CLAIMANT'S CERTIFICATION OF OUT-OF-POCKET EXPENSES (FV16)

Instructions for Filling out Form FV16

Please complete and sign this document.

Name of Claimant
This is either for a living veteran or a single surviving spouse. Do not put a deceased veteran here. If it is for a sick spouse of a healthy veteran the claimant is the veteran.

Name of Veteran
This must always be the veteran regardless of who the claimant is and whether the veteran is alive or dead.

VA Claim Number or Veteran's Social Security Number
You will not have a VA claim number unless you have filed a previous claim. Use the veteran's social security number whether the veteran is living or dead.

Recurring monthly charges for nursing home, assisted living, home care, etc…
List all monthly charges separately for both the veteran and the veteran's spouse. If not a couple, then the total monthly for the single veteran or the single surviving spouse.

Monthly health insurance premiums
This would be for a Medicare Supplement, Medicare Advantage, Employer Insurance, or Medicare Prescription plan. Put in the monthly amount for the couple or the single if applicable. We do need the company that is providing the insurance.

Monthly Ongoing Prescriptions
Only put in ongoing prescription costs. Do not put in intermittent prescription expenses.

Other deductible recurring medical expenses
These are expenses that can be proven will recur every month over the coming 12 months. This might include: rental of medical equipment, rental of medical alert and medical monitoring and other similar charges.

Subtotal of All Recurring expenses

Less all reimbursement for these charges
Reimbursement would typically represent insurance covering the charges. Deductible medical expenses for purposes of receiving pension must be out-of-pocket so any reimbursements must be deducted from the medical expenses. Usually this will be Long Term Care insurance monies.

Total monthly out-of-pocket after reimbursement

Signature of Claimant
This must always be the veteran if the veteran is living. If the veteran is deceased, this will be the signature of the surviving spouse.

Claimant's Certification of Out-of-Pocket Expenses - Form FV16

Claimant's Name:	Veteran's Name:	VA Claim # or SS# of Veteran:
Veteran's (or Claimant's) Address:	City, State, Zip:	Phone #:

RECURRING OUT OF POCKET EXPENSES:

Type of Care or Service	Person for whom expense is paid	Name of Provider or Company	Date service began	Monthly Amount $
Home Care				
Assisted Living				
Nursing Home				
Independent Living				
Medicare B Premium Husband & Wife if applicable				
Health Insurance				
Medicare Supplement				
Medicare Rx Plan				
Ongoing Prescriptions				
Other:				
Other:				
		Subtotal		
		Subtract any reimbursement		–
		Total Monthly Costs		

CLAIMANT CERTIFICATION
I certify the expenses listed above as "Total Monthly Costs" is being paid from personal household funds (paid out-of-pocket). I request this amount be used as a prospective 12-month, annualized deduction for the purpose of calculating my household IVAP.

Signature of Claimant	*Date*

Signature of Witnesses	*Signatures of Witnesses*

Witnesses are only required if the claimant signs with a mark or x. Two different individuals must witness the mark.