

Training Module 8

11. Deceased veteran's remarried mother is in receipt of DIC. She and her husband operate a small business. Gross income from the business averages about \$25,000 per year. Last year they lost \$2,500 for the year, and expect they will not make a profit again this year. Can they deduct their operating losses from the business to reduce their income for VA purposes? 8-4
- a. Yes
 - b. No
12. The veteran and spouse were heavily in debt when he died. He had an outstanding unsecured loan of \$15,000, as well as owing another \$50,000 for the purchase of an automobile. In addition, he incurred more than \$100,000 in hospital bills which have not been paid. His burial costs were over \$10,000. Which of these may be deducted as final expenses and just debts from the surviving spouse's income for VA purposes? 8-4
- a. \$15,000 unsecured loan
 - b. \$50,000 secured loan for automobile
 - c. \$100,000 or more hospital bill
 - d. \$10,000 funeral and burial costs

FORMS

INCOME VERIFICATION REPORTS- (EVRs)

Correct type of EVR:

21-0516-1 - #6	Veteran/Spouse/No children
21-0517-1 - #7	Veteran/Spouse with Children
21-0518-1 - #8	Surviving Spouse/ No Children
21-0519S-1 - #9S	Surviving Spouse with Children
21-0519C-1 - #9C	Child or Children
21-0514-1 - #4	Parent's DIC Eligibility Verification Report
21-8416 -	Medical Expense Report

All Income (for Correct Time Period)

All Unreimbursed Medical Expenses

All Paid Educational Expenses

Any Paid Final Expenses (for qualifying dependents)

Training Module 8

MEDICAL EXPENSES – ITEMS TO BE CONSIDERED

Listed below are items to be considered as medical and dental expenses in the determination of medical expenses. This list is not inclusive but is merely a guide.

Abdominal supports	Pediatrician
Acupuncture service	Physical examinations
Ambulance fees	Physician
Anesthetist	Physical therapist
Arch supports	Podiatrist
Artificial limbs and teeth	Prescriptions
Back supports	Psychiatrist
Braces	Psychoanalyst
Cardiographs	Psychotherapy
Chiroprapist	Radium therapy
Convalescent Home (for medical treatment only)	Sacroiliac belt
Crutches	Seeing-eye dog and maintenance
Dental service (e.g. cleaning, x-ray, filling teeth)	Speech therapist
Dentures	Splints
Dermatologist	Supplementary medical insurance (Part B) under Medicare
Eyeglasses	Surgeon
Food or Beverages specially prescribed by a physician (for treatment of illness, and in addition to, not as substitute for, regular diet: physician's statement needed)	Telephone/Teletype or special communications equipment for the deaf or Life Line for Seniors
Gynecologist	Transportation expenses for medical purposes (20 cents per mile plus parking or fares for public transportation)
Hearing aids and batteries	Vaccines
Home Health Services	Vitamins prescribed by a doctor (but not as a food supplement or to preserve general health)
Hospital expenses	Wheelchairs
Insulin Treatment	Whirlpool baths for medical purpose
Insurance Premiums (medical)	X-rays
Invalid chair	
Lab tests	
Lip reading lessons (designed to overcome a handicap)	
Neurologist	
Nursing services (for medical care, including nurse's board paid by you)	
Occupational therapist	
Ophthalmologist	
Optician	
Optometrist	
Oral surgery	
Orthopedic Appliances	
Osteopath, licensed	

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN John Allen Doe		 Department of Veterans Affairs IMPROVED PENSION ELIGIBILITY VERIFICATION REPORT (VETERAN WITH NO CHILDREN) 6	
YOUR COMPLETE MAILING ADDRESS 110 Veteran Avenue Raleigh, NC 27999		VA FILE NUMBER C 23 985 947	
		VA REGIONAL OFFICE RETURN ADDRESS	
IMPORTANT - Please read the enclosed EVR Instructions (VA Form 21-0510) prior to completing this form.			
1A. YOUR SOCIAL SECURITY NUMBER 111-22-3333		1B. YOUR SPOUSE'S SOCIAL SECURITY NUMBER 987-65-4321	
1C. FIRST, MIDDLE, LAST NAME OF SPOUSE Ann Doe		1D. SPOUSE'S DATE OF BIRTH (Mo., day, yr.) Aug, 15, 50	
2. MARITAL STATUS (Check only one box)			
(1) <input checked="" type="checkbox"/> MARRIED—LIVING WITH SPOUSE (You are legally married and you live with your spouse or are separated for medical reasons.) (2) <input type="checkbox"/> MARRIED—NOT LIVING WITH SPOUSE (You are legally married but estranged from your spouse.) Show the amount you contributed to your spouse's support during the last 12 months \$ _____ If you separated within the last 12 months, show the date of separation _____ (3) <input type="checkbox"/> NOT MARRIED (You have never married or are now divorced or widowed.) If your marriage ended within the last 12 months, show the date of divorce or death _____			
3. NUMBER OF UNMARRIED, DEPENDENT CHILDREN (See Paragraph 1 of the EVR Instructions, VA Form 21-0510)			
IN YOUR CUSTODY <u>0</u> NOT IN YOUR CUSTODY <u>0</u>			
AMOUNT CONTRIBUTED DURING PAST 12 MONTHS TO CHILDREN NOT IN YOUR CUSTODY \$ <u>0.00</u>			
4A. ARE YOU A PATIENT IN A NURSING HOME? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "YES," complete Items 4B through 4D. If "NO," go to Item 5.)		4C. ENTER THE NAME, COMPLETE ADDRESS, AND TELEPHONE NUMBER OF NURSING HOME (Please include ZIP Code)	
4B. SHOW THE DATE YOU ENTERED THE NURSING HOME			
4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME FEES? <input type="checkbox"/> YES <input type="checkbox"/> NO			
5. DID EITHER YOU OR YOUR SPOUSE RECEIVE ANY WAGES OR WERE EITHER OF YOU EMPLOYED AT ANY TIME DURING THE PAST 12 MONTHS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
6. DO YOU RECEIVE ANY OTHER VA BENEFITS AS A VETERAN, PARENT, OR SURVIVING SPOUSE ? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "YES," write in the VA file number of the other benefit) _____			

7A. MONTHLY INCOME (Read Paragraphs 2 and 3 of the EVR Instructions)				
GROSS MONTHLY AMOUNTS (If no income was received from a particular source, write "0" or "none." DO NOT LEAVE ANY ITEMS BLANK.)				
SOURCE	VETERAN		SPOUSE	
SOCIAL SECURITY	600.00		400.00	
U.S. CIVIL SERVICE	0.00		0.00	
U.S. RAILROAD RETIREMENT	0.00		0.00	
BLACK LUNG BENEFITS	0.00		0.00	
MILITARY RETIREMENT	0.00		0.00	
OTHER (Show Source)	0		0	
OTHER (Show Source)	0		0	
7B. ANNUAL INCOME (Read Paragraphs 2 and 4 of the EVR Instructions)				
If no income was received from a particular source, write "0" or "none." DO NOT LEAVE ANY ITEMS BLANK.				
NOTE: Report annual income for the dates indicated. If no dates are shown above the columns that follow, then report last calendar year (January through December) income in the left-hand column and current calendar year income in the right-hand column.				
SOURCE	VETERAN		SPOUSE	
	FROM: 01/01/2008 THRU: 12/31/2008	FROM: 01/01/2009 THRU: 12/31/2009	FROM: 01/01/2008 THRU: 12/31/2008	FROM: 01/01/2009 THRU: 12/31/2009
GROSS WAGES FROM ALL EMPLOYMENT	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
TOTAL INTEREST AND DIVIDENDS	0.00	0.00	0.00	0.00
ALL OTHER (Show Source)	0	0.00	0	0.00
ALL OTHER (Show Source)	0	0.00	0	0.00
7C. DID ANY INCOME CHANGE (Increase/Decrease) DURING THE PAST 12 MONTHS? (Answer "NO" if there were no income changes or if the only change was a Social Security/VA cost-of-living adjustment. Answer "YES" if there were any other income changes or if you received any NEW source of income or any ONE-TIME income.)				
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "YES," complete Items 7D through 7F. If "NO," go to Item 7G.)				
7D. WHAT INCOME CHANGED? (Show what income changed; for example, wages, city pension, etc.)		7E. WHEN DID THE INCOME CHANGE? (Show the dates you received any new income or the date income changed)		7F. HOW DID INCOME CHANGE? (Explain what happened; for example, quit work, got raise, received inheritance)
7G. NET WORTH (Read Paragraph 5 of the EVR Instructions)				
SOURCE	VETERAN		SPOUSE	
CASH/NON-INTEREST-BEARING BANK ACCOUNTS	\$ 3,000.00		\$ 0.00	
INTEREST-BEARING BANK ACCOUNTS	0.00		0.00	
IRA'S, KEOGH PLANS, ETC.	0.00		0.00	
STOCKS, BONDS, MUTUAL FUNDS, ETC.	0.00		0.00	
REAL PROPERTY (Not your home)	0.00		0.00	
ALL OTHER PROPERTY	0.00		0.00	
8. MEDICAL EXPENSES (Read Paragraph 6 of the EVR Instructions)				
Normally, medical expenses are reported at the end of the year. If you are using this form as your annual Eligibility Verification Report and Paragraph 6 of the EVR Instructions indicates that you should report medical expenses, use VA Form 21-8416, Medical Expense Report, to report your medical expenses. If you are using this form as a supplement to a pending claim, you do not need to report medical expenses. If entitlement is established, you will have an opportunity to report your medical expenses at the end of the year.				
9. VETERAN'S EDUCATIONAL AND VOCATIONAL REHABILITATION EXPENSES (Read Paragraph 7 of the EVR Instructions)				
Show amounts paid by you during the last 12 months. DO NOT REPORT DEPENDENTS' EXPENSES.			\$ 0.00	
10A. SIGNATURE OF VETERAN (Read Paragraph 9 of the EVR Instructions before signing)			10B. DATE SIGNED	
John A. Doe			01/15/2009	
10C. TELEPHONE NUMBERS (Include Area Code)				
DAYTIME		EVENING		
(919) 777-0000		(919) 777-8888		
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.				



Department of Veterans Affairs

MEDICAL EXPENSE REPORT

1. NAME OF VETERAN <i>(First, middle, last)</i> John Allen Doe		2. VA FILE NUMBER C 23 985 947
3A. NAME AND ADDRESS OF CLAIMANT 110 Veteran Avenue, Raleigh, NC 27999	3B. CHANGE OF ADDRESS <i>(Check box if address in Item 3A is different from last address furnished to VA)</i> <input type="checkbox"/>	3C. E-MAIL ADDRESS <i>(If applicable)</i>
4. VETERAN'S SOCIAL SECURITY NO. 111-22-3333		

NOTE: Family medical expenses actually paid by you may be deductible from your income. Report the actual amount of unreimbursed medical expenses you paid for yourself or relatives who are members of your household. Do not report any expenses you did not pay or expenses for which you were or will be reimbursed. Any expenses reasonably related to medical or dental care may be allowed as medical expenses. Examples of allowable medical expenses include the following: hospital expenses, office visits, drugs and medicines, eyeglasses, dental fees, medical insurance premiums (including the Medicare deduction), hearing aids, nursing home fees, home health services, and transportation for medical purposes (28.5 cents per mile, plus parking and tolls or fares for taxis, buses, etc.). If you are not sure whether a particular expense can be allowed, furnish a complete description of the purpose of the payment. We will let you know if an expense cannot be allowed. If more space is needed, 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.

You may be asked to verify the amounts you actually 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 payments for at least 3 years after we make a decision of your medical expense claim. If you are unable to provide documentation of the claimed medical expenses when asked to do so by VA, your benefits will be retroactively reduced or terminated.

Report medical expenses for the period 01/01/2008 thru 12/31/2008 . If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates your medical expense report should cover.

5. ITEMIZATION OF MEDICAL EXPENSES				
A. PURPOSE <i>(Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)</i>	B. AMOUNT PAID BY YOU	C. DATE PAID <i>(Mo/Day/Yr)</i>	D. NAME OF PROVIDER <i>(Name of doctor, dentist, hospital, lab, etc.)</i>	E. FOR WHOM PAID <i>(Self, spouse, child)</i>
MEDICARE (PART B) PRIVATE MEDICAL INSURANCE	\$2,312.00	01/01/2008 to 12/31/2008	Social Security	Self & Spouse
Private Medical Insurance	\$2,500.00	01/01/2008 to 12/31/2008	BCBS	Self & Spouse
Prescription Drugs	\$1,000.00	01/01/2008 to 12/31/2008	GetWell Pharmacy	Self & Spouse
Over-the-counter Medications	\$128.00	01/01/2008 to 12/31/2008	GetWell Pharmacy	Self & Spouse
Dentist	\$80.00	01/01/2008 to 12/31/2008	Dr. David Smith	Self & Spouse
Doctor Visits	\$298.00	01/01/2008 to 12/31/2008	Dr. David Smith, Jr.	Self & Spouse
Medical Travel (Doctor Visits)	\$36.00	01/01/2008 to 12/31/2008	180 miles @ \$.20/mile	Self & Spouse
Medical Travel (Pharmacy Visits)	\$36.00	01/01/2008 to 12/31/2008	180 miles @ \$.20/mile	Self & Spouse

IMPORTANT: Be sure to sign this form in Item 7A on the reverse side. Unsigned reports will be returned.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN John Allen Doe		 Department of Veterans Affairs IMPROVED PENSION ELIGIBILITY VERIFICATION REPORT (SURVIVING SPOUSE WITH NO CHILDREN) 8
FIRST NAME - MIDDLE NAME - LAST NAME OF SURVIVING SPOUSE Ann Doe		
COMPLETE MAILING ADDRESS OF SURVIVING SPOUSE 110 Veteran Avenue Raleigh, NC 27999		VA FILE NUMBER XC 23 985 947
		VA REGIONAL OFFICE RETURN ADDRESS
IMPORTANT - Please read the enclosed EVR Instructions (VA Form 21-0510) prior to completing this form.		
1A. YOUR SOCIAL SECURITY NUMBER 987-65-4321	1B. VETERAN'S SOCIAL SECURITY NUMBER 111-22-3333	
1C. YOUR DATE OF BIRTH (Mo., day, yr.) Aug, 15, 50		
2. YOUR MARITAL STATUS (Check only one box)		
(1) <input checked="" type="checkbox"/> I HAVE NOT REMARRIED SINCE THE VETERAN DIED (You have not married anyone since the veteran's death.)		
(2) <input type="checkbox"/> I REMARRIED ON _____ (Date) AND I AM STILL MARRIED (You married after the veteran's death and you are currently married. Enter the date you married your current spouse.)		
(3) <input type="checkbox"/> I REMARRIED AFTER THE VETERAN DIED BUT THE MARRIAGE ENDED BY DEATH OR DIVORCE ON _____. (You remarried but you are not currently married. Show the date your latest marriage ended.)		
3. NUMBER OF UNMARRIED, DEPENDENT CHILDREN (See Paragraph 1 of the EVR Instructions)		
IN YOUR CUSTODY <u>0</u> NOT IN YOUR CUSTODY <u>0</u>		
AMOUNT CONTRIBUTED DURING PAST 12 MONTHS TO CHILDREN NOT IN YOUR CUSTODY \$ <u>0.00</u>		
4A. ARE YOU A PATIENT IN A NURSING HOME? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "YES," complete Items 4B through 4D. If "NO," go to Item 5.)	4C. ENTER THE NAME, COMPLETE ADDRESS, AND TELEPHONE NUMBER OF NURSING HOME (Please include ZIP Code)	
4B. SHOW THE DATE YOU ENTERED THE NURSING HOME		
4D. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME FEES? <input type="checkbox"/> YES <input type="checkbox"/> NO		
5. DID YOU RECEIVE ANY WAGES OR WERE YOU EMPLOYED AT ANY TIME DURING THE PAST 12 MONTHS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
6. DO YOU RECEIVE ANY OTHER VA BENEFITS AS A VETERAN, PARENT, OR SURVIVING SPOUSE ? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "YES," write in the VA file number of the other benefit) <u>0</u>		

7A. MONTHLY INCOME (Read Paragraphs 2 and 3 of the EVR Instructions)			
If no income or net worth was received from a particular source, write "0" or "none." DO NOT LEAVE ANY ITEMS BLANK.			
SOURCE		SURVIVING SPOUSE	
SOCIAL SECURITY	\$		750.00
U.S. CIVIL SERVICE			0.00
U.S. RAILROAD RETIREMENT			0.00
MILITARY RETIREMENT			0.00
OTHER (Show Source)			0.00
OTHER (Show Source)			0.00
7B. ANNUAL INCOME (Read Paragraphs 2 and 4 of the EVR Instructions)			
If no income was received from a particular source, write "0" or "none." DO NOT LEAVE ANY ITEMS BLANK.			
NOTE: Report annual income for the dates indicated. If no dates are shown above the columns that follow, then report last calendar year (January through December) income in the left-hand column and current calendar year income in the right-hand column.			
SOURCE	FROM: 01/01/2008 THRU: 12/31/2008	FROM: 01/01/2009 THRU: 12/31/2009	
GROSS WAGES FROM ALL EMPLOYMENT	\$ 0.00		0.00
TOTAL INTEREST AND DIVIDENDS	0.00	\$	0.00
ALL OTHER (Show Source)	0	0	
ALL OTHER (Show Source)	0	0	
7C. DID ANY INCOME CHANGE (Increase/Decrease) DURING PAST 12 MONTHS? (Answer "NO" if there were no income changes or if the only change was a Social Security/VA cost-of-living adjustment. Answer "YES" if there were any other income changes or if you received any NEW source of income or any ONE-TIME income)			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If "YES," complete Items 7D through 7F. If "NO," go to Item 7G.)			
7D. WHAT INCOME CHANGED? (Show what income changed; for example, wages, city pension, etc.)		7E. WHEN DID THE INCOME CHANGE? (Show the dates you received any new income or the date income changed)	7F. HOW DID INCOME CHANGE? (Explain what happened; for example, quit work, got raise, received inheritance)
7G. NET WORTH (Read Paragraph 5 of the EVR Instructions)			
SOURCE		SURVIVING SPOUSE	
CASH/NON-INTEREST BEARING BANK ACCOUNTS	\$		0.00
INTEREST BEARING BANK ACCOUNTS			0.00
IRA'S, KEOGH PLANS, ETC.			0.00
STOCKS, BONDS, MUTUAL FUNDS, ETC.			0.00
REAL PROPERTY (Not your home)			0.00
ALL OTHER PROPERTY			0.00
8. FAMILY MEDICAL EXPENSES (Read Paragraph 6 of the EVR Instructions)			
Normally, medical expenses are reported at the end of the year. If you are using this form as your annual Eligibility Verification Report and Paragraph 6 of the EVR Instructions indicates that you should report medical expenses, use VA Form 21-8416, Medical Expense Report, to report your medical expenses. If you are using this form as a supplement to a pending claim, you do not need to report medical expenses. If entitlement is established, you will have an opportunity to report your medical expenses at the end of the year.			
9. SURVIVING SPOUSE'S EDUCATIONAL AND VOCATIONAL REHABILITATION EXPENSES (Read Paragraph 7 of the EVR Instructions). Show amounts paid by you during the past 12 months. DO NOT REPORT CHILDRENS' EXPENSES.			0.00
			\$
10A. SIGNATURE OF PAYEE (Read Paragraph 9 of the EVR Instructions before signing)			10B. DATE SIGNED
<i>Ann Dae</i>			01/15/2009
10C. TELEPHONE NUMBERS (Include Area Code)			
DAYTIME		EVENING	
(919) 777-0000		(919) 777-8888	
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.			



Department of Veterans Affairs

MEDICAL EXPENSE REPORT

1. NAME OF VETERAN <i>(First, middle, last)</i> John Allen Doe		2. VA FILE NUMBER XC 23 985 947
3A. NAME AND ADDRESS OF CLAIMANT Ann Doe 110 Veteran Avenue, Raleigh, NC 27999	3B. CHANGE OF ADDRESS <i>(Check box if address in Item 3A is different from last address furnished to VA)</i> <input type="checkbox"/>	3C. E-MAIL ADDRESS <i>(If applicable)</i>
4. VETERAN'S SOCIAL SECURITY NO. 111-22-3333		

NOTE: Family medical expenses actually paid by you may be deductible from your income. Report the actual amount of unreimbursed medical expenses you paid for yourself or relatives who are members of your household. Do not report any expenses you did not pay or expenses for which you were or will be reimbursed. Any expenses reasonably related to medical or dental care may be allowed as medical expenses. Examples of allowable medical expenses include the following: hospital expenses, office visits, drugs and medicines, eyeglasses, dental fees, medical insurance premiums (including the Medicare deduction), hearing aids, nursing home fees, home health services, and transportation for medical purposes (28.5 cents per mile, plus parking and tolls or fares for taxis, buses, etc.). If you are not sure whether a particular expense can be allowed, furnish a complete description of the purpose of the payment. We will let you know if an expense cannot be allowed. If more space is needed, 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.

You may be asked to verify the amounts you actually 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 payments for at least 3 years after we make a decision of your medical expense claim. If you are unable to provide documentation of the claimed medical expenses when asked to do so by VA, your benefits will be retroactively reduced or terminated.

Report medical expenses for the period 01/01/2008 thru 12/31/2008 . If no dates appear on this line, refer to the accompanying letter or Eligibility Verification Report for the dates your medical expense report should cover.

5. ITEMIZATION OF MEDICAL EXPENSES				
A. PURPOSE <i>(Physician or Hospital Charges, Eyeglasses, Oxygen Rental, Medical Insurance, etc.)</i>	B. AMOUNT PAID BY YOU	C. DATE PAID <i>(Mo/Day/Yr)</i>	D. NAME OF PROVIDER <i>(Name of doctor, dentist, hospital, lab, etc.)</i>	E. FOR WHOM PAID <i>(Self, spouse, child)</i>
MEDICARE (PART B) PRIVATE MEDICAL INSURANCE	\$1,156.00	01/01/2008 to 12/31/2008	Social Security	Self
Private Medical Insurance	\$1,440.00	01/01/2008 to 12/31/2008	BCBS	Self
Prescription Drugs	\$960.00	01/01/2008 to 12/31/2008	GetWell Pharmacy	Self
Over-the-counter Medications	\$65.00	01/01/2008 to 12/31/2008	GetWell Pharmacy	Self
Dentist	\$40.00	01/01/2008 to 12/31/2008	Dr. David Smith	Self
Doctor Visits	\$197.00	01/01/2008 to 12/31/2008	Dr. David Smith, Jr.	Self
Medical Travel (Doctor Visits)	\$36.00	01/01/2008 to 12/31/2008	180 miles @ \$.20/mile	Self
Medical Travel (Pharmacy Visits)	\$36.00	01/01/2008 to 12/31/2008	180 miles @ \$.20/mile	Self

IMPORTANT: Be sure to sign this form in Item 7A on the reverse side. Unsigned reports will be returned.

