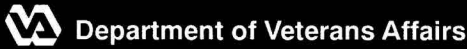
 Department of Veterans Affairs		REQUEST FOR NURSING HOME INFORMATION IN CONNECTION WITH CLAIM FOR AID AND ATTENDANCE		VA DATE STAMP (Do Not Write In This Space)	
INSTRUCTIONS: For free help in completing this form, call VA toll-free at 1-800-827-1000. (Hearing Impaired TDD line 1-800-829-4833.)					
Section I - IDENTIFICATION INFORMATION					
1A. NAME OF NURSING HOME			1B. ADDRESS OF NURSING HOME		
2. ADDRESS OF VA REGIONAL OFFICE					
3. FIRST NAME - MIDDLE INITIAL- LAST NAME OF CLAIMANT					
4. SOCIAL SECURITY NUMBER			5. VA FILE NUMBER		
SECTION II - NURSING HOME INFORMATION (To be completed by a Nursing Home Official)					
6. DATE ADMITTED TO NURSING HOME (Month, Day, Year)			7. DATE MEDICAID BEGAN (Month, Day, Year)		
8. AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET					
\$					
9. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: (Check one)					
<input type="checkbox"/> SKILLED NURSING CARE <input type="checkbox"/> INTERMEDIATE NURSING CARE					
10. NURSING HOME OFFICIAL'S NAME (First & Last) (Please print)					
11. NURSING HOME OFFICIAL'S TITLE (Please print)				12. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER (Include Area Code)	
13A. SIGNATURE OF NURSING HOME OFFICIAL				13B. DATE SIGNED	
<p>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 5, Code of Federal Regulations 1.526 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 Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. While you are not required to respond, your cooperation in providing this relevant and necessary information will help us determine the claimant's maximum benefit entitlement under the law. Information that you furnish may be utilized in computer matching programs with other Federal or state agencies for the purpose of determining the claimant's eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of the claimant's participation in any benefit program administered by the Department of Veterans Affairs.</p> <p>RESPONDENT BURDEN: We need this information to determine eligibility for benefits and the proper rate of payment (38 U.S.C. 5503, 38 U.S.C. 1115 (1)(E)), 38 U.S.C. 1311(c), 38 U.S.C. 1315(h)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 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.whitehouse.gov/omb/library/OMBINV.VA.EPA.html#VA. If you desire, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.</p>					



REQUEST FOR NURSING HOME INFORMATION IN CONNECTION WITH CLAIM FOR AID AND ATTENDANCE

VA DATE STAMP
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Section I - IDENTIFICATION INFORMATION

1A. NAME OF NURSING HOME Serenity Care Facility	1B. ADDRESS OF NURSING HOME 33829 Broadway, NY, NY 21002
2. ADDRESS OF VA REGIONAL OFFICE 4850 49th Street NY, NY 23001	
3. FIRST NAME - MIDDLE INITIAL- LAST NAME OF CLAIMANT Joe J Schmoe	
4. SOCIAL SECURITY NUMBER 999-99-9999	5. VA FILE NUMBER E299-39902

SECTION II - NURSING HOME INFORMATION (To be completed by a Nursing Home Official)

6. DATE ADMITTED TO NURSING HOME (Month, Day, Year)	7. DATE MEDICAID BEGAN (Month, Day, Year)
8. AMOUNT PATIENT IS RESPONSIBLE FOR OUT OF POCKET \$	
9. I CERTIFY THAT THE CLAIMANT IS A PATIENT IN THIS FACILITY BECAUSE OF MENTAL OR PHYSICAL DISABILITY AND IS RECEIVING: (Check one) <input type="checkbox"/> SKILLED NURSING CARE <input type="checkbox"/> INTERMEDIATE NURSING CARE	
10. NURSING HOME OFFICIAL'S NAME (First & Last) (Please print)	
11. NURSING HOME OFFICIAL'S TITLE (Please print)	12. NURSING HOME OFFICIAL'S OFFICE TELEPHONE NUMBER (Include Area Code)
13A. SIGNATURE OF NURSING HOME OFFICIAL	13B. DATE SIGNED

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