

VETERAN'S SOCIAL SECURITY NUMBER - -

SECTION IV: IS VETERAN/CLAIMANT HOSPITALIZED?

14A. IS THE CLAIMANT HOSPITALIZED?

☐ YES (If "YES," complete Items 14B, 14C & 14D)

☐ NO (If "NO," skip to Section V)

14B. DATE ADMITTED (MM/DD/YYYY)

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14C. NAME OF HOSPITAL

14D. ADDRESS OF HOSPITAL

SECTION V: CERTIFICATION AND SIGNATURE

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

15A. VETERAN/CLAIMANT'S SIGNATURE (Required)

15B. DATE SIGNED (MM/DD/YYYY)

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SECTION VI: EXAMINATION INFORMATION
(IMPORTANT: Remainder of form **MUST** be filled out by Examiner)

NOTE: Examiner **must be** a Medical Doctor (MD) or Doctor of Osteopathic (DO) medicine, physician assistant or advanced practice registered nurse.

16. DATE OF EXAMINATION (MM/DD/YYYY)

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NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the veteran/claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person. Please provide as much description as needed for each question as this will assist VA to determine if the disease(s) or injury(ies) listed may lead to physical or mental impairment, loss of coordination or enfeeblement that require assistance with daily living. 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 they ambulate, where they go, and what they are able to do during a typical day.

17. PROVIDE COMPLETE DIAGNOSIS WITH MOST SIGNIFICANT SYMPTOMS FOR EACH CONDITION (Diagnosis needs to equate to the level of assistance described in Items 26 through 37) (Describe below)

18. WHAT DISABILITY(IES) ARE CONSIDERED PERMANENT AND TOTALLY DISABLING? (Describe below)

A.

D.

B.

E.

C.

F.

19A. AGE

19B. WEIGHT

ACTUAL LBS.

ESTIMATED LBS.

19C. HEIGHT

FEET

INCHES

20. NUTRITION

21. GAIT

22. BLOOD PRESSURE

23. PULSE RATE

24. RESPIRATORY RATE

25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

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26. IF THE PATIENT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED

From 9 PM to 9 AM: From 9 AM to 9 PM:

27. DOES THE PATIENT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING ACTIVITIES? (Select ALL that apply)

- | | | |
|--|--|---|
| ☐ BATHING/SHOWERING | ☐ TENDING TO HYGIENE NEEDS | ☐ ADDITIONAL ACTIVITIES (i.e., housekeeping, laundering, meal preparation, etc.) (Specify additional activity below) |
| ☐ EATING OR SELF-FEEDING | ☐ TRANSFERRING IN OR OUT OF BED/CHAIR | |
| ☐ DRESSING | ☐ TOILETING | |
| ☐ AMBULATING WITHIN THE HOME OR LIVING AREA | ☐ MEDICATION MANAGEMENT | |

28A. IS THE PATIENT LEGALLY BLIND? (If "Yes," provide explanation)

☐ YES

☐ NO

28B. CORRECTED VISION

LEFT EYE

RIGHT EYE

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

☐ YES

☐ NO

30. IN YOUR JUDGMENT, DOES THE PATIENT HAVE THE MENTAL CAPACITY TO MANAGE THEIR BENEFIT PAYMENTS, OR ARE THEY ABLE TO DIRECT SOMEONE TO DO SO?

☐ YES

☐ NO

(If "NO," provide the disability(ies) that prevent them from performing this function and any rationale to support your conclusion in the space provided)

31. WHAT IS THE POSTURE AND GENERAL APPEARANCE OF THE PATIENT? (Describe)

32. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED THEMSELVES, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE

33. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURES OR OTHER INTERFERENCE. (**NOTE:** If indicated, comment specifically on weight bearing, balance and propulsion of each lower extremity)

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

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35. DESCRIBE ALL OTHER PATHOLOGY INCLUDING THE LOSS OF BOWEL OR BLADDER CONTROL OR THE EFFECTS OF ADVANCING AGE; SUCH AS DIZZINESS, LOSS OF MEMORY OR POOR BALANCE, THAT AFFECTS PATIENT'S ABILITY TO PERFORM SELF-CARE, OR IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA

36. HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES (to include the level of assistance required) IS THE PATIENT ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES (Describe)

37. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION?

☐ YES (If "YES," check the applicable box or specify distance)

☐ 1 BLOCK

☐ 5 OR 6 BLOCKS

☐ 1 MILE

OTHER (Specify distance) _____

☐ NO

SECTION VII: EXAMINER'S SIGNATURE

38. PRINTED NAME OF EXAMINER

39. TITLE OF EXAMINER

40. SIGNATURE OF EXAMINER (REQUIRED)

41. DATE SIGNED (MM/DD/YYYY)

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SECTION VIII: EXAMINER'S INFORMATION

42. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER OF EXAMINER

43. NAME OF MEDICAL FACILITY

44. ADDRESS OF MEDICAL FACILITY (Number and street or rural route, city, state, ZIP Code and Country)

45. TELEPHONE NUMBER OF MEDICAL FACILITY (Include Area Code)

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Enter International Phone Number (If applicable)

PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

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 38, code of Federal Regulations 1.576 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 Veteran Readiness and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. Giving us your Social Security Number (SSN) account information is mandatory. Applicants are required to provide their SSN under Title 38, U.S.C. 5701(c)(1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits provided under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs.

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0721, and it expires 06/30/2029. Public reporting burden for this collection of information is estimated to average 30 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Please refer to OMB Control No. 2900-0721 in any correspondence. Do not send your completed VA Form 21-2680 to this email address.