

INSTRUCTIONS FOR MEDICAL EXPENSE REPORT

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

Report any medical or dental expenses that you paid for yourself or for a relative who is a member of your household (spouse, grandchild, parent, etc.) for which you were not reimbursed and do not expect to be reimbursed. Below are examples of expenses you should 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

IMPORTANT NOTES

- 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 the VA office handling your claim.
- If you are a veteran, VA can deduct allowable expenses paid by either you or your spouse.
- If you are not sure whether VA can deduct a payment for a particular expense, furnish a complete description of the purpose of the payment. We will let you know if we cannot deduct an expense.
- If you are claiming expenses for an in-home care provider or for assisted living or similar care, you *must* complete the appropriate worksheet on page 5 *or* 6 to determine whether VA may deduct all or some of your payments to the provider or facility.
- VA may require you to verify the amounts you paid, so keep all receipts or other documentation of payments for at least 3 years after we make 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.
- If you need more space to report expenses, attach a separate sheet of paper with columns corresponding to those on this form. Be sure to write your VA file number on any attachments.

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 agent may charge you a fee for assisting in seeking further review of a claim for VA benefits only after VA has issued an initial decision on the 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 Vocational Rehabilitation 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 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 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.

OMB Control No. 2900-0161 Respondent Burden: 30 minutes Expiration Date: 12/31/2024

Department of Veterans A	Affairs					A DATE STAMP WRITE IN THIS SPACE
MEDICA	L EXPENS	SE RE	PORT			
1. NAME OF VETERAN (First, Middle Initial, Last)						
2. SOCIAL SECURITY NUMBER			3. VA FILE NUMBER (If applie	cable)		
4. NAME OF CLAIMANT (First, Middle Initial, Last)						
5. CURRENT MAILING ADDRESS OF CLAIMANT No. &	(Number and street o	r rural route	, P. O. Box, City, State, ZIP Code	e and Country)		
Street Apt./Unit Number	City					
State/Province Country	ZIP (Code/Postal	Code	_		
6. CHANGE OF ADDRESS (Check box if address is	different from last ad	dress furnis	hed to VA)			
7. TELEPHONE NUMBER OF CLAIMANT (Include A	Area Code)	8. E-MAIL	ADDRESS			
Enter International Phone Number						
(If applicable) 9. MILEAGE F	FOR PRIVATELY (OWNED V	EHICLE TRAVEL FOR MED	DICAL PURP	OSES	
have a letter, please report unreimbursed medical exp	. If no dates appear on enses on a calendar ye	this line, retear basis (ex	fer to the accompanying letter for . 01/01/XXXX thru 12/31/XXXX	the dates you sl). We will calcu	nould report medulate the allowab	dical expenses. If you do not
mileage based on the current POV mileage reimburse NOTE: You may also claim deductions for other Report these types of medical travel expenses in I	payments related to					oublic transportation.
A. MEDICAL FACILITY TO WHICH TRAVELED	B. TOTAL ROU MILES TRAV		C. AMOUNT REIMBURSED FROM ANOTHER SOURCE (Such as a VA Medical Center)	TRA	DATE VELED 'Day/Year)	E. WHO NEEDED TO TRAVEL? (Self, spouse, child)
				Month Da	y Year	
				Month Da	y Year	
				Month Da	ay Year	
				Month Da	ay Year	
				Month Da	ay Year	
				Month Da	ay Year	
IMPORTANT: Be sure to sign and	d date this for	m in Iter	ns 12A & 12B on pag	e 4. Unsig	ned repor	ts will be returned

	40 10 110115 455	CAIDANT EVERY	-0	
IMPORTANT - You must complete the attached In-H Report amounts paid between the dates _ should report medical expenses. If you do not have a le	Iome Attendant Worksheet	. If no dates appear	attendant expenses.	ying letter for the dates you (XXX thru 12/31/XXXX).
A. NAME OF PROVIDER	B. HOURLY RATE/ NUMBER OF HOURS	C. AMOUNT PA	ID D. DATE PAID (Month/Day/Year)	E. FOR WHOM PAID (Self, spouse, child, etc.)
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	
		F MEDICAL EXPENSE		1
IMPORTANT - If you are claiming expenses for care Report medical expenses that you paid between the cletter for the dates you should report medical expenses (ex. 01/01/XXXX thru 12/31/XXXX).	e in an assisted living, adult dates s. If you do not have a letter,	day care, or a similar facil and, please report unreimburs	lity, you must complete the approp If no dates appear on this line ed medical expenses on a calendar	oriate worksheet (page 6). The refer to the accompanying ryear basis
A. MEDICAL EXPENSE (Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)	B. AMOUNT PAID	C. DATE PAID (Month/Day/Year)	D. NAME OF PROVIDER (Name of doctor, dentist, hospital, lab, etc.)	E. FOR WHOM PAID (Self, spouse, child, etc.)
		Month Day Year		
MEDICARE (PART B)				
		Month Day Year		
MEDICARE (PART D)				
		Month Day Year		
PRIVATE MEDICAL INSURANCE				
		Month Day Year		
		Month Day Year		
		Month Day Year		

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Month Day

Year

	ITEMIZATION OF ME					
IMPORTANT - If you are claiming expenses for care in Report medical expenses that you paid between the day	in an assisted living, adul	t day car	re, or a	similar faci	ility, you must complete the appro	priate worksheet (page 6).
Report medical expenses that you paid between the daletter for the dates you should report medical expenses. (ex. 01/01/XXXXX thru 12/31/XXXX).	If you do not have a lette	r, please	e report	unreimburs	sed medical expenses on a calenda	r year basis
A. MEDICAL EXPENSE (Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)	B. AMOUNT PAID		. DATE	PAID y/Year)	D. NAME OF PROVIDER (Name of doctor, dentist, hospital, lab, etc.)	E. FOR WHOM PAID (Self, spouse, child, etc.)
		Month	Day	Year		
MEDICARE (PART B)						
		Month	Day	Year		
MEDICARE (PART D)						
		Month	Day	Year		
PRIVATE MEDICAL INSURANCE						
		Month	Day	Year		
		Month	Day	Year		
		Month	Day	Year		
		Month	Day	Year		
		Month	Day	Year		
		Month	Day	Year		1
			•			
		Month	Day	Year		
						_
		Month	Day	Year		
CERTIFICATION: I have not and will not re	eceive reimburseme	nt for t	hese e	xpenses.	I certify that the above inf	ormation is true.
12A. SIGNATURE OF CLAIMANT (Do NOT print)					Month Day	Year

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES					
NOTE: Only complete this worksheet if you are claiming expenses for in-home care.					
IMPORTANT: VA recognizes the fol	lowing five activities as Activities of Daily Living (ADLs) for medical expense purposes:				
(1) Eating(2) Bathing/Showering(3) Dressing(4) Transferring (for example, from b(5) Using the toilet	ped to chair)				
Custodial Care is regular -	ADLs, or n with a mental disorder is unsafe if left alone due to the mental disorder				
with these activities as medical expe	es are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally does not recognize assistance enses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; all purposes such as transportation to a doctor's appointment).				
INSTRUCTIONS: Use this workshee	et if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.				
Follow the steps below to determine	whether or not:				
	th care provider for VA purposes and assistance with IADLs as well as assistance with ADLs and custodial care				
STEP 1. Are you (the claimant)	the disabled person?				
YES NO	(If "NO," skip to Step 6)				
STEP 2. Has VA determined that	at you are eligible for special monthly pension? (Special monthly pension means pension at the aid and attendance				
or housebound rate or	Parents' DIC at the aid and attendance level) (If "YES," the attendant does not need to be a health care provider. Skip to Step 3)				
() IEG () NO	(If "NO," skip to Step 4)				
	(if "YES," payments to this in-home attendant to provide you with health care services or custodial care? (if "YES," payments to this in-home attendant qualify as medical expenses (even if the attendant also assists you with IADLs). You may claim these expenses in Item 10. Skip to Step 8)				
(YES (NO	(If "NO," payments to this in-home attendant for assistance with IADLs <i>do not</i> qualify as medical expenses. Payments for health care services and custodial care qualify as medical expenses. You may claim these expenses in Item 10. Skip to Step 8)				
STEP 4. Are you claiming spec	• •				
YES NO	(If "YES," please complete and attach with this application VA Form 21-2680, Examination for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every item on this form is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS)) (If "NO," the attendant must be a health care provider and payments for assistance with IADLs do not qualify as medical expenses.				
	Payments for health care services or assistance with ADLs qualify as medical expenses. You may claim these expenses in Item 10. Skip to Step 8)				
STEP 5. Is the primary respon	asibility of the in-home attendant to provide you with health care or custodial care?				
C 1/50 C 1/0	(If "YES," payments to this in-home attendant may qualify as medical expenses <i>if</i> VA rates you as eligible for special monthly pension. Please report separately in Item 10 amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider, (2) assistance with IADLs; and (3) custodial care. Skip to Step 8)				
	(If "NO," payments to this in-home attendant for assistance with IADLs do not qualify as medical expenses. Please report separately in Item 10 applicable amounts you pay an in-home attendant for: (1) health care services or assistance with ADLs provided by a health care provider, and (2) custodial care. Skip to Step 8)				
STEP 6. Does the disabled person disabled person's mentage.	on require the health care services or custodial care that the in-home attendant provides to him or her because of the				
OYES ONO	(if "YES," you must submit a statement from a physician or physician assistant that: (1) the disabled person requires the health care services or custodial care that the attendant provides him or her because of mental or physical disability, and (2) describes the mental or physical disability. The in-home attendant <i>does not</i> need to be a health care provider)				
	(If "NO," the attendant <i>must be a health care provider</i> and payments for assistance with IADLs <i>do not</i> qualify as medical expenses. Payments to the in-home attendant for health care services or assistance with ADLs provided by a health care provider qualify as medical expenses. You may claim these expenses in Item 10. Skip to Step 8)				
	ibility of the in-home attendant to provide the disabled person with health care and/or custodial care?				
YES NO	(If "YES," payments to the in-home attendant qualify as medical expenses (even if the attendant also assists the disabled person with IADLs. You may claim these expenses in Item 10) (If "NO," payments to the in-home attendant for assistance with IADLs <i>do not</i> qualify as medical expenses. Payments to the in-home attendant for <i>health care or custodial care</i> qualify as medical expenses. You may report these expenses in Item 10)				
	by that the attendant assists the disabled person with:				
ADLs: CEATING B	ATHING/SHOWERING				
IADLs:					
USING THE TELEPHONE TRANSPORTATION FOR NON-MEDICAL PURPOSES STEP 9. In Home Attendant Contification: Places submit a current breakdown of the time the attendant spends assisting the disabled person with					
STEP 9. In-Home Attendant Certification: Please submit a current breakdown of the time the attendant spends assisting the disabled person with health care services, ADLs and IADLs. CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and					
reflects the current environment pertaining to and his or her care from					
enects the current environment perte	(Name of Person Requiring Care) (Name of Attendant)				
(Name, Signature a	nd Title of Certifying Official) (Date Certified)				

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WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR A SIMILAR FACILITY						
NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.						
IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:						
(1) Eating						
(2) Bathing/Showering						
(3) Dressing						
(4) Transferring (for example, from bed to chair)						
(5) Using the toilet						
Custodial Care is regular -						
INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar famedical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility	icility as unreimbursed					
STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing medical foster home? (If "NO," continue to Step 2)	ng home, or VA approved					
YES NO (If "YES," <i>all</i> payments to the facility qualify as medical expenses. You may claim these expenses in Item 11. You are finished completing this worksheet)						
STEP 2. Do all of the following apply to the facility? The facility is licensed (if the State or country requires it) The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both. If the facility is residential, it is staffed 24 hours per day with caregivers						
YES NO (If "NO," payments to the facility <i>do not</i> qualify as medical expenses. You are finished completing this workshed	et)					
STEP 3. Are you (the claimant) the disabled person? Are you a veteran, surviving spouse, or Parents' DIC claimant?						
YES NO (If "NO," to either of these questions, skip to Step 8)						
STEP 4. Has VA determined that you are eligible for special monthly pension? (Special monthly pension means pension at the air housebound rate or Parents' DIC at the aid and attendance level)	d and attendance or					
YES NO (If "NO," skip to Step 6)						
STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the <i>primary reason</i> you live in the facility (or attend day care in the facility)?						
(If "YES," all payments to this facility qualify as medical expenses. You may claim these expenses in Item 11. Ski	p to Step 10)					
YES NO (If "NO," payments to this facility for meals and lodging <i>do not</i> qualify as medical expenses. Only claim amounts health care services or custodial care)	you pay the facility for					
STEP 6. Are you claiming special monthly pension?	o ar Darmanant Maad					
(If "YES," please complete and attach with this application VA Form 21-2680, Examination for Housebound State for Regular Aid and Attendance. Please make sure every item is complete and the form is signed by a Physician Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS)) (If "NO," payments to this facility for meals and lodging do not qualify as medical expenses. Only claim amounts health care services or assistance with ADLs provided by a health care provider in Item 11. Skip to Step 1	, Physician Assistant (PA), s you pay the facility for					
STEP 7. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care.	.,					
Is this the <i>primary reason</i> you live in the facility (or attend day care in the facility)? (If "YES," all payments to this facility <i>may</i> qualify as medical expenses <i>if</i> VA rates you as eligible for special mor DIC. Please report separately in Item 11 applicable amounts you pay the facility for: (1) lodging and meals, (2) <i>h</i> assistance with ADLs provided by a health care provider, and (3) custodial care. Skip to Step 10)						
(If "NO," payments to this facility for meals and lodging <i>do not</i> qualify as medical expenses. Please report separ applicable amounts you pay the facility for: (1) <i>health care services or assistance with ADLs provided by a h</i> and (2) <i>custodial care</i> . Skip to Step 10)						
STEP 8. Does the disabled person require the health care services or custodial care that the facility provides to him or her becau person's mental or physical disability?						
(If "YES," you must submit a statement from a physician or physician assistant that: (1) the disabled person requ services or custodial care that the facility provides to him or her because of mental or physical disability, and (2) physical disability) (If "NO," claim only amounts you pay the facility for <i>health care services or assistance with ADLs provided by</i> Item 11. Skip to Step 10)	describes the mental or					
STEP 9. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custod primary reason the disabled person lives in the facility or attends day care in the facility?	ial care. Is this the					
(If "YES," claim <i>all</i> payments to this facility (to include meals and lodging) as medical expenses in Item 11) (If "NO," payments to this facility for meals and lodging <i>do not</i> qualify as medical expenses. <i>Only</i> claim amounts	you pay the facility for					
health care services or custodial care in Item 11) STEP 10. Facility Certification: Please submit a current statement showing the fees claimant pays to your facility and breakdow I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accur.						
	ner care at this					
(Name of person staying at your facility)						
facility						
(Name and address of facility) (Name, Signature and Title of Person Certifying for the Facility)	(Date Certified)					
(Name, Signature and True of Person Certifying for the Pacility)	,					

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