# VETERANS ASSISTANCE COMMISSION OF LAKE COUNTY

**NSC Pension Packet**

## CONTENTS



## USEFUL CONTACT INFORMATION

- VA Hotline
  - 800-827-1000
- James A Lovell Federal Health Care Center
  - Main: 847-688-1900
  - Enrollment: 224-610-1463
  - Billing: 877-874-2273
- Lake County Assessors Office
  - 847-377-2050
- Defense Finance Accounting Services
  - 888-332-7411
- Illinois Department of Veterans Affairs
  - 800-437-9824
- Lake County Veterans and Family Services
  - 847-986-4622
- Illinois Armed Forces Legal Aid Network
  - 855-452-3526

## CONTACT US AT:


**847-377-3344**

**847-984-5750**

**veterans@lakecountyil.gov**

**501 N Riverside Dr**
**Suite 106**
**Gurnee, IL 60031**


## WELCOME TO THE VAC.

Thank you for reaching out for assistance with your NSC Pension and/or Aid & Attendance application. The following packet is meant to be an initial review of your basic eligibility. NSC Pension has 3 main eligibility criteria, 1) service during a wartime period, 2) assets, 2) income. Once completed a VSO will review the information provided to determine your initial eligibility. We will then schedule a phone appointment to discuss our findings and next steps.


## LAST REVISION

4/30/2021

Feel free to use this timeline to check off your progress through the VA claims process.

# MY TIMELINE

Name

## 1 PENSION QUESTIONNAIRE

- Complete and submit the questionnaire.
- Call 847-377-3344 to schedule your first appointment with a VSO after submittal.

## 2 GATHER DOCUMENTS

- Prior to your appointment, gather any relevant documentation such as financial statements or medical records.

## 3 FIRST APPOINTMENT

- Meet with a VSO to discuss service history, medical history and VA benefits in general.
- You may be tasked with gathering additional evidence to support your claim.

## 4 RECORD REVIEW

- Your VSO will thoroughly review the financial documentation that you've provided to gather evidence for your pension claim.

## 5 FINAL APPOINTMENT

- Before your pension claim is submitted, you'll sit down with a VSO one final time to review the compiled packet.

## 6 CLAIM SUBMISSION

- With your final approval, the claim packet will be signed and securely transmitted to the VA Pension Management Center for intake and processing.

# VETERANS ASSISTANCE COMMISSION OF LAKE COUNTY

**Appointment Sheet**

## CONTACTS

_____

_____

_____

_____

_____

## I NEED TO...

## MY VAC APPOINTMENTS

Date _____

Time _____

Date _____

Time _____

Date _____

Time _____

Date _____

Time _____

Date _____

Time _____

Date _____

Time _____

# VETERANS ASSISTANCE COMMISSION OF LAKE COUNTY

## EXPLANATION OF FORMS

**PLEASE NOTE: THE SIGNATURE PAGE AND THE CLAIMS QUESTIONNAIRE MUST BE COMPLETED AND RETURNED PRIOR TO YOUR FIRST APPOINTMENT.**

### VA FORM 21-22

The VA Form 21-22 will appoint us as your representatives for VA claims and appeals. Additionally, it will grant us access to your VA file so that we can review historical claims and evidence. Samples have been included so that you can review the forms to which your digital signature will be applied.

### VA FORM 21-0966

The VA Form 21-0966 establish the earliest possible effective date for benefits and will entitle you to a lump sum retroactive payment if your claim is approved. Samples have been included so that you can review the forms to which your digital signature will be applied.

For example, if this form is filed in July of 2021, and your claim is approved in June 2022, you will be entitled to retroactive pay going back to July 2021.

### PENSION QUESTIONNAIRE

The pension questionnaire will help us get an initial overview of your situation so that a VSO can determine if you meet the initial eligibility requirements for VA pension.

### SIGNATURE PAGE

With your permission, the signature page will allow us to digitize your signature for easier and faster claims filing in the future. The signature will only be used for VA purposes and with your permission.

# VETERANS ASSISTANCE COMMISSION OF LAKE COUNTY

## SIGNATURE PAGE

### PLEASE SIGN LEGIBLY INSIDE THE BOX BELOW

With your consent, this signature will be scanned and used as a digital signature for future claim forms or documents that need to be submitted to the VA.

For VA purposes only

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 02/28/2022

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

# APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

**IMPORTANT**: Please read the Privacy Act and Respondent Burden Information on Page 3 before completing the form.

**NOTE:** If you prefer to have an individual assist you with your claim instead of a veterans service organization, please complete VA Form 21-22a, *Appointment of Individual as Claimant's Representative*. When completed you can mail *or* fax this form to the appropriate intake center address shown on Page 4. VA forms are available at www.va.gov/vaforms.

## SECTION I: VETERAN'S 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 of the form.

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

2. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*

3. VA FILE NUMBER *(If applicable)*

4. VETERAN'S DATE OF BIRTH — Month / Day / Year

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

6. INSURANCE NUMBER(S) *(If applicable) (Include letter prefix)*

7. VETERAN'S 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

8. VETERAN'S TELEPHONE NUMBER *(Include Area Code)*

9. VETERAN'S EMAIL ADDRESS *(Optional)*

## SECTION II: CLAIMANT'S INFORMATION (If other than veteran)

10. CLAIMANT'S NAME *(First, Middle Initial, Last)*

11. CLAIMANT'S 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

12. CLAIMANT'S TELEPHONE NUMBER *(Include Area Code)*

13. CLAIMANT'S EMAIL ADDRESS *(Optional)*

14. RELATIONSHIP TO VETERAN

## SECTION III: SERVICE ORGANIZATION INFORMATION

15. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on Page 3 before selecting organization)*

064-National Association of County Veterans Service Officers

16A. NAME OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 15 *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

16B. JOB TITLE OF PERSON NAMED IN ITEM 16A

17. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 15

veterans@lakecountyil.gov

18. DATE OF THIS APPOINTMENT *(MM/DD/YYYY)*

VETERAN'S SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

## SECTION IV: AUTHORIZATION INFORMATION

**19. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.** - By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☑ I **authorize** the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 15 all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. *Redisclosure of these records by my service organization* representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named in Item 15, either by explicit revocation or the appointment of another representative.

**20. LIMITATION OF CONSENT**- I authorize disclosure of records related to treatment for all conditions listed in Item 19 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

**21. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS** - By checking the box below, I authorize the organization named in Item 15 to act on my behalf to change my address in my VA records.

☑ I **authorize** any official representative of the organization named in Item 15 to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 16A is not my appointed fiduciary.

I, the claimant named in Items 1 ***or*** 10, hereby **appoint** the service organization named in Item 15 as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items [illegible] 20), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.6. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

## SECTION V: SIGNATURES

**NOTE: THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC**

| 22A. SIGNATURE OF VETERAN/CLAIMANT *(Do Not Print)* | 22B. DATE SIGNED *(MM/DD/YYYY)* |
|---|---|
| | |
| **23A. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 16A** *(Do Not Print)* | **23B. DATE SIGNED** *(MM/DD/YYYY)* |
| | |

**NOTE**: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

| **VA USE ONLY** | COPY OF VA FORM 21-22 SENT TO: ☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE | DATE SENT | ACKNOWLEDGED *(Date)* | REVOKED *(Reason and date)* |
|---|---|---|---|---|
| | | | | |

**PENALTY**: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement of a material fact, knowing it to be false or for the fraudulent acceptance of any payment to which you are not entitled.

OMB Control No. 2900-0826
Respondent Burden: 15 minutes
Expiration Date: 08/31/2021

**Department of Veterans Affairs**

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

# INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

**(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)**

NOTE: Please read the Privacy Act and Respondent Burden below before completing the form.

## SECTION I: CLAIMANT/VETERAN IDENTIFICATION

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 of the form.

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

2. CLAIMANT'S SOCIAL SECURITY NUMBER — 3. VA FILE NUMBER *(If applicable)* — 4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY) Month Day Year

5. VETERAN'S NAME *(First, Middle Initial, Last)* ***(If different from claimant)***

6. VETERAN'S SOCIAL SECURITY NUMBER — 7. VETERAN'S SEX ☐ MALE ☐ FEMALE — 8. VETERAN'S SERVICE NUMBER *(If applicable)*

9. CURRENT 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

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA? ☐ YES ☐ NO

11. TELEPHONE NUMBER *(Include Area Code)*

12. EMAIL ADDRESS *(If applicable)*

## SECTION II: GENERAL BENEFIT ELECTION

***IMPORTANT:*** *VA may not be able to use this form to establish an effective date for benefits if you **do not** select one or more of the general benefits listed below.*

**13. I intend to file for the general benefit(s) checked below: *(Choose all that apply)***

☐ COMPENSATION ☐ PENSION

**NOTE: Only check the box below if you are a surviving dependent of the veteran.**

☐ SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)

**IMPORTANT:** After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online at www.va.gov. If you give VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

## SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits***; (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form,

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE

14B. DATE SIGNED *(MM,DD,YYYY)*

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*

(NOTE: This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

**PRIVACY ACT NOTICE:** 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 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. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by 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 the appropriate application and provide it to the claimant.

**RESPONDENT BURDEN:** We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 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 desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Andrew Tangen, Superintendent
Sherry Kruse, Assistant Superintendent
Veterans Assistance Commission of Lake County
501 N. Riverside Dr, Ste 106
Gurnee, IL 60031
P: 847-377-3344 F: 847-984-5750
veterans@lakecountyil.gov
www.facebook.com/lakecountyvac

# VA Housebound/Aid & Attendance Eligibility Worksheet

## Applicant Information

Veteran Name: _____ DOB: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Phone: _____ Email _____

Spouse Name:
(if applicable) _____ DOB: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Phone: _____ Email _____

## Military Service Information

Did the Veteran serve during one of the following wartime eras? YES ☐ NO ☐

**If you answer "NO" to the previous question-please do not continue completing the form. You are ineligible for VA pension or Aid and Attendance.**

| | | | |
|---|---|---|---|
| WWII | 12/07/1941 – 12/31/1946 | Vietnam War | 02/28/1961 – 05/07/1975 |
| Korean War | 06/27/1950 – 01/31/1955 | Gulf War | 08/02/1990 -- Present |

If yes, what branch of service? _____ Type of Discharge? _____

What are the Veteran's dates of service? _____ -- _____

## Current Health Information — Veteran

Does the Veteran need any assistance with the following? (check all that apply)

| Eating | Bathing | Dressing | Toileting | Transferring | Other |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

If other, please explain: _____

_____

## Current Health Information — Surviving Spouse of Veteran

Does the surviving spouse need any assistance with the following? (check all that apply)

| Eating | Bathing | Dressing | Toileting | Transferring |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

If other, please explain: _____

_____

## Housing Information — Veteran

| | YES | NO |
|---|---|---|
| Does the Veteran live alone, without any assistance? | ☐ | ☐ |
| Does the Veteran currently reside in an assisted living facility? | ☐ | ☐ |
| Does the Veteran currently reside in a nursing home? | ☐ | ☐ |
| Is the Veteran receiving care through a caregiver agreement in-home or in a nursing facility? | ☐ | ☐ |

## Housing Information — Surviving Spouse

| | YES | NO |
|---|---|---|
| Does the surviving spouse live alone, without any assistance? | ☐ | ☐ |
| Does the surviving spouse currently reside in an assisted living facility? | ☐ | ☐ |
| Does the surviving spouse currently reside in a nursing home? | ☐ | ☐ |
| Is the surviving spouse receiving care through a caregiver agreement in-home or in a nursing facility? | ☐ | ☐ |

## Total Household Assets

In order to qualify for Aid & Attendance, your total household assets **must not** exceed $130,773.

Does your household's total assets exceed $130,773 (excluding your primary residence)? YES ☐ NO ☐

Have you transferred any assets in the past 36 months (3 years)? YES ☐ NO ☐

If yes, please explain: _____

_____

Please insert the value of each asset in the appropriate space below:

| Asset | Veteran | Spouse |
|---|---|---|
| Checking Account | $ | $ |
| Savings Account | $ | $ |
| Money Market Account | $ | $ |
| Certificate of Deposit | $ | $ |
| Real Estate (other than primary residence) | $ | $ |
| Mutual Funds | $ | $ |
| Stocks | $ | $ |
| Bonds | $ | $ |
| Annuities | $ | $ |
| IRA | $ | $ |
| Other Pensions | $ | $ |
| Nursing Home Deposit | $ | $ |
| Other Assets (list below): | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |

## Life Insurance Policies

| Company Name | Type | Death Benefit Value | Face Value | Cash Value | Insured | Owner | Beneficiary |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**POLICY CASH OUT VALUE ONLY**

## Unreimbursed Medical Expenses

Please list any medical or dental expenses that you paid for yourself or for a dependent for which you were not reimbursed and do not expect to be reimbursed.

Examples of eligible expenses include:

Hospital expenses
Doctor's office fees
Dental fees
Prescription/non-prescription drug costs
Medical insurance premiums
Durable Medical Equipment (DME)
Funeral expenses within the past 12 months
Nursing home costs
Hearing aid costs
Home health service expenses
Transportation to medical facilities
Medicare Part B premium
Smoking cessation products
Service animal costs

| Monthly Expenses | Veteran | Surviving Spouse |
|---|---|---|
| Nursing home | /MO | /MO |
| Assisted Living | /MO | /MO |
| Home Health Care | /MO | /MO |
| Medicare Premiums | /MO | /MO |
| Private Insurance Premiums | /MO | /MO |
| Prescriptions | /MO | /MO |
| Other Expenses (list below) | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |

**Please list all expenses on a MONTHLY basis.**

| Unreimbursed Medical Expenses (Continued) | | |
|---|---|---|
| Monthly Expenses | Veteran | Surviving Spouse |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |
| | /MO | /MO |

**Please list all expenses on a MONTHLY basis.**

Do you expect any changes to your monthly expenses for the next calendar year? YES ☐ NO ☐

If yes, please explain: _____

_____

## Monthly Income

Please list **all** countable income for the household in the table below:

| | Veteran | Surviving Spouse |
|---|---|---|
| Social Security Benefits (Gross) | | |
| Retirement Benefits (Gross) | | |
| Annuity Income | | |
| Rental Property, Farm or Business Income | | |
| Wages (including self-employment) | | |

## Additional Comments

_____

_____

_____

_____

_____

## Final Checklist

| | YES | NO |
|---|---|---|
| Copy of Veteran's DD214 (Member 4 copy)? | ☐ | ☐ |
| Completed and signed VA Form 21-22? | ☐ | ☐ |
| Completed and signed VA Form 21-0996? | ☐ | ☐ |

Signature of Veteran or Claimant: _____

Date Signed: _____

## Once complete, please return this eligibility application to

Veterans Assistance Commission of Lake County
501 North Riverside Dr, Suite 106
Gurnee, IL 60031

Email: veterans@lakecountyil.gov
Fax: (847) 984-5750

Thank you for submitting the Aid and Attendance eligibility application. Upon receipt, your application will be reviewed by a Veteran Service Officer and eligibility will be determined in a timely manner. If, after review, you are determined eligible for Aid and Attendance, you will be contacted to provide supporting financial documentation.