OMB Control No. 2900-0721 Respondent Burden: 30 minutes Expiration Date: 02/28/2026

Department of Veterans Affairs

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

**VA DATE STAMP** (DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 4. Use this form to determine eligibility for aid and attendance or housebound benefits. For more information, you can contact us online through Ask VA: <a href="https://ask.va.gov/">https://ask.va.gov/</a> . Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at <a href="https://www.va.gov/vaforms">www.va.gov/vaforms</a> .						
SECTION I: VETERAN'S	IDENTIFICATION INFORMATION					
<b>NOTE</b> : You may complete the form online or by hand. If completing by half help expedite processing of the form.	nd, print neatly and legibly in ink, and completely fill in each applicable check box to					
VETERAN/BENEFICIARY'S NAME (First, Middle Initial, Last)						
2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)					
4. VETERAN'S SERVICE NUMBER (If applicable)	5. DATE OF BIRTH (MM/DD/YYYY)					
SECTION II: CLAIMAINT	S IDENTIFICATION INFORMATION					
6. CLAIMANT'S NAME (First, Middle Initial, Last)						
7. CLAIMANT'S SOCIAL SECURITY NUMBER 8. RELATIONSHIP OF	CLAIMANT TO VETERAN 9. CLAIMANT'S DATE OF BIRTH (MM/DD/YYYY)					
│	PARENT					
SPOUSE	CHILD					
10. MAILING ADDRESS (Number and street or rural route, P. O. Box, City, State, Z	IP Code and Country)					
No. &						
Street						
Apt./Unit Number City						
State/Province Country ZIP Code/Postal Code						
11. TELEPHONE NUMBER (Optional) (Include Area Code)						
Enter International Phone Number /If annicable)						
Enter International Phone Number (If applicable)						
12. EMAIL ADDRESS (Optional)	e from VA in regards to my claim.					
SECTION III.	CLAIM INFORMATION					
SECTION III: CLAIM INFORMATION  13. SELECT ONE OF THE FOLLOWING BENEFITS (Choose one)						
<b>Special Monthly Compensation (SMC)</b> - Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to						
the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation.						
A veteran or a deceased veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a veteran, the disability causing the need for aid and attendance or housebound status must be related to						
service. These benefits are paid in addition to monthly compensation or Dependency Indemnity Compensation (DIC). They are not paid without eligibility to						
compensation.						
Special Monthly Pension (SMP) - Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of						
	day living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting					
prosthetic devices, or protecting them from the hazards of their daily environment, or are housebound (substantially confined to their immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a veteran or survivor who is eligible						
for Veterans Pension or Survivors benefits.						

SECTION W; IS VETERANCLAMANT HOSPITALIZED?   148. DATE ADMITTED (MADDYYYY)   147. NAME to Section V)   140. NAME of HOSPITAL   140. NAME OF HOSPITAL   140. ADDRESS OF HOSPITAL   140	VETERAN'S SOCIAL SECURITY NUMBER						
YES dt "YES," compete litere \$148, 140 & 140)   NOTE: Examiner must be a Medical Doctor (Mp) or Doctor of Oscopathic (DO) medicine, physician assistant or advanced practice registered nurse.	SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?						
NOTE: Examiner must be a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.  16. DATE OF EXAMINATION MANDED Provided and belief.  17. NOTE: Examiner must be a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.  18. DATE OF EXAMINATION INFORMATION.  NOTE: EXAMINER PLEASE READ CAREFULLY  The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veteran/claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. Please provide as much description as needed for each question as a this will assist V1 to determine if the disease(s) or injuryles) listed or benefits, the report should reflect how well they ambulate, where they go, and what they are able to do during a typical day.  18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)  18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)  18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)  20. NUTNITION  21. SATING WEIGHT  18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)  22. SATING WEIGHT  18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)  23. SATING WEIGHT  18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)  24. SATING WEIGHT  18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)  25. SATING WEIGHT  26. SATING WEIGHT  27. SATING WEIGHT  28. SATING WEIGHT  198. WEIGHT  198. WEIGHT  199. WEIG	14A. IS THE CLAIMANT HOSPITALIZED?	14B. DATE ADMITTED (MM/DD/YYYY)					
I.C. NAME OF HOSPITAL  IND. ADDRESS OF HOSPITAL  SECTION Y: CERTIFICATION AND SIGNATURE  I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.  196. VETERANICLAMANTS SIGNATURE (Required)  SECTION Y: EXAMINATION INFORMATION  (IMPORTANT: Remainder of form MUST be filled out by Examiner)  NOTE: Examiner must be a Medical Doctor (MPORTANT: Remainder of form MUST be filled out by Examiner)  NOTE: EXAMINATION INMODIFYTY)  INDIFICIAL FOR EXAMINATION INMODIFYTY  INDIFICIAL FOR EXAMINATION INMODIFYTY  INDIFICIAL FOR EXAMINATION INFORMATION INFORMA	YES (If "YES," complete Items 14B, 14C & 14D)	ES," complete Items 14B, 14C & 14D)					
SECTION V: CERTIFICATION AND SIGNATURE    ICERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.	☐ NO (If "NO," skip to Section V)	-		-			
SECTION V: CERTIFICATION AND SIGNATURE  I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.  15A. VETERANICLAIMANT'S SIGNATURE (Required)  SECTION V: EXAMINATION INFORMATION  (IMPORTANT'R Remainder of form MUST be filled out by Examiner)  NOTE: Examiner must be a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.  15. DATE OF EXAMINATION (IMMDDYYYY)  NOTE: EXAMINATION (IMMDDYYYY)  The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veleranicalization are much description as needed for each question as this will assist Val to determine if the diseases (so) in injury(is) and any the state of the regular aid and attendance of another person. Please provide as much description as needed for each question as this will assist Val to determine if the diseases (so) in injury(is) and may be a substantial to the physical or mental impairment, loss of coordination or enfeoblement that require assistance with faily ining. Findings should be recorded to show whether the claimant is link or bedridden. Whether the claimant site histosebound or aid and attendance benefits, the report should reflect how well they ambulate, where they go, and what they are able to do during a typical day.  17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR EACH CONDITION (Diagnosis needs to equals to the level of assistance described in interns 28 through 37) (Describe below)  A.	14C. NAME OF HOSPITAL						house, and
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20. NUTRITION 21. GAIT	19A. AGE 19B. WEIGHT						19C. HEIGHT
	ACTUAL LBS.	ESTIMATE	D LBS.				FEET INCHES
22. BLOOD PRESSURE 23. PULSE RATE 24. RESPIRATORY RATE 25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?	20. NUTRITION 21. GAIT						
22. BLOOD PRESSURE 23. PULSE RATE 24. RESPIRATORY RATE 25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?							
22. BLOOD FRESSORE 20.1 SECTION 10.1 THE EIGHEN THE EIG	22 BLOOD PRESSURE 23, PULSE RATE 24, RESPIRATORY RATE 25, WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?						
	22, BLOOD FILESCORE 20.1 SEE 13.1	, NEOF HATTORY		20, 111	D1-	<b>NDIE</b>	TIEG REGINGT THE EIGTES AGTAINED TO CO. C. C.

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VETERAN'S SOCIAL SECURITY NUMBER								
26. IF THE PATIENT IS CONFINED TO BED,	, INDICATE THE NUMBER OF HOURS IN BED							
From 9 PM to 9 AM: From 9 A	AM to 9 PM:							
l	ANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply	y) CTIVITIES (i.e., housekeeping, laundering, meal						
BATHING/SHOWERING	TENDING TO HYGIENE NEEDS preparation, etc	c.) (Specify additional activity below)						
EATING OR SELF-FEEDING	TRANSFERRING IN OR OUT OF BED/CHAIR							
DRESSING	TOILETING							
OR LIVING AREA	MEDICATION MANAGEMENT							
28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)  28B. CORRECTED VISION  LEFT EYE RIGHT EYE								
YES								
NO								
29. DOES THE PATIENT REQUIRE NURSIN	IG HOME CARE? (If "Yes," provide explanation)							
YES								
□ NO								
30. IN YOUR JUDGMENT, DOES THE PATIE DIRECT SOMEONE TO DO SO?	ENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYME	ENTS, OR ARE THEY ABLE TO						
☐ YES								
□ NO								
(If "NO," provide the								
disability(ies) that prevent them from performing this function and any rationale								
to support your conclusion in the space								
provided)								
31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)								
32. DESCRIBE RESTRICTIONS OF EACH UI	PPER EXTREMITY WITH PARTICULAR REFERANCE TO GRIP, FINE MOV	/EMENTS, AND ABILITY TO FEED THEMSELVES,						
TO BUTTON CLOTHING, SHAVE AND ATTE	ND TO THE NEEDS OF NATURE							
22 DESCRIPE DESTRICTIONS OF FACH I	OWER EXTREMITY WITH PARTICULAR REFERANCE TO THE EXTENT O	E LIMITATION OF MOTION ATPOPHY AND						
	NCE. (NOTE: If indicated, comment specifically on weight bearing, balance an							
34. DESCRIBE RESTRICTION OF SPINE, TR	RUNK, AND NECK							

VETERAN'S SOCIAL SECURITY NUMBER								
35. DESCRIBE ALL OTHER PATHOLOGY LOSS OF MEMORY OR POOR BALANCE, AREA	INCLUDI THAT A	ING THE I	LOSS	OF BOWE	EL OR LITY T	BLADDI O PERF	ER CO ORM S	NTROL OR THE EFFECTS OF ADVANCING AGE; SUCH AS DIZZINESS, SELF-CARE, OR IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL
				*				
26 HOW OFTEN DED DAY OF WEEK AND	LINDER	NAULATIC	NDCI II	MOTANICI	FO /4-	Section 4		al of accidence accident to the DATIENT ADDIT TO LEAVE THE HOME OD
IMMEDIATE PREMISES (Describe)	UNDER	CVHATC	ARCUI	MSTANCE	=5 (10	include t	ine ieve	el of assistance required) IS THE PATIENT ABLE TO LEAVE THE HOME OR
37. ARE AIDS SUCH AS CANES, BRACES,	CRUTCI	HES OR	THE A	ASSISTAN	ICE O	F ANOTH	HFR PF	ERSON REQUIRED FOR LOCOMOTION?
YES (If "YES," check the applicable box or specify distance)	_	BLOCK		5 OR 6 BL			1 MILE	OTHER
□ NO	<u> </u>	520011	П,	0 0,10 00	200110			(Specify distance)
		STATE OF	SEC	CTION V	II: EX	AMINE	R'S S	IGNATURE
38. PRINTED NAME OF EXAMINER							39. 7	TITLE OF EXAMINER
40. SIGNATURE OF EXAMINER (REQUIRE)	0)							
	-,						41.	DATE SIGNED (MM/DD/YYYY)
	4 20 1		SECT	rion VIII	: EXA	AMINER	R'S INF	FORMATION
42. NATIONAL PROVIDER IDENTIFIER (NE	i) NUMB	3ER OF E	XAMIN	NER				
43. NAME OF MEDICAL FACILITY								
44. ADDRESS OF MEDICAL FACILITY (Number and street or rural route, city, state, ZIP Code and Country)								
45. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)								
Enter International Phone Number (If applicable)								
<b>PENALTY</b> : 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 document you are not entitled to.								
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 Veteran Readiness and Employment Records - VA, 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 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								

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), 1315(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 website at <a href="http://www.reginfo.gov/public/do/PRAMain">http://www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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.

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