OMB Control No. 2900-0721
Respondent Burden: 30 minutes
Expiration Date: 02/28/2026

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

EXAMINATION FOR HOUSEBOUND STATUS OR PERMANENT NEED FOR REGULAR AID AND ATTENDANCE

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 4. Use this form to determine eligibility for aid and attendance or housebound benefits. For more information, you can contact us online through Ask VA: https://ask.va.gov/. Ask us a question online or call us toll-free at 1-800-827-1000 (TTY: 711). VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completing by hand, print neatly and legibly in ink, and completely fill in each applicable check box to help expedite processing of the form.

1. VETERAN/BENEFICIARY NAME *(First, Middle Initial, Last)*: JOHN A SAMPLE

2. SOCIAL SECURITY NUMBER *(999-99-9999)*: 123 – 45 – 6789

3. VA FILE NUMBER *(If applicable)*: 123456789

4. VETERAN'S SERVICE NUMBER *(If applicable)*:

5. DATE OF BIRTH *(MM/DD/YYYY)*: 03 – 15 – 1948

SECTION II: CLAIMAINT'S IDENTIFICATION INFORMATION

6. CLAIMANT'S NAME *(First, Middle Initial, Last)*: JOHN A SAMPLE

7. CLAIMANT'S SOCIAL SECURITY NUMBER *(999-99-9999)*: 123 – 45 – 6789

8. RELATIONSHIP OF CLAIMANT TO VETERAN
- [X] SELF
- [ ] PARENT
- [ ] SPOUSE
- [ ] CHILD

9. CLAIMANT'S DATE OF BIRTH *(MM/DD/YYYY)*: 03 – 15 – 1948

10. MAILING ADDRESS *(Number and street or rural route, P. O. Box, City, State, ZIP Code and Country)*

No. & Street: 123 MAIN STREET

Apt./Unit Number:

City: SPRINGFIELD

State/Province: IL

Country: US

ZIP Code/Postal Code: 62704 –

11. TELEPHONE NUMBER *(Optional) (Include Area Code) ((999) 999-9999)*: 217 – 555 – 0123

Enter International Phone Number (If applicable):

12. EMAIL ADDRESS *(Optional)*

[ ] I agree to receive electronic correspondence from VA in regards to my claim.

SECTION III: CLAIM INFORMATION

13. SELECT ONE OF THE FOLLOWING BENEFITS *(Choose one)*

[X] **Special Monthly Compensation (SMC) -** Veterans and surviving spouses or parents who are eligible to receive VA compensation due to a service-related disability or death and require aid and attendance 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, or protecting oneself from the hazards of the daily environment may be eligible for Special Monthly Compensation. A veteran or a deceased veteran's surviving spouse may also be eligible for Special Monthly Compensation based on being housebound (substantially confined to the immediate premises because of permanent disability). For a veteran, the disability causing the need for aid and attendance or housebound status must be related to service. These benefits are paid in addition to monthly compensation or Dependency Indemnity Compensation (DIC). They are not paid without eligibility to compensation.

[ ] **Special Monthly Pension (SMP) -** Veterans and survivors who are eligible for Veteran's Pension and/or Survivors benefits and require the aid and attendance of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting them from the hazards of their daily environment, or are housebound (substantially confined to their immediate premises because of permanent disability), may be eligible for Special Monthly Pension (SMP). This benefit is an increased monthly amount paid to a veteran or survivor who is eligible for Veterans Pension or Survivors benefits.

VETERAN'S SOCIAL SECURITY NUMBER 123 – 45 – 6789

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)***

John A. Sample

15B. DATE SIGNED *(MM/DD/YYYY)*
08 – 18 – 2026

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)*
08 – 18 – 2026

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)*

1. Parkinson's disease: bilateral resting tremor, cogwheel rigidity, bradykinesia, postural instability, festinating gait with freezing episodes, hypophonia, and recurrent falls. 2. Major neurocognitive disorder due to Parkinson's disease: impaired short-term memory, executive dysfunction, and poor judgment and safety awareness (MoCA 16/30). 3. Bilateral knee osteoarthritis: chronic pain, crepitus, limited flexion, difficulty rising and negotiating stairs. 4. Orthostatic hypotension: dizziness on standing; one syncopal episode in the past year. 5. Urge urinary incontinence: episodes several times weekly requiring hygiene assistance.

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

A. Parkinson's disease with postural instability	**D.**
B. Major neurocognitive disorder due to Parkinson's disease	**E.**
C. Bilateral knee osteoarthritis	**F.**

19A. AGE	19B. WEIGHT	19C. HEIGHT
78	ACTUAL LBS. 152 ESTIMATED LBS.	FEET 5 INCHES 9

20. NUTRITION
Fair. 12 lb unintentional weight loss over the past year. Requires meal preparation and cueing to maintain intake.

21. GAIT
Shuffling, festinating gait with freezing; walker and standby assist.

22. BLOOD PRESSURE	23. PULSE RATE	24. RESPIRATORY RATE	25. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?
132/78	74	16	Parkinson's disease and dementia restrict all activities in Item 27. Knee osteoarthritis and orthostatic hypotension further limit ambulation, transfers, and bathing.

VETERAN'S SOCIAL SECURITY NUMBER 123 – 45 – 6789

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

From 9 PM to 9 AM: 10 From 9 AM to 9 PM: 3

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

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

Meal preparation, housekeeping, laundry, shopping, transportation, and management of finances are performed entirely by the spouse and a home health aide.

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

[ ] YES [X] NO

Not legally blind. Corrected acuity is functional for daily activities.

28B. CORRECTED VISION

LEFT EYE	RIGHT EYE
20/40	20/50

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

[ ] YES [X] NO

Nursing home care is not required at this time. Needs are met at home by the spouse with a home health aide 20 hours per week. Without this level of in-home assistance and supervision, skilled facility placement would be necessary.

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 [X] 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)*

Major neurocognitive disorder due to Parkinson's disease prevents management of benefit payments. Deficits include impaired short-term memory, calculation, and executive function (MoCA 16/30). Orientation and judgment fluctuate, and the patient cannot reliably direct another person to manage funds. The spouse manages all household finances.

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

Stooped, flexed posture with masked facies and hypophonia. Frail, appears older than stated age. Visible resting tremor of both hands. Well groomed with caregiver assistance. Cooperative with slowed responses.

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

Bilateral resting tremor, right greater than left, with cogwheel rigidity and bradykinesia. Grip strength 3/5 bilaterally with impaired fine motor control. Unable to fasten buttons, manage zippers, write legibly, or shave safely. Drops utensils; requires food cut, tray setup, and cueing to complete meals. Needs assistance with clothing fasteners and with hygiene after attending 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)*

Bilateral knee osteoarthritis with crepitus; flexion limited to approximately 90 degrees; mild quadriceps atrophy. Bradykinesia and rigidity impair initiation of movement. Weight bearing tolerated only for short distances. Balance is poor with retropulsion; propulsion is impaired by festination and freezing. Unable to rise from a chair without upper extremity push-off and standby assistance. Three falls in the past six months.

34. DESCRIBE RESTRICTION OF SPINE, TRUNK, AND NECK

Stooped kyphotic posture with axial rigidity. Cervical and trunk rotation markedly reduced, limiting the ability to turn, reach, dress, and bathe. Impaired postural reflexes with loss of balance on minimal perturbation.

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

Urge urinary incontinence with episodes several times weekly requiring hygiene assistance and garment changes. Orthostatic hypotension with dizziness on standing and one syncopal episode in the past year. Impaired short-term memory, executive dysfunction, and poor safety awareness; has left the stove on unattended and requires 24-hour supervision. All medications are administered by the spouse. These deficits, combined with the effects of advancing age, prevent safe independent self-care and protection from the hazards of the daily environment.

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)*

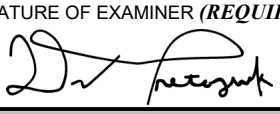
Leaves the home only for medical appointments, approximately two to three times per month, always accompanied by the spouse or a caregiver. Requires assistance transferring in and out of the vehicle and uses a wheelchair for distances beyond approximately 100 feet. Does not leave the home for social, recreational, or errand purposes.

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

[X] YES *(If "YES," check the applicable box or specify distance)* [ ] 1 BLOCK [ ] 5 OR 6 BLOCKS [ ] 1 MILE OTHER *(Specify distance)* Less than 100 feet

[ ] NO

SECTION VII: EXAMINER'S SIGNATURE

38. PRINTED NAME OF EXAMINER	39. TITLE OF EXAMINER
David Protaziuk, MSN, APRN, FNP-C	Family Nurse Practitioner
40. SIGNATURE OF EXAMINER ***(REQUIRED)***	41. DATE SIGNED *(MM/DD/YYYY)*
	08 – 18 – 2026

SECTION VIII: EXAMINER'S INFORMATION

42. NATIONAL PROVIDER IDENTIFIER *(NPI)* NUMBER OF EXAMINER

1275200149

43. NAME OF MEDICAL FACILITY

Veteran Medical Opinions

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

7501 Lemont Rd, Suite 345D, Woodridge, IL 60517, USA

45. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code) ((999) 999-9999)*

708 – 244 – 2627 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: We need this information to determine your eligibility for aid and attendance or housebound benefits. Title 38, United States Code 1521 (d) and (e), 1115(1)(e), 1311(c) and (d), 1315(h), 1122, 1541(d)(e), and 1502 (b) and (c) allows us to ask for this information. We estimate that you will need an average of 30 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 website at http://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.