



**Hillsborough
County Florida**

**U.S. Dept. of Veterans Affairs Financial Assistance: Aid and Attendance, or
Housebound Pension for Wartime Veterans or Their Surviving Spouses.
For Calendar Year 2025**

- Ensure criteria on Tab “A” is met before continuing.
- Obtain required documents and applicable Information in Tab
- Provide required information on Tab "C" Worksheet
- Provide The VA Form 21-2680, Examination for Housebound Status or Permanent Need for Aid and Attendance. Please make sure every box is complete. The Veteran or Surviving Spouse will need to complete Block 15A and 15B. The form may be completed by Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS).
- Complete ONE of the following;
 - Tab D for Assisted Living Facility (ALF)
 - Tab E for In Home Care Assistance

Deliver the completed documents with supporting documentation to a Veterans Service Officer.
Please do not fax or mail.

Consumer and Veterans Services Main office:

[3602 US HWY 301 N, bldg. 3610](#)
[Tampa, FL 33619](#)

Phone (813) 635-8316

Fax (813) 272-5002

cvs@hcfl.gov

More locations on our website:

<https://www.hcfl.gov/residents/human-services/veterans/veterans-services-offices>

**Brandon Regional Service
Center:**

[311 Pauls Dr., Suite 100](#)
[Brandon, FL 33511](#)

**South Shore Regional
Service Center:**

[410 30th St. E., Suite 104](#)
[Ruskin, FL 33570](#)

**James A. Haley VA
Primary Care Annex:**

[13615 Lake Terrace Lane](#)
[Tampa, FL 33637](#)

VA PENSION CRITERIA

Generally, a Veteran must have at least 90 days of active-duty service, with at least one day during a wartime period to qualify for a VA Pension. If you entered active duty after September 7, 1980, generally you must have served at least 24 months or the full period for which you were called or ordered to active duty (with some exceptions), with at least one day during a wartime period.

In addition to meeting minimum service requirements, the Veteran must be:

- Age 65 or older, **OR**
- Totally and permanently disabled, **OR**
- A patient in a nursing home receiving skilled nursing care, **OR**
- Receiving Social Security Disability Insurance, **OR**
- Receiving Supplemental Security Income **AND**
- Must be receiving care in either an Assisted Living Facility (ALF) or with an In-Home Health Care provider at the time of submission of or prior to submission of the claim.

Your yearly family income must be less than the amount set by Congress to qualify for the Veterans Pension benefit. If eligible, your pension benefit is the difference between your “countable” income and the annual pension limit set by Congress. VA generally pays this difference in 12 equal monthly payments. For additional information, please visit:

<http://www.benefits.va.gov/pension/index.asp>

Eligible Wartime Periods

Under current law, VA uses the following wartime periods to determine eligibility for VA Pension benefits:

- World War II (December 7, 1941 – December 31, 1946)
- Korean conflict (June 27, 1950 – January 31, 1955)
- Vietnam era (November 1, 1955 – May 7, 1975, for Veterans who served in the Republic of Vietnam during that period; otherwise, August 5, 1964 – May 7, 1975)
- Gulf War - Pre-9/11 (August 2, 1990 – September 10, 2001); Post-9/11 (September 11, 2001, through date to be prescribed by Presidential proclamation or law)

Aid & Attendance (A&A)

The Aid & Attendance (A&A) increased monthly pension amount may be added to your monthly pension amount if you meet one of the following conditions:

- You require the aid 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, need help ambulating in the home/living area, or protecting yourself from the hazards of your daily environment
- You are bedridden, in that your disability or disabilities requires that you remain in bed apart from any prescribed course of convalescence or treatment
- You are a patient in a nursing home due to mental or physical incapacity
- Your eyesight is limited to a corrected 5/200 visual acuity or less in both eyes: or concentric contraction of the visual field to 5 degrees or less

Housebound

This increased monthly pension amount may be added to your monthly pension amount when you are substantially confined to your immediate premises because of permanent disability.

REQUIRED SUPPORTING DOCUMENTATION FOR PENSION

DISCHARGE / SEPARATION MILITARY PAPERS (DD-214):

To request Military discharge or records, complete form SF-180 or refer to the following website:

<https://www.archives.gov/>

COPY OF MARRIAGE CERTIFICATE:

If previously married: Please provide information for both the Veteran and spouse. Include the name, date, and place of both the marriage and end of marriage as well as the reason for termination of marriage.

COPY OF DEATH CERTIFICATE (WIDOW ONLY):

Must show cause of death (This will be the long form if the death occurred in Florida.)

COPY OF CURRENT SOCIAL SECURITY AWARD LETTER(S)

PROOF OF ALL MONTHLY GROSS INCOME:

Retirement pensions, Income, Interest, Trust, etc. You will need to provide for both the Veteran and spouse. Often listed on monthly bank statements.

HOUSEHOLD NET WORTH INFORMATION:

All banking; Stocks, Bonds, IRA's, CD's, Annuities, Properties other than primary residence.

HOUSEHOLD PRIVATE INSURANCE PREMIUMS: Not reimbursed.

VOIDED CHECK FOR DIRECT DEPOSIT OF PENSION

PHYSICIAN'S FORM (VA FORM 21-2680):

Must show complete diagnosis, inability to live independently and the need of assistance with activities of Daily Living (ADLs). Please make sure every box is complete and signed by a Physician, Physician Assistant (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS). Provider's signature, address, and telephone number is required.

APPLICABLE CARE WORKSHEETS: Assisted Living (Tab D) / In Home Attendant (Tab E)

VA Form 21P-0969, INCOME AND ASSET STATEMENT IN SUPPORT OF CLAIM FOR PENSION OR PARENT'S DIC may need to be completed along with the pension or survivor pension form in many cases due to the net worth transfer reporting requirements.

The VAF 21P-0969 must be completed if the Veteran or Survivor has more than 4 different types of income other than Social Security; received any income, other than Social Security from last year, which you no longer are receiving; has more than 2 acre of land that can be sold without selling their primary residence; has more than \$25,000 in assets, or has transferred assets in the previous 3 years.

WORKSHEET

POINT OF CONTACT ADDRESS CITY, STATE, ZIP TELEPHONE EMAIL	

VETERAN'S INFORMATION

NAME		SSN	
DATE OF BIRTH		DATE ENTERED	
PLACE OF BIRTH		MIL/SERVICE NUMBER	
DATE OF DEATH		DATE LEFT MILITARY	
PLACE OF DEATH		BRANCH OF SERVICE	

SPOUSE'S INFORMATION

NAME	DATE OF BIRTH	SSN
DATE OF MARRIAGE	PLACE OF MARRIAGE	

MONTHLY GROSS INCOME

VETERAN'S INCOME		SPOUSE'S INCOME	
SOCIAL SECURITY PENSION INTEREST OTHER SOURCES		SOCIAL SECURITY PENSION INTEREST OTHER SOURCES	

TOTAL ASSETS

<i>(DO NOT INCLUDE HOME OR AUTOMOBILE)</i>		
	VETERAN	SPOUSE
CHECKING SAVINGS STOCKS BONDS CDs ETC		

TOTAL MONTHLY EXPENDITURES

	VETERAN	SPOUSE
ASSISTED LIVING FACILITY		
IN HOME HEALTH CARE		
MEDICARE PART (B)		
MEDICARE PART (D)		
PRIVATE MEDICAL INS.		
OTHER		

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)
 - -

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)

- -

**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)

- -

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?

VETERAN'S SOCIAL SECURITY NUMBER

□□□□ - □□□□ - □□□□□□

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

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 REFERANCE 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 REFERANCE 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

WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR A SIMILAR FACILITY

NOTE: This worksheet is to be completed by an administrator or licensed medical professional from a residential care, adult daycare, or similar facility. To count this medical provider as an expense, they must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

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2. WHO IS COMPLETING THIS WORKSHEET? (Name of Provider, either an Administrator or Licensed Medical Professional)

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3. WHAT ROLE OR POSITION DO YOU PERFORM AT THE FACILITY?

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4. WHAT IS THE NAME OF THE FACILITY? (As shown on facility license or official website)

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5. WHAT IS THE FACILITY TELEPHONE NUMBER? International Phone Number (If applicable)

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6. WHAT IS THE MAILING ADDRESS OF THE FACILITY'S ADMINISTRATIVE OFFICE?

No. & Street

--

Apt./Unit Number

--

 City

--

State/Province

--

 Country

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 ZIP Code

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7. WHAT IS THE FACILITY'S WEBSITE ADDRESS?

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8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE FACILITY IS PROVIDING TO THE CARE RECIPIENT.

A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR

D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE CHECK THE APPROPRIATE BOX IF THIS STATEMENT IS TRUE:

THE STATE OR COUNTRY **REQUIRES** THIS FACILITY TO BE LICENSED

THE FACILITY IS LICENSED

THE FACILITY IS RESIDENTIAL

THE FACILITY IS STAFFED 24 HOURS

10. DOES THE FACILITY'S STAFF PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE OR BOTH. (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

YES NO, Care is being provided by a third-party provider. NO, Care is not being provided to this claimant.

If care is provided by a third-party provider, please ensure the claimant has each In-Home provider complete an In-Home Attendant Worksheet.

11. PLEASE PROVIDE THE DATE OF ADMISSION FOR THE CARE RECIPIENT STAYING AT THE FACILITY. (MM/DD/YYYY) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align: center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align: center;">/</td> <td style="width:60%; height: 20px;"></td> </tr> </table>		/		/		12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY) (Select "Indefinite" if the care you provide is not temporary.) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align: center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align: center;">/</td> <td style="width:60%; height: 20px;"></td> <td style="width:10%; text-align: center;"><input type="radio"/> INDEFINITE</td> </tr> </table>		/		/		<input type="radio"/> INDEFINITE
	/		/									
	/		/		<input type="radio"/> INDEFINITE							

13. PLEASE PROVIDE THE MONTHLY CHARGES THE CARE RECIPIENT STAYING AT THE FACILITY IS RESPONSIBLE FOR PAYING.

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 PER MONTH

FACILITY CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR A RESIDENTIAL CARE, ADULT DAYCARE, OR SIMILAR FACILITY is accurate and reflects the current environment of the Care Recipient and the facility.

14. SIGNATURE OF PROVIDER (From question 2)	15. DATE SIGNED (MM/DD/YYYY) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align: center;">/</td> <td style="width:10%; height: 20px;"></td> <td style="width:10%; text-align: center;">/</td> <td style="width:60%; height: 20px;"></td> </tr> </table>		/		/	
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WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: This worksheet is to be completed by your in-home care provider -OR- if an agency is providing you in-home care please have an agency administrator complete this form. These expenses must be claimed on your application for benefits or VA Form 21P-8416, *Medical Expense Report*. In addition, VA Form 21-2680, *Examination for Housebound Status or Permanent Need for Regular Aid and Attendance* may be needed to count these expenses.

1. WHO ARE YOU COMPLETING THIS WORKSHEET FOR? (Name of Care Recipient, either the Claimant or Dependent)

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2. WHO IS COMPLETING THIS WORKSHEET? (In-Home Care Attendant or Agency Administrator, Provider)

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3. IS THE IN-HOME CARE PROVIDED BY A LICENSED MEDICAL PROFESSIONAL?
(A licensed health care provider refers to a person licensed to furnish health services by the State or country in which the services are provided.)

YES NO

4. DO YOU WORK FOR AN AGENCY OR ORGANIZATION?

YES NO (If "NO," skip to question 7)

5. WHAT IS THE NAME OF THE AGENCY OR ORGANIZATION?

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6. WHAT IS THE AGENCY TELEPHONE NUMBER?

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7. WHAT IS YOUR MAILING ADDRESS OR THAT OF YOUR AGENCY'S ADMINISTRATIVE OFFICE?

No. & Street

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Apt./Unit Number

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 City

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State/Province

--

 Country

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 ZIP Code

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8. PLEASE SELECT EACH ACTIVITY OF DAILY LIVING (ADL) THAT THE IN-HOME CARE ASSISTANT PROVIDED TO THE CARE RECIPIENT.

- A. EATING B. BATHING/SHOWERING C. TRANSFERRING IN OR OUT OF BED OR CHAIR
 D. DRESSING E. USING THE TOILET F. AMBULATING WITHIN HOME OR LIVING AREA

9. PLEASE SELECT EACH INSTRUMENTAL ACTIVITY OF DAILY LIVING (IADL) THAT THE IN-HOME CARE ASSISTANT PROVIDES TO THE CARE RECIPIENT.

- A. SHOPPING B. FOOD PREPARATION C. NON-MEDICAL TRANSPORTATION
 D. LAUNDERING E. USING TELEPHONE F. MANAGING FINANCES
 G. HOUSEKEEPING H. HANDLING MEDICATIONS

10. IS THE PRIMARY RESPONSIBILITY OF THE IN-HOME ATTENDANT TO PROVIDE THE CARE RECIPIENT WITH HEALTH CARE OR CUSTODIAL CARE? (Custodial Care is regular assistance with two or more ADLs (Question 8), or supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to their daily environment.)

YES NO

11. PLEASE PROVIDE THE DATE CARE BEGAN FOR THE CARE RECIPIENT. (MM/DD/YYYY)

	/		/	
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12. ON WHAT DATE DO YOU EXPECT THIS CARE TO END? (MM/DD/YYYY)
(Select "Indefinite" if the care you provide is not temporary.)

	/		/		<input type="radio"/> INDEFINITE
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13. PLEASE PROVIDE THE HOURLY CHARGES THE CARE RECIPIENT IS RESPONSIBLE FOR PAYING.

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 PER HOUR

14. PLEASE PROVIDE THE TOTAL HOURS PER MONTH THAT YOU PROVIDE CARE TO THE CARE RECIPIENT.

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 HOURS PER MONTH

CERTIFICATION

I CERTIFY that the information stated within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment of the care recipient and the care services listed in questions eight and nine (8-9) above.

15. SIGNATURE OF PROVIDER (From question 2)

16. DATE SIGNED (MM/DD/YYYY)

	/		/	
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2025 Monthly VA Pension and DIC Benefit Rates

(Amounts set by the U.S. Congress)

Basic Pension (Monthly/Annual)

- Single Veteran - \$ 1,414 / \$ 16,965
- Married Veteran - \$ 1,851 / \$ 22,216
- Surviving Spouse - \$ 948 / \$ 11,380

Aid and Attendance Pension (Monthly/Annual)

- Single Veteran - \$ 2,358 / \$ 28,300
- Married Veteran - \$ 2,796 / \$ 33,548
- Surviving Spouse - \$ 1,515 / \$ 18,187

The net worth limits to qualify for Veterans Pension benefit as of December 1, 2024, is: \$ 159,240 (Not included: Home, Car, Basic Items like Appliances).

Example of Net Worth and Eligibility: If you had \$141,000 in assets and \$14,000 in annual income, then your net worth would be \$155,000. This is less than the net worth limits of \$159,240. So, you would be eligible for Veterans or Survivors Pension benefits.

The 2025 VA Dependency and Indemnity Compensation (DIC), Surviving Spouse basic monthly rate is \$ 1,653.07.

When calculating your income, the VA will not count Welfare benefits or Supplemental Security Income (SSI). It's also important to note, that your Unreimbursed Medical Expenses, help reduce your earned income.

For more information, or to speak with one of our accredited Veteran Service Officers, please call (813)-635-8316, or visit HCFL.gov/Veterans.



**Hillsborough
County Florida**