



INSTRUCTIONS FOR COMPLETING APPLICATION 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
- 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 amounts. Contributions can include 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.



APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

1A. TYPE OF BENEFIT(S) APPLIED FOR <i>(You may check more than one)</i>					
<input type="checkbox"/> HEALTH SERVICES		<input type="checkbox"/> NURSING HOME		<input type="checkbox"/> DOMICILIARY	
<input type="checkbox"/> DENTAL		<input type="checkbox"/> ENROLLMENT			
1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER					
2. VETERAN'S NAME <i>(Last, First, MI)</i>			3. OTHER NAMES USED		4. GENDER <i>(Check one)</i>
					<input type="checkbox"/> M <input type="checkbox"/> F
5. SOCIAL SECURITY NUMBER	6. CLAIM NUMBER	7. DATE OF BIRTH <i>(mm/dd/yyyy)</i>		8. RELIGION	
9A. CURRENT MAILING ADDRESS <i>(Street)</i>		9B. CITY		9C. STATE	9D. ZIP
9E. COUNTY		10. HOME TELEPHONE NUMBER ()		11. WORK TELEPHONE NUMBER ()	
12. CURRENT MARITAL STATUS <i>(Check one)</i>					
<input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCE <input type="checkbox"/> 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	
B. DO YOU HAVE A VA SERVICE-CONNECTED RATING		YES	NO	I. DO YOU HAVE A SPINAL CORD INJURY	
B1. IF YES, WHAT IS YOUR RATED PERCENTAGE		%		J. ARE YOU ELIGIBLE FOR MEDICAID	
C. ARE YOU RECEIVING A VA PENSION		YES	NO	K. ARE YOU ENROLLED IN MEDICARE HOSPITAL	
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	
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 <i>(check one)</i> <i>If employed or retired, complete item 15B</i>			15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		
<input type="checkbox"/> NOT EMPLOYED					
<input type="checkbox"/> EMPLOYED / /					
<input type="checkbox"/> RETIRED <i>Date of retirement</i>					
16A. SPOUSE'S EMPLOYMENT STATUS <i>(check one)</i> <i>If employed or retired, complete item 16B</i>			16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		
<input type="checkbox"/> NOT EMPLOYED					
<input type="checkbox"/> EMPLOYED / /					
<input type="checkbox"/> RETIRED <i>Date of retirement</i>					
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			20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER ()		
			20C. EMERGENCY CONTACT'S WORK TELEPHONE ()		
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. <i>(Check one)</i> <i>(This does not constitute a will or transfer of title.)</i>					
<input type="checkbox"/> EMERGENCY CONTACT			<input type="checkbox"/> NEXT OF KIN		
22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY <i>(Check one)</i>			22B. IS NEED FOR CARE DUE TO ACCIDENT <i>(Check one)</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO		

