OMB Approved No. 2900-0091
Estimated Burden Avg. 20 min.

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATIONS FOR HEALTH BENEFITS

DEFINITIONS

SERVICE-CONNECTED: A veteran with a VA determination that an illness or injury was incurred or aggravated while on active duty.

SERVICE-CONNECTED COMPENSABLE: A veteran who is paid VA monthly compensation for the service-connected disability.

SERVICE-CONNECTED NONCOMPENSABLE: A veteran who is rated 0% service-connected and not paid VA monthly compensation.

NONSERVICE-CONNECTED: A veteran who does not have a VA determined service related condition.

SECTIONS TO COMPLETE

The checks (✔) in the table below indicate which Sections of the Application for Health Benefits should be completed by the applicant. The Sections in the shaded blocks should be completed only if Section IIB is checked as "YES."

APPLICANT	SECTION						
	I	IIA	IIB	IIC	IID	IIE	III
0% SERVICE-CONNECTED, NONCOMPENSABLE	✔	✔	✔	✔	✔	✔	✔
0 TO 20% SERVICE-CONNECTED, COMPENSABLE	✔	✔	✔	✔	✔		✔
30 TO 40% SERVICE-CONNECTED, COMPENSABLE	✔	✔	✔	✔	✔		✔
50% OR GREATER, SERVICE-CONNECTED, COMPENSABLE	✔						✔
NONSERVICE-CONNECTED	✔	✔	✔	✔	✔	✔	✔
FORMER POW OR WWI VETERAN	✔	✔	✔	✔	✔		✔
NSC PENSION	✔						✔

SECTION I - GENERAL INFORMATION

Complete all questions if applying for Health Services, Nursing Home, Domiciliary or Dental benefits. Please edit all preprinted information and provide updated information. Skip all blocks with "N/A" or "For Future Use" preprinted in them.

SECTION II - FINANCIAL ASSESSMENT

The financial assessment is used to determine certain veterans' priority level for enrollment, possible exemption from co-payment requirements, and eligibility for total benefits. Veterans with a combined VA service-connected disability rating of 50% or greater and veterans in receipt of VA pension benefits are exempt from this assessment and should not complete this section.

SECTION IIA - DEPENDENT INFORMATION

If you answer YES in Section IIB. Complete Sections IIA, IIC, IID and IIE that apply to you. For example, if you are completing the form in June 1998, provide calendar year 1997 information. See table above for sections to complete.

SECTION IIB - FINANCIAL DISCLOSURE

Complete Section IIA if you answered YES in Section IIB. Use a separate sheet of paper for additional dependent children.

- You may count your spouse as your dependent even if you did not live together, as long as you contributed $600 or more in support.
- Children under the age of 18 are not required to have attended school in order to be counted as a dependent.
- A child between the ages of 18 and 23 can only be counted as a dependent if they attend high school, or college or vocational school on a full or part time basis.
- Count child support contributions even if not paid in regular set amonts. Contributions can included tuition payments or payments of medical bills.

CONSENT TO RELEASE INFORMATION

I hereby authorize the Department of Veterans Affairs to disclose any such history, diagnostic and treatment information from my medical records (including information relating to the diagnosis, treatment of other therapy for the conditions of substance abuse, alcoholism or alcohol abuse, sickle cell anemia, or testing for or infection with the human immunodeficiency virus) 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.

SOCIAL SECURITY NUMBER	DATE OF BIRTH
SIGNATURE OF PATIENTS	DATE

SECTION IIC -PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

Complete Section IIC if you answered YES in Section IIB. Answer all questions. If the question does not apply or is not applicable, enter N/A. If you answer YES to Question 3, you will be provided additional forms to report your business expenses if your income (or combined income and net worth) exceeds the established threshold.

REPORT: All income BEFORE DEDUCTIONS for you and your spouse. Include:

- All wages, bonuses and tips, severance pay, or other accrued benefits (including gross income from your farm, ranch, property or business)
- Retirement and pension income
- Social Security Retirement income
- Social Security Disability income
- Compensation benefits such as: VA disability, unemployment, workers and black lung
- Cash gifts
- Interest and dividends, including tax exempt earnings
- Distributions from Individual Retirement Accounts (IRAs) or annuities
- Your child's unearned income information if it could have been used to pay you household expenses

DO NOT REPORT:

- Work income of dependent children attending high school, college, vocational rehabilitation or training
- Welfare or Supplemental Security Income (SSI) payments
- Payments from a government entity that are based on your financial need
- Profit from the occasional sale of property
- Income tax refunds
- Reinvested interest on Individual Retirement Accounts (IRAs)
- Scholarships and grants for school attendance
- Disaster relief payments or proceeds of casualty insurance
- Loans
- Agent Orange and Alaska Native Claim
- Settlement Acts income
- Payments to foster parents

SECTION IID - DEDUCTIBLE EXPENSES

Complete Section IID if you answered YES in Section IIB. Answer all questions. If the question does not apply or is not applicable, enter N/A. Nonreimbursed medical expenses include medical and dental care, drugs, eyeglasses, Medicare and medical insurance premiums, and other health care expenses. Do not list medical expenses if you expect to receive reimbursement from insurance or other sources.

SECTION IIE - NET WORTH

Complete Section IIE if you answered YES in Section IIB and you are a nonservice-connected veteran or a 0% service-connected noncompensable veteran. Do not complete this section if your gross household income, less deductible expenses, is above the threshold for the current year.

SECTION III - CONSENT AND SIGNATURE

ALL APPLICANTS MUST SIGN AND DATE THE APPLICATION FOR HEALTH BENEFITS.

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 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

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 medical benefits. 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, we 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 give VA you Social Security Number, VA will use it to administer your VA benefits, to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

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Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

1A. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)*

☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL ☐ ENROLLMENT

1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER

2. VETERAN'S NAME (*Last, First, MI*)	3. OTHER NAMES USED	4. GENDER *(Check one)*
		☐ M ☐ F

5. SOCIAL SECURITY NUMBER	6. CLAIM NUMBER	7. DATE OF BIRTH *(mm/dd/yyyy)*	8. RELIGION

9A. CURRENT MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP

9E. COUNTY	10. HOME TELEPHONE NUMBER	11. WORK TELEPHONE NUMBER
	( )	( )

12. CURRENT MARITAL STATUS *(Check one)*

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

13A. LAST BRANCH OF SERVICE	13B. LAST ENTRY DATE	13C. LAST DISCHARGE DATE	13D. DISCHARGE TYPE	13E. MILITARY SERVICE NUMBER
				-

14. CIRCLE YES OR NO

A. ARE YOU A FORMER PRISONER OF WAR	YES	NO	H. DO YOU HAVE A MILITARY DENTAL INJURY	YES	NO
B. DO YOU HAVE A VA SERVICE-CONNECTED RATING	YES	NO	I. DO YOU HAVE A SPINAL CORD INJURY	YES	NO
B1. IF YES, WHAT IS YOUR RATED PERCENTAGE	%		J. ARE YOU ELIGIBLE FOR MEDICAID	YES	NO
C. ARE YOU RECEIVING A VA PENSION	YES	NO	K. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A	YES	NO
D. ARE YOU RETIRED FROM THE MILITARY	YES	NO	K1. EFFECTIVE DATE		
D1. WAS YOUR RETIREMENT THE RESULT OF A DISABILITY	YES	NO	L. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B	YES	NO
D2. WERE YOU REGULARLY RETIRED - (20+yrs.)	YES	NO	L1. EFFECTIVE DATE		
E. WERE YOU EXPOSED TO TOXINS IN THE GULF WAR	YES	NO	M. MEDICARE CLAIM NUMBER		
F. WERE YOU EXPOSED TO AGENT ORANGE	YES	NO	N. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD		
G. WERE YOU EXPOSED TO RADIATION	YES	NO			

15A. VETERAN'S EMPLOYMENT STATUS *(check one)*	15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED *If employed or retired, complete item 15B* / / *Date of retirement*	

16A. SPOUSE'S EMPLOYMENT STATUS *(check one)*	16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED *If employed or retired, complete item 16B* / / *Date of retirement*	

17A. VETERAN'S HEALTH INSURANCE COMPANY	18A. SPOUSE'S HEALTH INSURANCE COMPANY

17B. NAME OF POLICY HOLDER	18B. NAME OF POLICY HOLDER

17C. POLICY NUMBER	17D. GROUP CODE	18C. POLICY NUMBER	18D. GROUP CODE

19A. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	19B. NEXT OF KIN'S HOME TELEPHONE NUMBER ( )
	19C. NEXT OF KIN'S WORK TELEPHONE NUMBER ( )

20A. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT	20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER ( )
	20C. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER ( )

21. I DESIGNATE THE FOLLOWING INDIVIDUAL TO RECEIVE POSSESSION OF ALL MY PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER MY DEPARTURE OR AT THE TIME OF MY DEATH. *(Check one)* ***(This does not constitute a will or transfer of title.)***

☐ EMERGENCY CONTACT ☐ NEXT OF KIN

22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY *(Check one)*	22B. IS NEED FOR CARE DUE TO ACCIDENT *(Check one)*
☐ YES ☐ NO	☐ YES ☐ NO

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME	SOCIAL SECURITY NUMBER

SECTION II - FINANCIAL ASSESSMENT

IIA - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, MI)*	2. CHILD'S NAME *(Last, First, MI)*	
3. SPOUSE'S SOCIAL SECURITY NUMBER	4. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	5. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*
6. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*	7. CHILD'S SOCIAL SECURITY NUMBER	
8. SPOUSE'S MAIDEN NAME	9. CHILD'S RELATIONSHIP TO YOU *(Circle one)* Son Daughter Stepson Stepdaughter	
10. DATE OF MARRIAGE *(mm/dd/yyyy)*	11. DATE CHILD BECAME YOUR DEPENDENT	
12. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE $ CHILD $	13. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(tuition, books, materials, etc.)* $	
14. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO	15. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	

IIB - FINANCIAL DISCLOSURE

You are not required to provide the financial information in this Section. However, current law may require VA to consider your household financial situation to determine your eligibility for enrollment and/or cost-free care of your nonservice-connected (NSC) conditions. If you are 0% SC noncompensable or NSC (and are not an Ex-POW, WWI veteran or VA pensioner) and your annual household income (or combined income and net worth) exceeds the established threshold, you must agree to pay VA co-payments for care of your NSC conditions to be eligible for enrollment. See Section III - Consent and Signature.

☐ **YES,** I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO HAVE ELIGIBILITY FOR CARE DETERMINED. *Complete all sections below that apply to you with last calendar year's information. Sign and date the application.*

☐ **NO,** I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. *I understand I will be assigned the appropriate enrollment priority based on nondisclosure of my financial information. By checking NO and signing below, I am agreeing to pay the applicable VA co-payment. Sign and date the application.*

IIC - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

	VETERAN	SPOUSE	CHILDREN
1. WHAT WAS YOUR GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* , AS WELL AS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. LIST OTHER INCOME AMOUNTS *(Social Security, compensation, pension, interest, dividends) Exclude welfare.*	$	$	$
3. WAS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS *(If yes, refer to page 2, Section IIC of the instructions.)* ☐ YES ☐ NO			

IID - DEDUCTIBLE EXPENSES

1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(payments for doctors, dentists, drugs, Medicare, health insurance, hospital and nursing home)*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section IIA)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(tuition, books, fees, materials, etc.) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

IIE - NET WORTH

	VETERAN	SPOUSE
1. CASH, AMOUNT IN BANK ACCOUNTS *(Checking and savings accounts, certificates of deposit, individual retirement accounts, etc.)*	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *Do not count your primary home. Include value of farm, ranch, or business assets.*	$	$
3. STOCKS AND BONDS AND VALUE OF OTHER PROPERTY OR ASSETS *(art, rare coins, etc.)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. *Exclude household effects and family vehicles.*	$	$

SECTION III - CONSENT AND SIGNATURE

CO-PAYMENT NOTICE: If you are a 0% service-connected noncompensable or a nonservice-connected veteran (and are not an Ex-POW, WWI veteran or VA pensioner) **and** your household income (or combined income and net worth) exceeds the established threshold, you may be eligible for enrollment only if you agree to pay VA co-payments for treatment of your NSC conditions. By signing this application you are agreeing to pay the applicable VA co-payment if required by law.

I CERTIFY THE FOREGOING STATEMENT(S) ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.	DATE *(mm/dd/yyyy)*
SIGN HERE *(Signature of applicant or applicant's representative)*	

THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION.