OMB Approved No: 2900-0652
Respondent Burden: 10 Minutes
Expiration Date: 02/29/2020

Department of Veterans Affairs

VA DATE STAMP
(Do Not Write In This Space)

REQUEST FOR NURSING HOME INFORMATION IN CONNECTION WITH CLAIM FOR AID AND ATTENDANCE

INSTRUCTIONS: If you have any questions about completing this form, call VA toll-free at 1-800-827-1000 (Hearing Impaired TDD federal relay number is 711).

Section I - VETERAN/CLAIMANT'S IDENTIFICATION INFORMATION

NOTE: You can *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing the form.

1. VETERAN/CLAIMANT'S NAME *(First, Middle Initial, Last)*

2. VETERAN/CLAIMANT'S SOCIAL SECURITY NUMBER — —

3. VA FILE NUMBER

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*
Month — Day — Year

5. VETERAN'S SERVICE NUMBER *(If applicable)*

SECTION II - NURSING HOME INFORMATION

6. NAME OF NURSING HOME

7. ADDRESS OF NURSING HOME *(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 —

SECTION III - GENERAL INFORMATION *(To be completed by a Nursing Home Official)*

8. DATE ADMITTED TO NURSING HOME *(MM/DD/YYYY)*
Month — Day — Year

9. IS THE NURSING HOME FACILITY MEDICAID OR EQUIVALENT APPROVED?
☐ YES ☐ NO

10. HAS THE PATIENT APPLIED FOR MEDICAID?
☐ YES ☐ NO

11A. IS THE PATIENT COVERED BY MEDICAID OR EQUIVALENT PLAN?
☐ YES ☐ NO *(If "YES," complete Item 11B)*

11B. DATE MEDICAID OR EQUIVALENT PLAN BEGAN
Month — Day — Year

12. MONTHLY AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET
$

13. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: *(Check one)*
☐ SKILLED NURSING CARE ☐ INTERMEDIATE NURSING CARE

14. NURSING HOME OFFICIAL'S NAME *(First and Last) (Please print)*

15. NURSING HOME OFFICIAL'S TITLE *(Please print)*

16. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER *(Include Area Code)*

SECTION IV - DECLARATION OF INTENT

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

17. SIGNATURE OF NURSING HOME OFFICIAL *(Sign in ink)*

18. DATE SIGNED *(MM,DD,YYYY)*

PRIVACY ACT NOTICE: The 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 5, Code of Federal Regulations 1.526 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. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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 you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.