



APPLICATION FOR EXTENDED CARE SERVICES

Section I - General Information

1. VETERAN'S NAME <i>(Last, First, MI)</i>	2. SOCIAL SECURITY NUMBER
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ANSWER YES OR NO WHERE APPLICABLE (OTHERWISE PROVIDE THE REQUESTED INFORMATION)

3. ARE YOU ELIGIBLE FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	3A. ARE YOU ENROLLED IN MEDICARE PART A <i>(Hospital Insurance)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	3B. EFFECTIVE DATE <i>(If "Yes")</i>
4. ARE YOU ENROLLED IN MEDICARE PART B <i>(Medical Insurance)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	4A. EFFECTIVE DATE <i>(If "Yes")</i>	4B. MEDICARE CLAIM NUMBER <i>(If applicable)</i>

Section II - INSURANCE INFORMATION

5. ARE YOU COVERED BY HEALTH INSURANCE *(including coverage through a spouse)? (If "YES", provide the following information for all insurance company(s) providing coverage to you.)*

 YES NO

6. NAME OF INSURANCE COMPANY		6A. ADDRESS OF INSURANCE COMPANY		6B. PHONE NUMBER OF INSURANCE COMPANY	
6C. NAME OF POLICY HOLDER	6D. RELATIONSHIP OF POLICY HOLDER	6E. POLICY NUMBER		6F. GROUP NAME AND/OR NUMBER	
7. NAME OF INSURANCE COMPANY		7A. ADDRESS OF INSURANCE COMPANY		7B. PHONE NUMBER OF INSURANCE COMPANY	
7C. NAME OF POLICY HOLDER	7D. RELATIONSHIP OF POLICY HOLDER	7E. POLICY NUMBER		7F. GROUP NAME AND/OR NUMBER	
8. NAME OF INSURANCE COMPANY		8A. ADDRESS OF INSURANCE COMPANY		8B. PHONE NUMBER OF INSURANCE COMPANY	
8C. NAME OF POLICY HOLDER	8D. RELATIONSHIP OF POLICY HOLDER	8E. POLICY NUMBER		8F. GROUP NAME AND/OR NUMBER	

SECTION III - SPOUSE/DEPENDENT INFORMATION

9. SPOUSE'S NAME *(Last, First, MI)*

9A. SPOUSE RESIDING IN THE COMMUNITY? <i>(Provide address and phone number if different from veteran)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "No", explain)</i>	9B. SPOUSE'S SOCIAL SECURITY NUMBER	
10. DEPENDENT'S NAME <i>(Last, First, MI)</i>	10A. DEPENDENT'S DATE OF BIRTH	10B. DEPENDENT'S SOCIAL SECURITY NUMBER
10C. DEPENDENT RESIDING IN THE COMMUNITY? <i>(Provide address and phone number if different from veteran)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "No", explain)</i>		
11. DEPENDENT'S NAME <i>(Last, First, MI)</i>	11A. DEPENDENT'S DATE OF BIRTH	11B. DEPENDENT'S SOCIAL SECURITY
11C. DEPENDENT RESIDING IN THE COMMUNITY? <i>(Provide address and phone number if different from veteran)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If "No", explain)</i>		

We need to collect information regarding income, assets and expenses for you and your spouse. If you do not wish to provide this information you must sign agreeing to make copayments and will be charged the maximum copayment amount for all services. See the top of page 2, read, sign and date.

I do not wish to provide my detailed financial information. I understand that I will be assessed the maximum copayment amount for extended care services and agree to pay the applicable VA copayment as required by law.

SIGNATURE	DATE
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Section IV - Fixed Assets (Veteran and Spouse)	VALUE
1. Residence (<i>Market value minus any outstanding mortgage or lien - exclude if veteran receiving only non-institutional services or spouse or dependent residing in community</i>).	\$
2. Other Residences/Land/Farm or Ranch (<i>Market value minus any outstanding mortgage or lien</i>)	\$
3. Vehicle(s) (<i>Value minus any outstanding lien - exclude if veteran receiving only non-institutional services or spouse or dependent residing in community</i>).	\$
SUBTOTAL (Sum of lines 1 through 3)	\$

SECTION V - LIQUID ASSETS (VETERAN AND SPOUSE)	VALUE
1. Cash, e.g., interest, dividends from IRA, 401K's and other tax deferred annuities (<i>including checking, savings, money market, etc.</i>).	\$
2. Stocks, bonds, mutual funds, SEP's, and other retirement accounts (<i>e.g., IRA, 401K, annuities, self-employed person</i>).	\$
3. Other Liquid Assets (<i>Includes such items as stamp or coin collections, art work, collectibles, household furniture and other household goods, clothing, jewelry and personal items minus amount owed.</i>).	\$
SUBTOTAL (Sum of lines 1 through 3)	\$

SUM OF ALL LINES FIXED AND LIQUID ASSETS	TOTAL ASSETS	\$
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CATEGORY	VETERAN		SPOUSE	
	HOW MUCH	HOW OFTEN	HOW MUCH	HOW OFTEN
Current income, e.g. gross income (<i>including, but not limited to, wages and income from a business, bonuses, tips, severance pay, accrued benefits, cash gifts</i>).	\$		\$	
Social Security Retirement/Disability	\$		\$	
Interest/Dividends (<i>i.e., interest income, standard dividend income from non tax deferred annuities</i>).	\$		\$	
Retirement and Pension income	\$		\$	
Civil Service Retirement	\$		\$	
U.S. Railroad Retirement	\$		\$	
VA Pension	\$		\$	
Spouse VA disability/compensation	\$		\$	
Unemployment Benefits/Compensation	\$		\$	
Other compensation, e.g. Workers Compensation and Black Lung	\$		\$	
Military Retirement	\$		\$	
Other Retirement	\$		\$	
Court Mandated (<i>e.g. alimony, child support</i>) (<i>Veteran and spouse</i>)	\$		\$	
Other Income (<i>i.e.; inheritance amounts, tort settlement payments</i>).	\$		\$	
TOTALS	\$		\$	

APPLICATION FOR EXTENDED CARE SERVICES, Continued	VETERANS NAME	SOCIAL SECURITY NUMBER
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Section VI - Expenses		
ITEMS		AMOUNT
1. Education <i>(veteran, spouse or dependent)</i>		\$
2. Funeral and Burial <i>(spouse or child)</i>		\$
3. Rent/Mortgage <i>(Monthly)</i>		\$
4. Utilities <i>(Average monthly in the past 12 months)</i>		\$
5. Car Payment Only <i>(excludes gas, insurance, parking fees)</i>		\$
6. Food		\$
7. Non-reimbursed medical expenses		\$
8. Court-ordered payments		\$
9. Insurance <i>(exclude life insurance)</i>		\$
10. Taxes <i>(on any amount include in gross income, property, personal)</i>		\$
TOTALS		\$

Section VII - Consent for Assignment of Benefits	
<p>I hereby authorize the Department of Veterans Affairs to disclose any such history, diagnostic and treatment information from my medical records to the contractor of any health plan contract under which I am apparently eligible for medical care or payment of the expense of care or to any other party against whom liability is asserted. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. Without my express revocation, this consent will automatically expire when all action arising from VA's claim for reimbursement for my medical care has been completed. I authorize payment of medical benefits to VA for any services for which payment is accepted.</p>	
SIGNATURE	DATE

Section VIII - Consent and Agreement To Make Copayments	
<p>Completion of this form with signature of the Veteran or veteran's representative is certification that the veteran/representative has received a copy of the Privacy Act Statement and agrees to make appropriate copayments.</p> <p>I certify the foregoing statement(s) are true and correct to the best of my knowledge and belief and agree to make the applicable copayment for extended care services as required by law.</p>	

Section IX - Paperwork and Privacy Act Information	
<p>The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 90 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. If you have comments regarding this burden estimate or any other aspect of this collection, call 202.273.8247 for mailing information on where to send your comments.</p> <p>Privacy Act Information: The VA is asking you to provide the information on this form under Title 38, United States Code, sections 1710, 1712 and 1722 in order for VA to determine your eligibility for extended care benefits and to establish financial liability, if applicable, when placed in extended care services. The information collected will become a part of the consolidated Health Record, which complies with the Privacy Act of 1974. These forms are part of the systems of records identified as 24VA136 "Patient Medical Record-VA". Financial information gathered on VA Form 10-10EC will be maintained in the system identified as 89VA161 "Health Eligibility Records-VA". The information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure for 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. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.</p>	
SIGNATURE	DATE

ADDITIONAL COMMENTS:	
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INSTRUCTIONS FOR COMPLETING APPLICATION FOR EXTENDED CARE SERVICES (VAF 10-10EC)

It is recommended that Social Work personnel involved in the extended care planning assist the veteran and/or family in understanding what information and financial data needs to be collected in order to fully complete VA Form 10-10EC. Social Work personnel are a good resource as they are familiar with some of the State and local requirements of alternative services available in the community and can provide information about options that may be available to the veteran. Once the VA Form 10-10EC is completed and long term care copayment determination made, Social Work personnel will review the projected copayments and spend down calculation of assets with the veteran and/or family as a part of case management and placement into extended (long term) care.

Section I - General Information

A veteran applying for extended care services may be required to complete VA Form 10-10EC, Application for Extended Care Services, when requesting the services. Certain veterans are exempt from extended care copayments and will not be required to complete VA Form 10-10EC. However, they may be required to provide Means Test income information in order to determine extended care copayment exemption status. Prior to the completion of VA Form 10-10EC, the veteran must have completed either an Application for Health Benefits (*VA Form 10-10EZ*) or a Long Term Care Copayment Exemption Test (*Income Information Section of VAF 10-10EZ*), whichever is applicable. HAS/Registration will be responsible for obtaining this information, if not already on file, from a veteran applying for extended care services. Extended care services subject to copayments include Adult day health care, Domiciliary care, institutional respite care, institutional geriatric evaluation, non-institutional respite care, non-institutional geriatric evaluation, or nursing home care. The social worker, or designated representative involved with the extended care planning will normally assist in the completion of the form. If the veteran is unable to complete the form, the spouse or veteran's representative may complete the form for the veteran. All questions should be answered completely and accurately.

The following veterans are exempt from extended (long term) care copayments and will NOT BE REQUIRED to complete VA Form 10-10EC:

- A veteran compensable with a service-connected disability.
- A veteran's whose annual income is less than the Single Veterans Pension Rate in effect under 38. U.S.C 1521(b).
- A veteran receiving care for a service-connected disability as determined by a VA health care provider and documented in the medical records.
- A veteran receiving extended care services that began on or before November 30, 1999.
- A veteran receiving care for Vietnam-era herbicide-exposure, radiation-exposure, Persian Gulf War and post-Persian Gulf War combat-exposure.
- A veteran receiving treatment for military sexual trauma as authorized under 38 U.S.C. 1720D.
- A veteran receiving certain care or services for cancer of the head or neck as authorized under 38 U.S.C. 1720E.
- A veteran receiving Hospice Care as a part of extended care services.

As a condition of receiving extended care services, any non-exempt veteran must agree to pay VA a copayment. A veteran has no copayment obligation for the first 21 days of extended care services in any 12 month period from the date the extended care services began. For each day beyond the first 21 days, unless an exemption applies, a veteran is obligated to pay VA a copayment amount for each day that extended care services are provided to the extent that the veteran has available resources. A veteran's monthly extended care copayment amount is based on the calculation (*cap formula*) of the financial data gathered on VA Form 10-10EC. Therefore, the monthly copayment amount for extended care services will vary for each veteran based on the cap formula.

The extended care copayment amounts per day for specified extended care services are:

- | | |
|------------------------------------------|------|
| ● Adult day health care | \$15 |
| ● Domiciliary care | \$5 |
| ● Institutional respite care | \$97 |
| ● Institutional geriatric evaluation | \$97 |
| ● Non-institutional respite care | \$15 |
| ● Non-institutional geriatric evaluation | \$15 |
| ● Nursing Home Care | \$97 |

NOTE; Please complete each section, blocks are numbered consecutively left to right.

Line 1. Veteran's name (*last name, first name, middle initial*). Enter the veteran's name. Example: *Doe, John J.*

Line 2. Enter the veteran's Social Security number. Example: *123-45-6789*

Section II - Medicare/Medicaid Eligibility - Answer the following questions as they apply to the veteran.

Although VA cannot bill Medicare or Medicaid, it is important to obtain information regarding a patient's Medicare or Medicaid eligibility.

3. Are you eligible for Medicaid? **Yes or No**

(**MEDICAID** is a government program, financed by your State, of hospitalization and medical insurance for persons of all ages within certain income limits.)

Line 3A. Is the veteran enrolled in Medicare Part A (*Hospital Insurance*)? **Yes or No**

Medicare Part A hospital insurance pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care. Most people are enrolled in Part A automatically when they turn age 65. They do not have to pay a monthly payment called a premium for Part A because they or a spouse paid Medicare taxes while they were working.

3B. If the answer to 3A is **YES**, furnish the effective date listed on the Medicare card. (*mm/dd/yyyy*)

The effective date is the date approved to receive Medicare Part A. The Medicare card will include the beneficiary's name, Medicare claim number, the type of coverage (*Part A, Part B, or both*), and the effective date of coverage.

4. Is the veteran enrolled in Medicare Part B? **Yes or No**

Medicare Part B (*also known as medical insurance*) covers doctors, services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are **medically necessary**.

Beneficiaries enrolled in Medicare Part B must pay a monthly premium, which is usually taken out of monthly Social Security, railroad retirement, or civil service retirement payments.

4A. If the answer to 4 is **YES**, furnish the effective date listed on the Medicare card. (*mm/dd/yyyy*)

The effective date is the date approved to receive Medicare Part B. The Medicare card will include your name, Medicare claim number, the type of coverage you have (*Part A, Part B, or both*), and the effective date of coverage.

4B. If the answer to either 3A or 4 is **YES**, furnish the Medicare claim number listed on the Medicare

Section III - Insurance Information

It is very important that we obtain all health insurance coverage for the veteran (*including coverage through a spouse*). An individual can have more than one type of coverage. Provide information for all insurance companies providing coverage to the veteran.

Insurance is defined as payments against expenses incurred through illness of the insured. The following are types of insurance coverages:

- Employer/union
- Privately purchased (*not related to employment*)
- Military health care (*CHAMPVA, TRICARE, TRICARE for Life, Indian Health Services*)
- Medicare supplemental
- Disease specific insurance (*specifically for treatment of a disease such as cancer*)

5. Is the veteran covered by health insurance (*including coverage through a spouse*)? **Yes or No**

6. If the answer to 5 is **Yes**, enter the name of the insurance company (*primary insurance coverage*) as it appears on the insurance card issued to the policyholder and/or covered dependent. **Example:** *Blue Cross of Georgia*. If the veteran is covered by more than one insurance company, list the primary insurance first, then the secondary insurance.

6A. Furnish the address of the insurance company that covers the veteran. (*This usually is found on the insurance card.*) **Example:** *P.O. Box 9907; Columbus, Georgia 31809.*

6B. Furnish the phone number of the insurance company that covers the veteran. (*This is found on the insurance card.*) **Example:** *1-800-282-2473 for Customer Service.*

6C. Enter the name of the policyholder of the insurance. The policy holder is one that holds an insurance contract or policy; the individual in whose name an insurance policy is written; an insured. **Example:** *John J. Doe.*

6D. Enter the relationship of the policyholder to the veteran. **Example:** *Self*

6E. Enter the policy number. This number is found on the insurance card issued to the policyholder and/or covered dependent. This number may or may not be the same as the policy holder's social security number. **Example:** *123-45-6789*

6F. Enter the group name and/or number. This number is found on the the insurance card issued to the policyholder and/or covered dependent. **Example:** *General Motors/GM1202*

7. If the veteran is covered by more than one insurance company, enter the name of second insurance company (*secondary insurance coverage*) as it appears on the insurance card issued to the policyholder and/or covered dependent.

7A. Enter the address of the insurance company as it is listed on the insurance card issued to the policyholder and/or covered dependent.

7B. Enter the phone number of the insurance company as it is listed on the insurance card issued to the policyholder and/or covered dependent.

7C. Enter the name of the policyholder of the insurance. The policyholder is one that that holds an insurance contract or policy; the individual in whose name an insurance policy is written; an insured.

7D. Enter the relationship of the policyholder to the veteran.

7E. Enter the policy number. This number is found on the insurance card issued to the policyholder and/or covered dependent. This may or may not be the same as the policyholder's social security number.

7F. Enter the group name and/or number. This number is found on the insurance card issued to the policyholder and/or covered dependent.

8. If the veteran is covered by more than one insurance company, enter the name of other insurance company as it appears on the insurance card issued to the policyholder and/or covered dependent.

8A. Enter the address of the insurance company as it is listed on the insurance card issued to the policyholder and/or covered dependent.

8B. Enter the phone number of the insurance company as it is listed on the insurance card issued to the policyholder and/or covered dependent.

8C. Enter the name of the policyholder of the insurance. The policyholder is one that that holds an insurance contract or policy; the individual in whose name an insurance policy is written; an insured.

8D. Enter the relationship of the policyholder to the veteran.

8E. Enter the policy number. This number is found on the insurance card issued to the policyholder and/or covered dependent. This may or may not be the same as the policyholder's social security number.

8F. Enter the group name and/or number. This number is found on the insurance card issued to the policyholder and/or covered dependent.

Section IV - Spouse/Dependent Information

In order to determine if a veteran must pay an extended care copayment amount, it is necessary to identify spousal and/or dependent information. It is important to specify if the spouse and/or dependent resides in the community (*i.e. primary residence*). Residing in the community indicates that the spouse and/or dependent is maintaining the household and residing in the primary residence. Indicate if the spouse or dependent is residing in an assisted living home, nursing home, or other institutional setting. A dependent other than the spouse would be son, daughter, stepson, or stepdaughter. Provide address and phone number if different from the veteran.

9. Enter spouse's Name (*last name, first name, middle initial*). Example: Doe, Mary J

9A. Is the spouse residing in the community? **Yes/No** (*If NO, explain*). This information is needed to determine if the spouse is maintaining the household or is in an institutionalized setting. If the spouse is residing in an assisted living home, or other institutional setting, indicate that this is the case. If the spouse and veteran maintain separate residences, enter the address and phone number of the spouse.

9B. Enter spouse's Social Security number. Example: 456-78-9012

10. Enter dependent's name (*last name, first name, middle initial*). Enter only if the veteran has dependents other than spouse.

10A. Enter dependent's date of birth. (*mm/dd/yyyy*)

10B. Enter dependents Social Security number.

10C. Is the dependent residing in the community? **Yes/No** (*If NO, explain*). This information is needed to determine if the dependent is maintaining the household or is in an institutionalized setting. If the dependent is residing in an assisted living home, nursing home, or other institutional setting indicate that this is the case. Provide address and phone number if different from the veteran.

11. Enter dependent's name (*last name, first name, middle initial*). Enter only if the veteran has dependents other than spouse.

11A. Enter dependent's date of birth. (*mm/dd/yyyy*)

11B. Enter dependents Social Security number.

11C. Is the dependent residing in the community? **Yes/No** (*If NO, explain*). This information is needed to determine if the dependent is maintaining the household or is in an institutionalized setting. If the dependent is residing in an assisted living home or nursing home, indicate that this is the case. Provide address and phone number if different from the veteran.

The following sections deal with financial information. We need to collect current financial information to include income, assets and expenses for the veteran and spouse. A veteran is obligated to pay the copayment to the extent the veteran and spouse have available resources. Available resources means the sum of the value of the fixed assets, the liquid assets, and the income of the veteran and spouse, minus the sum of the veteran allowance and spousal allowance and deductible expenses. The veteran and spousal allowance is allocated at \$20 per day for both the veteran and the spouse, times the number of days in the month the veteran is receiving extended care services. The financial information for VA Form 10-10EC will be used to determine the monthly extended care copayment amount. The financial information for the Means Test (VA Form 10-10EZ) is used to determine certain veterans' priority level for enrollment, possible exemption from copayments requirements, and eligibility of total benefits. The financial information submitted for VA Form 10-10EZ reflects income for the past year; whereas the financial information submitted for VA Form 10-10EC reflects the veteran's and spouse's current income and assets.

If the veteran does not want to provide the necessary financial information to determine copayment obligation, the veteran or family member must read, sign and date the statement at the top of page 2 of VA Form 10-10EC. This signifies the veteran agrees to make the maximum copayment amount for all extended care services.

Section IV - Fixed Assets (veteran and spouse)

Fixed assets means real property and other non-liquid assets excluding:

- burial plots;
- primary residence of the veteran if he is receiving only non-institutional extended care services or 180 days or less of institutional extended care services;
- primary residence of the veteran's spouse or dependent if the veteran is receiving institutional extended care services;
- vehicle of the veteran if veteran is receiving only non-institutional extended care service or 180 days or less of institutional extended care services; and
- vehicle of the veteran's spouse or dependent if the veteran is receiving institutional extended care services;

Fixed assets are only included in the calculation of available resources for extended care copayments when a veteran reaches the 181st day of inpatient (*institutional*) extended care and the veteran does not have a spouse or dependent residing in the primary residence. Fixed assets will **not** be included in the calculation of available resources for extended care copayments if the veteran is receiving only outpatient (*non-institutional*) extended care, or if there is a spouse or dependent residing in the primary residence. You may have instances when a veteran and spouse are separated and maintain two separate residences and vehicles. In this instance only the value of the veteran's primary residence and vehicle would be included in the fixed assets.

1. List value of your primary residence *minus any outstanding mortgage or lien. Exclude if veteran is receiving only non-institutional (outpatient) extended care services or spouse or dependent is residing in the community. If the veteran and spouse maintain separate residences, and the veteran is receiving institutional (inpatient) extended care services, include value of the veteran's primary residence.*

Value \$ _____

2. List value of any other residences, land (*if not included in value of residence*), farm or ranch *minus any outstanding mortgage or lien*. This would include the value of a second home, vacation home, rental property, etc. minus any outstanding mortgage or lien.

Value \$ _____

3. List the value of primary vehicle(s) *minus any outstanding lien. Exclude if veteran is receiving only non-institutional (outpatient) extended care services or spouse or dependent is residing in the community. If the veteran and spouse maintain separate residences, and the veteran is receiving institutional (inpatient) extended care services, include the value of the veteran's vehicle.*

Value \$ _____

Subtotal Value of Fixed Assets \$ _____

Section V - Liquid Assets (veteran and spouse)

Liquid assets include, but not limited to, cash, interest, dividends and dividends from IRA, 401K's and other tax deferred annuities, stocks, bonds, mutual funds, retirement accounts, stamp or coin collections, art work, collectibles, household furniture, jewelry, and other personal items. Savings accounts, money market accounts, and other short-term investments are also considered liquid assets.

Liquid assets are only included in the calculation of available resources for extended care copayments when a veteran reaches the 181st day of inpatient (*institutional*) extended care and he does not have a spouse or dependent residing in the primary residence. Liquid assets will **not** be included in the calculation of available resources for extended care copayments if the veteran is receiving only outpatient (*noninstitutional*) extended care, or there is a spouse or dependent residing in the primary residence.

1. Cash balances, e.g. interest, dividends from IRA, 401K's, and other tax deferred annuities (*including Checking, savings, money market, etc.*)

Value \$ _____

Section V - Liquid Assets (veteran and spouse) (Continued)

2. Stocks, bonds, mutual funds, and retirement accounts (include IRA, 401K, annuities, self-employed persons).

Value \$ _____

3. Other Liquid Assets (includes such items as stamp or coin collections, art work, collectibles, household furniture and other household goods, clothing, jewelry and personal items, minus amount owed..)

Value \$ _____

Subtotal Value of Fixed Assets \$ _____

Sum of All Fixed and Liquid Assets = Total Assets \$ _____

The next section covers Income Information - Report all income BEFORE DEDUCTIONS for both veteran and spouse.

Current Income information for both the veteran and spouse should be entered. Do not include any income from dependents. The income amount and how often received should be entered (e.g., Railroad Retirement \$800, monthly).

Income means current income, e.g. gross income (including but not limited to, wages, income from a business minus business expenses, bonuses, tips, severance pay, accrued benefits, cash gifts, inheritance amounts, interest income, standard dividend income from non tax deferred annuities, retirement income, pension income, unemployment payments, worker's compensation payments, black lung payments, tort settlement payments, social security payments, court mandated payments, payments from VA or any other federal programs and any other income). The amount of current income will be stated in frequency of receipt, (e.g., Monthly, annually)

Social Security retirement/disability

Interest/dividends, including tax exempt earnings.

Retirement and Pension income

Civil Service Retirement

U.S. Railroad Retirement

VA Pension

Spouse VA disability/compensation

Unemployment benefits/compensation - Report any income received due to unemployment compensation for both the veteran and/or spouse

Other compensation, e.g. Workers Compensation and Black Lung - Report any income received from workers compensation due to an on the job injury/illness.

Military Retirement

Other Retirement

Court mandated (e.g. alimony, child support)

Other income (e.g. inheritance/settlements)

Section VI - Expenses Taxes

Expenses means basic subsistence expenses to include:

- Education (veteran, spouse or dependent) - any educational expenses incurred by the veteran, spouse or dependent.
- Funeral and burial - any funeral or burial expenses for your spouse or child.
- Rent/mortgage - monthly rent or mortgage payment for primary residence.
- Utilities - include the average monthly expenses during the past year for your utilities. (Utilities are defined as electricity, gas, water, and phone)
- Car payment for one vehicle only.
- Food for veteran, veteran's spouse and dependents.

Section VI - Expenses Taxes (Continued)

- Non-reimbursed medical expenses - include average monthly expenses during the past year for out-of-pocket medical care costs not otherwise covered by medical insurance for the veteran, veteran's spouse, and veteran's dependents.
- Court-ordered payments - include any expense resulting from a court order such as alimony, child support, etc.
- Insurance - Health, automotive, and average monthly expenses during the past year for insurance for the primary residence.
- Taxes (*on any amount include in gross income, property, personal*) - include the average monthly expenses during the past year for taxes paid on income.

Examples of expenses that are excluded are:

- Mortgage payments for property other than your primary residence.
- Life insurance premiums.
- Car payments for more than one vehicle.
- Gas for the vehicles or parking fees.
- TV Cable expenses.

Section VII - Consent to Release Information

The veterans or authorized representative must read, sign and date the following consent

I hereby authorize the Department of Veterans Affairs to disclose any such history, diagnostic and treatment information from my medical records to the contractor of any health plan contract under which I am apparently eligible for medical care or payment of the expense of care or to any other party against whom liability is asserted. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. Without my express revocation, this consent will automatically expire when all action arising from VA's claim for reimbursement for my medical care has been completed. I authorize payment of medical benefits to VA for any services for which payment is accepted.

SIGNATURE

DATE

Section VIII - Consent and Agreement to make Copayments

The veteran or authorized representative must read, sign and date the following statement agreeing to make copayments for extended care services.

Completion of this form with signature or the veteran or veteran's representative is certification that the veteran/representative has received a copy of the Privacy Act Statement and agrees to make appropriate copayments.

I certify the foregoing statement(s) are true and correct to the best of my knowledge and belief and agree to make the applicable copayment for extended care services as required by law.

SIGNATURE

DATE