



**Department of Veterans Affairs**

**VA DATE STAMP**  
 (DO NOT WRITE IN THIS SPACE)

**EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT  
 NEED FOR REGULAR AID AND ATTENDANCE**

**IMPORTANT:** Please read Privacy Act and Respondent Burden information before completing the form.

**SECTION I: VETERAN'S IDENTIFICATION INFORMATION**

**NOTE:** You can *either* complete the form online or by hand. Please print the information requested in ink, neatly and legibly to help process the form.

1. VETERAN'S NAME (First, Middle Initial, Last)		
2. SOCIAL SECURITY NUMBER  — —	3. VA FILE NUMBER (If applicable)	4. DATE OF BIRTH (MM-DD-YYYY)  — —
5. VETERAN'S SERVICE NUMBER (If applicable)	6. SEX  <input type="radio"/> MALE  <input type="radio"/> FEMALE	7. TELEPHONE NUMBER (Include Area Code)  — —
8. E-MAIL ADDRESS (Optional)		
9. PREFERRED MAILING ADDRESS (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 II: CLAIM INFORMATION**

10. CLAIMANT'S NAME (First, Middle Initial, Last) (Complete only if you are not the veteran)	
11. CLAIMANT'S SOCIAL SECURITY NUMBER  — —	12. RELATIONSHIP OF CLAIMANT TO VETERAN  <input type="radio"/> SPOUSE <input type="radio"/> SELF
13. CLAIMANT'S HOME ADDRESS	
No. & Street Apt./Unit Number City State/Province Country ZIP Code/Postal Code —	
14. BENEFIT YOU ARE APPLYING FOR (Choose One)	
<input type="radio"/> <b>Special Monthly Compensation (SMC)</b> - Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance of another person to perform personal functions required in everyday living such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A Veteran or a deceased Veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a Veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation. They are not paid <u>without</u> eligibility to compensation.	
<input type="radio"/> <b>Special Monthly Pension (SMP)</b> - Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting him/her from the hazards of his/her daily environment, or are housebound (substantially confined to his/her immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a Veteran or survivor who is eligible for Veterans Pension or Survivors benefits.	

**SECTION III: INFORMATION OF EXAMINATION**

15. DATE OF EXAMINATION (MM-DD-YYYY)  — —	16A. IS CLAIMANT HOSPITALIZED?  <input type="radio"/> YES <input type="radio"/> NO (If "Yes," complete Items 16B and 16C)	16B. DATE ADMITTED (MM-DD-YYYY)  — —
17A. NAME OF HOSPITAL		17B. ADDRESS OF HOSPITAL

**NOTE: EXAMINER PLEASE READ CAREFULLY**

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable. Findings should be recorded to show whether the claimant is blind or bedridden. Whether the claimant seeks housebound or aid and attendance benefits, the report should reflect how well he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

17C. COMPLETE DIAGNOSIS (Diagnosis needs to equate to the level of assistance described in questions 25 through 39)

18A. AGE	18B. WEIGHT		18C. HEIGHT	
	ACTUAL LBS.	ESTIMATED LBS.	FEET	INCHES

19. NUTRITION	20. GAIT
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21. BLOOD PRESSURE	22. PULSE RATE	23. RESPIRATORY RATE	24. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?
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25. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED  
 From 9 PM to 9 AM: \_\_\_\_\_ From 9 AM to 9 PM: \_\_\_\_\_

26. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? (Fill in Circle. If "No," provide explanation)

YES  NO

27. IS CLAIMANT ABLE TO PREPARE THEIR OWN MEALS? (Fill in Circle. If "No," provide explanation)

YES  NO

28. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? (If "Yes," provide explanation)

YES  NO

29A. IS THE CLAIMANT LEGALLY BLIND? (If "Yes," provide explanation)	29B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
<input type="radio"/> YES <input type="radio"/> NO		

30. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? (If "Yes," provide explanation)

YES  NO

31. DOES THE CLAIMANT REQUIRE MEDICATION MANAGEMENT? (If "Yes," provide explanation)

YES  NO

32. IN YOUR JUDGMENT, DOES THE VETERAN/CLAIMANT HAVE THE MENTAL CAPACITY TO MANAGE HIS OR HER BENEFIT PAYMENTS, OR IS HE OR SHE ABLE TO DIRECT SOMEONE TO DO SO? (If "No," provide examples and rationale to support your conclusion)

YES  NO

