAVELED	7D. DATE TRAVELED (MM/DD/YYYY) Month Day Year				
7B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		7E. AMOUNT REIMBURSED FROM ANY SOURCE (VA Medical Center, etc.) \$				
8A. WHO NEEDED TO TRAVEL? (Self, spouse, child, etc.) VETERAN SPOUSE CHILD (Specify) OTHER (Specify) Specify Name of Child or Other:	8C. TOTAL MILES TRAVELED	8D. DATE TRAVELED (MM/DD/YYYY)				
8B. PROVIDE LOCATION TRAVELED TO (Hospital, clinic, pharmacy, etc.)		(VA Medical Center, etc.)				

WORKSHEET FOR A RESIDENTIAL CARE,	, ADULT DAYCARE, OR A SIMILAR FACILITY			
NOTE : This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, <i>Medical Expense Report</i> . In addition, VA Form 21-2680, <i>Examination for Housebound Status or Permanent Need for Regular Aid and Attendance</i> may be needed to count these expenses.				
1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipier	ent, either the Claimant or Dependent)			
2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administ	strator or Licensed Medical Professional)			
3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?				
4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official we	ebsite)			
5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone	e Number (If applicable)			
6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE				
No. & Street				
Apt./Unit Number City				
State/Province Country ZIP Code	_			
7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?				
8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY	IS PROVIDING TO THE CARE RECIPIENT.			
A. EATING B. BATHING/SHOWERING C. TRANSFERRING I	IN OR OUT OF BED OR CHAIR			
	HIN HOME OR LIVING AREA			
9. FOR EACH STATEMENT BELOW PLEASE CHECK THE BOX IF THIS STATEMEN	NT IS TRUE FOR THE FACILITY:			
THE STATE OR COUNTRY REQUIRES THIS FACILITY TO BE LICENSED				
THE FACILITY IS LICENSED				
THE FACILITY IS RESIDENTIAL				
THE FACILITY IS STAFFED 24 HOURS				
10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision requires care or assistance on a regular basis to protect the individual from hazards or of	on because an individual with a physical, mental, developmental, or cognitive disorder			
YES NO, Care is being provided by a third-party provider.	NO, Care is not being provided to this claimant.			
If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.				
11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY (MM/DD/YYYY)	12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.)			
/ /				
13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.				
\$ ' _ PER MONTH				
	ERTIFICATION			
reflects the current environment of the Care Recipient and the facility.	SIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and			
14. SIGNATURE OF PROVIDER (From question 2)	15. DATE SIGNED (MM/DD/YYYY)			

WORKSHEET FOR IN-HOME	E ATTENDANT EXPENSES				
NOTE : This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, <i>Medical Expense Report</i> . In addition, VA Form 21-2680, <i>Examination for Housebound Status or Permanent Need for Regular Aid and Attendance</i> may be needed to count these expenses.					
1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient,	either the Claimant or Dependent)				
2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency Add	ministrator, Provider)				
 3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL? (A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.) 4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION? 					
	YES NO (If "NO," skip to question 7)				
5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?	6. WHAT IS THE AGENCY TELEPHONE NUMBER?				
7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRAT	IVE OFFICE?				
No. & Street					
Apt./Unit Number City					
State/Province Country ZIP Code	_				
8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CA	RE ASSISTANT PROVIDED TO THE CARE RECIPIENT.				
A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN O	R OUT OF BED OR CHAIR				
D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN	HOME OR LIVING AREA				
9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT	THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.				
A. SHOPPING B. FOOD PREPARATION C. NON-	MEDICAL TRANSPORTATION				
D. LAUNDERING E. USING TELEPHONE F. MAN	AGING FINANCES				
G. HOUSEKEEPING					
10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE Care is regular assistance with two or more ADLs (Question 8), or supervision because an or assistance on a regular basis to protect the individual from hazards or dangers incident t	individual with a physical, mental, developmental, or cognitive disorder requires care				
11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. (MM/DD/YYYY)	 ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.) 				
/ /					
13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING. 14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.					
\$ _ PER HOUR HOURS PER MONTH					
CERTIFICATION					
I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.					
15. SIGNATURE OF PROVIDER (From question 2)	16. DATE SIGNED (MM/DD/YYYY)				