Department of Veterans Affairs

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: 10/31/2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

MEDICAL EXPENSE REPORT

1. NAME OF VETERAN (First, Middle Initial, Last)

2. SOCIAL SECURITY NUMBER

3. VA FILE NUMBER (If applicable)

4. NAME OF CLAIMANT (First, Middle Initial, Last)

5. CURRENT MAILING ADDRESS OF CLAIMANT (Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

6. CHANGE OF ADDRESS (Check box if address is different from last address furnished to VA)

YES NO

7. TELEPHONE NUMBER OF CLAIMANT (Include Area Code)

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS

9. MILEAGE FOR PRIVATELY OWNED VEHICLE TRAVEL FOR MEDICAL PURPOSES

Report miles traveled to a hospital, doctor, or other medical facility in a privately owned vehicle (POV) such as a car, truck, or motorcycle. Itemize travel occurring between the dates _____ and _____ . If no dates appear on this line, refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX). We will calculate the allowable deduction for your mileage based on the current POV mileage reimbursement rate for automobiles specified by the United States General Services Administration (GSA).

NOTE: You may also claim deductions for other payments related to travel for medical purposes, such as taxi fares, buses, or other forms of public transportation. Report these types of medical travel expenses in Item 22.

A. MEDICAL FACILITY TO WHICH TRAVELED	B. TOTAL ROUNDTRIP MILES TRAVELED	C. AMOUNT REIMBURSED FROM ANOTHER SOURCE (Such as a VA Medical Center)	D. DATE TRAVELED (Month/Day/Year)	E. WHO NEEDED TO TRAVEL? (Self, spouse, child)
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	
			Month Day Year	

IMPORTANT: Be sure to sign and date this form in Items 12A & 12B on page 4. Unsigned reports will be returned.

10. IN-HOME ATTENDANT EXPENSES

IMPORTANT - You must complete the attached In-Home Attendant Worksheet (page 5) to claim in-home attendant expenses.
Report amounts paid between the dates __ and . If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX).

A. NAME OF PROVIDER	B. HOURLY RATE/ NUMBER OF HOURS	C. AMOUNT PAID	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	

11. ITEMIZATION OF MEDICAL EXPENSES

IMPORTANT - If you are claiming expenses for care in an assisted living, adult day care, or a similar facility, you must complete the appropriate worksheet (page 6).
Report medical expenses that you paid between the dates _____ and _____. If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX).

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.)
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		

11. ITEMIZATION OF MEDICAL EXPENSES *(Continued)*

IMPORTANT - If you are claiming expenses for care in an assisted living, adult day care, or a similar facility, you must complete the appropriate worksheet (page 6). Report medical expenses that you paid between the dates _____ and _____. If no dates appear on this line refer to the accompanying letter for the dates you should report medical expenses. If you do not have a letter, please report unreimbursed medical expenses on a calendar year basis (ex. 01/01/XXXX thru 12/31/XXXX).

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.)
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		
		Month Day Year		
		Month Day Year		
		Month Day Year		
		Month Day Year		

CERTIFICATION: I have not and will not receive reimbursement for these expenses. I certify that the above information is true.

12A. SIGNATURE OF CLAIMANT *(Do NOT print)*	12B. DATE SIGNED 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 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 -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet 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:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for 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 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)

◯ YES ◯ NO (If "YES," the attendant does not need to be a health care provider. Skip to Step 3)
(If "NO," skip to Step 4)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care services or custodial care?

◯ YES ◯ NO (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)
(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** 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 special monthly pension?

◯ 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 responsibility*** of the in-home attendant to provide you with health care or custodial care?

◯ YES ◯ NO (If "YES," payments to this in-home attendant may qualify as medical expenses ***if*** 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 require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

◯ YES ◯ NO (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 ***does not*** need to be a health care provider)
(If "NO," the attendant ***must be a health care provider*** and payments for assistance with IADLs ***do not*** 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)

STEP 7. Is the primary responsibility 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 ***do not*** qualify as medical expenses. Payments to the in-home attendant for ***health care or custodial care*** qualify as medical expenses. You may report these expenses in Item 10)

STEP 8. Check all activities below that the attendant assists the disabled person with:

ADLs: ◯ EATING ◯ BATHING/SHOWERING ◯ DRESSING ◯ TRANSFERRING ◯ USING THE TOILET ◯ SHOPPING ◯ FOOD PREPARATION

IADLs: ◯ HOUSEKEEPING ◯ LAUNDRY ◯ MANAGING FINANCES ◯ HANDLING MEDICATIONS
◯ USING THE TELEPHONE ◯ TRANSPORTATION FOR NON-MEDICAL PURPOSES

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.

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment pertaining to _____ (Name of Person Requiring Care) and his or her care from _____ (Name of Attendant)

_____ (Name, Signature and Title of Certifying Official)

_____ (Date Certified)

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 -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

(If "NO," continue to Step 2)

◯ YES ◯ NO (If "YES," ***all*** 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 ***do not*** qualify as medical expenses. You are finished completing this worksheet)

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 aid and attendance or housebound rate or Parents' DIC at the aid and attendance level)

◯ 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 ***primary reason*** you live in the facility (or attend day care in the facility)?

◯ YES ◯ NO (If "YES," all payments to this facility qualify as medical expenses. You may claim these expenses in Item 11. Skip to Step 10)

(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Only claim amounts you pay the facility for health care services or custodial care)

STEP 6. Are you claiming special monthly pension?

◯ 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 is complete and the form is signed by a Physician, Physician Assistant (PA), 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 you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Item 11. Skip to Step 10)

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 ***primary reason*** you live in the facility (or attend day care in the facility)?

◯ YES ◯ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses ***if*** VA rates you as eligible for special monthly pension or Parents' DIC. Please report separately in Item 11 applicable amounts you pay the facility for: (1) lodging and meals, (2) ***health care services or 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 ***do not*** qualify as medical expenses. Please report separately in Item 11 applicable amounts you pay the facility for: (1) ***health care services or assistance with ADLs provided by a health care provider***, and (2) ***custodial care***. 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 because of the disabled person's mental or physical disability?

◯ YES ◯ NO (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 facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," claim only amounts you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Item 11. Skip to Step 10)

STEP 9. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the ***primary reason*** the disabled person lives in the facility or attends day care in the facility?

◯ YES ◯ NO (If "YES," claim ***all*** 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 ***do not*** qualify as medical expenses. ***Only*** 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 breakdown of the care received.

I CERTIFY that the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to _____ and his or her 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)