Ward County Veteran Services
VA Pension Programs

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Pension Challenges

- Working with older clientele
- Dependent on assisted living facilities, nursing homes, doctors, etc.
- Complicated process, documentation
- St. Paul

Partners

- Claimant (vet or surviving spouse, relative)
- Doctor
- Nursing home/assisted living facility
- Hospital social worker
- County Social Services
- Friends/acquaintances

Pension Types

- Non-Service Connected Disability Pension
  - For the Veteran
  - Wartime service (90 days/1 day) with Honorable Discharge
  - Over 65 or Permanent and Total Disability
  - Must meet income and asset criteria
- Death Pension
  - Unremarried surviving spouse and/or dependent children
  - Must meet income and asset criteria
  - Not age dependent (surviving spouse)
  - Can apply to helpless child, any age

Levels of Pension

- Basic
  - Meets basic criteria
  - Lowest level of pension, lowest payments
  - Does not require medical documentation
- Housebound (HB)
  - Higher level of payments
  - “Permanently Housebound” when substantially confined to home or facility
  - Must meet medical criteria, have medical documentation
  - Need Care Expense Report or Nursing Home Certificate

Levels of Pension

- Aid and Attendance
  - Highest level of payments
  - Usually in nursing home or requires regular aid and attendance of another for clothing, bathing, feeding, and other protection from the environment
  - Blind
  - Must meet medical criteria; have medical documentation
  - Must have Care Expense Report or Nursing Home Certificate

Special Monthly Pension

- Housebound or Aid and Attendance (HB/A&A)
- Awarded when:
  - Blind in both eyes/severely visually impaired
  - Patient in a nursing home or permanently housebound
  - Evidence shows aid needed to perform daily living tasks

Documentation requires medical evidence for support, usually Care Expense Report (Assisted Living Facility), 21-2680 (Physician Statement), and/or 21-0779 (Nursing Home Certificate)

Net Worth/Eligibility

- Corpus of estate and net worth mean market value, less mortgages and other encumbrances, of all real and personal property owned, except claimant's dwelling and personal effects.
- Pension shall be denied or discontinued when corpus of estate are such that under all circumstances, including annual income, it is reasonable that some part of the of the corpus of such estates be consumed for the veteran's/spouse's maintenance. (CFR Title 38, Part 3)

Asset Guidelines

- Assets Cannot Exceed $80,000 (not absolute)
  - Does not include primary home, car, or personal property
  - Does not include burial account with funeral home
- Does Include All Other Liquid Assets
  - Checking, savings, CDs
  - Stock, bonds, mutual funds, IRA/401
  - Farm land, business property
  - Mineral acres/royalty agreements

Income Requirements

- Countable Income
  - Wages, salaries, tips, bonuses (gross)
  - Social Security, Railroad Retirement, government and private pensions, compensation
  - Annuities, interest, dividends, royalties
  - Net income from property, rent
  - Countable income equals all income minus eligible recurring medical expenses

Income Exclusions

- SSI payments
- Casualty insurance payments
- Conversion of assets (sale of car, home, etc.; could put them over asset limit, report to VA)
- Charitable contributions to claimant
- Volunteer service under RSVP, SCORE, ACTION, and other domestic volunteer programs
- Indian trust income up to $2000

Medical Expense Conditions

- Expenses actually paid by beneficiary or spouse
- Expenses are unreimbursed
- Expenses for beneficiary or relative who is a member of the household
- Expenses paid on or after date of pension application or entitlement (one year factor)
- Expenses exceed five percent deductible of Max Allowable Pension Rate (MAPR)

Medical Expenses

- Initial Pension Recurring Medical Expenses
  - Medicare Part B
  - Medicare Part D
  - Medicare Supplement
  - Last illness and burial expenses
  - Nursing Home expenses (Insurance?)
  - Assisted Living expenses (none, some, all)
    - Amount allowed determined by medical status (A&A,HB?)
    - Need medical evidence/doctors reports
  - Prescription meds, eyeglasses, hearing aids, dental, OTC meds, home health, etc not considered “recurring”.

Last Illness and Burial Expenses

- Last illness
  - Period from the onset of the acute attack causing death to date of death OR
  - Starting when person becomes so ill as to require daily aid
  - Generally maximum is one year
- Burial expenses
  - Any expense allowable under VA burial benefits criteria
  - Deduct reimbursement, including VA burial/plot allowance

Medical Expenses, UME's

- Lodging incurred for out-of-town medical appointments
- Transportation for medical purposes ($0.415/mile)
- Home health services ("licensed" not required if A&A or HB)
- Seeing eye dog
- Telephone and services for the deaf
- Whirlpool bath for medical purposes
- OTC meds (w/receipts)

Care Expense Report

Section 1: General Information *(To be completed by the facility administrator or care provider. Please print.)*

VA Claim number: _____

Veteran's name: _____

Patient's name: _____

Check the box which describes the patient's care status:

- ☐ In-Home Care
- ☐ Nursing Home Care
- ☐ Other Care Facility *(Foster Home, Adult Day Care, Rest Home, Group Home, or Assisted Living)*

*Name of facility or care provider: _____

*Phone number of facility or care provider: _____

*Address of facility or care provider: _____

_____

_____

***Date entered facility or in-home care began:** _____

***Will the patient need this care indefinitely?** ☐ YES ☐ NO

If "NO", when will the care end? _____

***Total monthly charge for the patient:** $_____ per month

***Total paid to provider by claimant in year _____ .** $_____

***Has the patient applied for Medicaid?** ☐ YES ☐ NO

*When did the patient apply for Medicaid? _____

*Is part of the patient's cost covered by Medicaid, Medicare, or insurance? ☐ YES ☐ NO

If "YES", please answer the following:

What is the source of payment? _____

What is the monthly amount covered by this source? $_____ per month

When did coverage begin? _____

What monthly amount does the veteran or patient pay from his/her own funds which is not reimbursed by one of the sources listed above?** ***(If the patient is receiving Medicaid, what amount does Medicaid take from the patient?) Rate per month: $_____

Effective Date: _____

If the patient is receiving Medicaid, attach a copy of the SDS-512 Medicaid Form.

Continue on page 2.

Be sure to sign and date in Section 6. >>>>

Section 2: In-Home Care Information *(To be completed by the care provider only if the patient is being provided in-home care.)*

***Do you provide any medical or nursing services for the patient?**
(i.e. administering medication; physical or mental therapy; assisting with personal hygiene, dressing, bathing, etc.) ☐ YES ☐ NO

***Describe the services you provide:** _____

***Are you a licensed health professional?** *(registered nurse, licensed vocational nurse, or LPN)* ☐ YES ☐ NO
If "YES", provide your license number _____

** **See Section 6 for documentation requirements for in-home care.**

Section 3: Nursing home information *(To be completed by the facility administrator only if the patient is in a nursing home.)*

Is your facility licensed by the State? ☐ YES ☐ NO
Is your facility Medicaid approved? ☐ YES ☐ NO
Is the patient in your nursing home because of a physical or mental disability? ☐ YES ☐ NO
Do you provide either skilled or intermediate level nursing care to the patient? ☐ YES ☐ NO

What was the admitting diagnosis? _____

Section 4: Other Care Facility Information *(To be completed by the facility administrator only if the patient is in a foster home, adult day care, rest home, group home or assisted living)*

Indicate type of facility: ☐ Foster Home ☐ Rest Home ☐ Assisted Living
☐ Adult Day Care ☐ Group Home ☐ Other _____

Do you provide any medical or nursing services for the patient? ☐ YES ☐ NO
(i.e. administering medication; physical or mental therapy; assisting with personal hygiene, dressing, bathing, etc.)

Describe the services you provide: _____

If the patient received medical or nursing services, are the services provided or supervised by a licensed health professional? *(registered nurse, licensed vocational nurse, or licensed practical nurse)* ☐ YES ☐ NO

We must have the monthly charge broken down into the following two categories:

1. Base Rate *(includes room, meals, housekeeping)*: $ _____ per month
2. Medical and Nursing Services: $ _____ per month

Section 5: In-Home Care Information *(To be completed by the care provider only if the patient is being provided in-home care.)*

To allow medical expenses for in-home caregivers, VA regulations require you to submit specific documentation of expenses from all your caregivers.

What We Need:

In order to allow fees for the in-home attendants, receipts or other documentation is required. Documentation includes:

- A receipt bill
- Statement on the provider's letterhead
- Computer summary
- Ledger, or
- Bank Statement

The Evidence Submitted Must Include:

- The amount paid
- The date payment was made
- The purpose of the payment (the nature of the product or service provided)
- The name of the person to or for whom the product or service was provided
- Identification of the provider to whom the payment was made

Note: A family member may be considered an in-home attendant only if he/she is actually **being paid.** Documentation must be submitted.

Section 6: Signatures *(To be completed by the facility administrator/care provider and the veteran/beneficiary.)*

**** I certify that the above statements are true and correct to the best of my knowledge and belief.**

_____ _____

Signature of facility administrator or care provider **Date**

**** I certify that the above statements are true and correct to the best of my knowledge and belief. I am paying $_____ per month for my care from my own funds.**

_____ _____

Signature of Veteran or Beneficiary **Date**

21-0779

OMB Approved No: 2900-0652
RESPONDENT BURDEN: 10 Minutes

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)* ☐ SKILLED NURSING CARE ☐ 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

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.

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.

VA FORM MAR 2010 **21-0779** SUPERSEDES VA FORM 21-0779, MAR 2004, WHICH WILL NOT BE USED.

2180 Pg 1

OMB Control No. 2900-0721
Respondent Burden: 30 minutes

Department of Veterans Affairs

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

1. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN	2. FIRST NAME - MIDDLE NAME - LAST NAME OF CLAIMANT *(If other than veteran)*	3. RELATIONSHIP OF CLAIMANT TO VETERAN

4A. VETERAN'S SOCIAL SECURITY NUMBER	4B. CLAIMANT'S SOCIAL SECURITY NUMBER	5. CLAIM NUMBER

6. DATE OF EXAMINATION	7. HOME ADDRESS

8A. IS CLAIMANT HOSPITALIZED?	8B. DATE ADMITTED	9. NAME AND ADDRESS OF HOSPITAL
☐ YES ☐ NO *(If "Yes," complete Items 8B and 9)*		

NOTE: EXAMINER PLEASE READ CAREFULLY

The purpose of this examination is to record manifestations and findings pertinent to the question of whether the claimant is housebound (confined to the home or immediate premises) or in need of the regular aid and attendance of another person.

The report should be in sufficient detail for the VA decision makers to determine the extent that disease or injury produces physical or mental impairment, that loss of coordination or enfeeblement affects the ability: to dress and undress; to feed him/herself; to attend to the wants of nature; or keep him/herself ordinarily clean and presentable.

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 he/she ambulates, where he/she goes, and what he/she is able to do during a typical day.

10. COMPLETE DIAGNOSIS *(Diagnosis needs to equate to the level of assistance described in questions 20 through 34)*

11A. AGE	11B. SEX	12. WEIGHT	13. HEIGHT
		ACTUAL: LBS. ESTIMATED: LBS.	FEET: INCHES:

14. NUTRITION	15. GAIT

16. BLOOD PRESSURE	17. PULSE RATE	18. RESPIRATORY RATE	19. WHAT DISABILITIES RESTRICT THE LISTED ACTIVITIES/FUNCTIONS?

20. IF THE CLAIMANT IS CONFINED TO BED, INDICATE THE NUMBER OF HOURS IN BED
From 9 PM To 9 AM: From 9 AM To 9 PM:

21. IS THE CLAIMANT ABLE TO FEED HIM/HERSELF? *(If "No," provide explanation)*
☐ YES ☐ NO

22. IS CLAIMANT ABLE TO PREPARE OWN MEALS? *(If "Yes," provide explanation)*
☐ YES ☐ NO

23. DOES THE CLAIMANT NEED ASSISTANCE IN BATHING AND TENDING TO OTHER HYGIENE NEEDS? *(If "Yes," provide explanation)*
☐ YES ☐ NO

24A. IS THE CLAIMANT LEGALLY BLIND? *(If "Yes," provide explanation)*	24B. CORRECTED VISION	
	LEFT EYE	RIGHT EYE
☐ YES ☐ NO		

25. DOES THE CLAIMANT REQUIRE NURSING HOME CARE? *(If "Yes," provide explanation)*
☐ YES ☐ NO

26. DOES CLAIMANT REQUIRE MEDICATION MANAGEMENT? *(If "Yes," provide explanation)*
☐ YES ☐ NO

27. DOES THE CLAIMANT HAVE THE ABILITY TO MANAGE HIS/HER OWN FINANCIAL AFFAIRS? *(If "No," provide explanation)*
☐ YES ☐ NO

VA FORM JUN 2008 **21-2680**

SUPERSEDES VA FORM 21-2680, OCT 1992, WHICH WILL NOT BE USED.

2180 Pg 2

28. POSTURE AND GENERAL APPRERANCE *(Attach a separate sheet of paper if additional space is needed)*

29. DESCRIBE RESTRICTIONS OF EACH UPPER EXTREMITY WITH PARTICULAR REFERENCE TO GRIP, FINE MOVEMENTS, AND ABILITY TO FEED HIM/HERSELF, TO BUTTON CLOTHING, SHAVE AND ATTEND TO THE NEEDS OF NATURE *(Attach a separate sheet of paper if additional space is needed)*

30. DESCRIBE RESTRICTIONS OF EACH LOWER EXTREMITY WITH PARTICULAR REFERENCE TO THE EXTENT OF LIMITATION OF MOTION, ATROPHY, AND CONTRACTURESOR OTHER INTERFERENCE. IF INDICATED, COMMENT SPECIFICALLY ON WEIGHT BEARING, BALANCE AND PROPULSION OF EACH LOWER EXTREMITY.

31. DESCRIBE RESTRICTION OF THE SPINE, TRUNK AND NECK.

32. SET FORTH 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 CLAIMANT'S ABILITY TO PERFORM SEL-CARE, AMBULATE OR TRAVEL BEYOND THE PREMISIES OF THE HOME, OR, IF HOSPITALIZED, BEYOND THE WARD OR CLINICAL AREA. DESCRIBE WHERE THE CLAIMANT GOES AND WHAT HE OR SHE DOES DURING A TYPICAL DAY.

33. DESCRIBE HOW OFTEN PER DAY OR WEEK AND UNDER WHAT CIRCUMSTANCES THE CLAIMANT IS ABLE TO LEAVE THE HOME OR IMMEDIATE PREMISES

34. ARE AIDS SUCH AS CANES, BRACES, CRUTCHES, OR THE ASSISTANCE OF ANOTHER PERSON REQUIRED FOR LOCOMOTION? *(If so, specify and describe effectiveness in terms of distance that can be traveled, as in Item 32 above)*

☐YES *(If "YES" give distance) (Check*
☐NO *applicable box or specify distance)* ☐ 1 BLOCK ☐ 5 OR 6 BLOCKS ☐ 1 MILE OTHER *(Specify distance)* _____

35A. PRINTED NAME OF EXAMINING PHYSICIAN	35B. SIGNATURE AND TITLE OF EXAMINING PHYSICIAN	35C. DATE SIGNED

36A. NAME AND ADDRESS OF MEDICAL FACILITY	36B. TELEPHONE NUMBER OF MEDICAL FACILITY *(Include Area Code)*

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 Vocational Rehabilitation Records-VA, and 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 © (1). The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN 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 page at www.whitehouse.gov/omb/library/OMBINV.VA.EPA.htm1#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA FORM 21-2680, JUN 2008

The Paperwork

- Veterans Non-service Connected Pension
  - 21-526, DVA 21, 21-22, DD 214 (certified)
  - Care Expense Report, 21-2680 (Assisted Living Facility)
  - 21-0779 (Skilled Nursing Home)

- Widow's Pension
  - 21-534/534EZ, DVA 21, 21-22, DD 214 (certified)
  - Care Expense Report, 21-2680 (Assisted Living Facility)
  - 21-0779 (Skilled Nursing Home)
  - Marriage license, death certificate

Pension Tables

IMPROVED PENSION RATES & ANNUAL INCOME LIMITATIONS
EFFECTIVE 1 DECEMBER 2012 for 2013

		BASIC	HB	A & A
VET	Med Deduction	$622	$755	$1,039
	Max Rate	$12,444	$15,108	$20,772
	Monthly Rate	$1,037	$1,259	$1,731
VET & 1	Med Deduction	$815	$942	$1,232
	Max Rate	$16,308	$18,840	$24,636
	Monthly Rate	$1,359	$1,570	$2,053

	Part "B" rates
2008	$96.40
2009	$96.40
2010	$96.40
2011	$96.50
2012	$99.90
2013	$104.90

EACH ADDITIONAL CHILD ADD $2129
STANDARD MEDICARE DEDUCTION: $104.90
Social Services A&A rate: Vet=$694; Widow=$417

	BASIC	H/B	A/A
WIDOW	$417	$511	$667
	$8,340	$10,212	$13,344
	$695	$851	$1,112
WIDOW & 1	$547	$666	$796
	$10,932	$13,320	$15,924
	$911	$1,110	$1,327

MEANS TEST - EFFECTIVE 1 JANUARY 2012

	CAT A (=or<)	CAT C (>)
VETERAN WITH NO DEPS	$30,460	
VETERAN WITH 1 DEP	$36,554	
VETERAN WITH 2 DEPS	$38,647	
VETERAN WITH 3 DEPS	$40,740	
WARD COUNTY GMT:		
VETERAN WITH NO DEPS	$36,300	
VETERAN WITH 1 DEP	$41,470	
VETERAN WITH 2 DEPS	$46,640	
www.va.gov/healtheligibility/library/annualthresholds.asp		

RX MEANS TEST

$8 COPAY APPLIES FOR:	
All Category "C" except "7/8"	
Category "A"	Income Limit
Single Vet	>$12,444
Vet & Spouse	>$16,308
Outpatient copayment-$15.00	
Inpatient copayment-$999.00 (this is for 1st 90 days, plus $10/day per diem fee)	
No $8 Rx copay if >50% SCD	
Priority 7/8 pays $9 Rx copay	

*ADD $2129 FOR EACH ADDITIONAL DEPENDENT
THE MEDICARE DEDUCTIBLE FOR THE CALENDAR YEAR 2013 IS $1258.00.
THE COMBINED INCOME AND ASSET LEVEL FOR CALENDAR YEAR 2013 IS $80,000 (10-10EZ MEANS TEST)

Medicaid and Pension

- Married veteran, in nursing home, self-pay, max rate $2053/month
- Single veteran/widow, on A&A, Medicaid, in nursing home, $90/month
- Single veteran, on A&A, Medicaid, in assisted living, $90/month (MAYBE – “basic care?”)

Bottom Line

- If you have a veteran or surviving spouse of a veteran as a client, contact us at 857-6490. We will work with the client or a family member to determine eligibility and accomplish the application process.
- Application process takes 6-12 months.
- We notify Social Services when the application has been submitted (for Medicaid benefits).

Medical Benefits

- Means test if not service connected or war zone
- Meds reduced price
- Requires annual visit to the CBOC
  - Waived if on HB or A&A
- Van available by appointment (Wed AM)
  - Must be able to board or have assistant
  - Schedule by Tuesday noon
  - Alternate Souris Basin Transportation

FOLLOWUP

- Pension Center CVSO 612-713-8978
- CFR Title 38, Part 3 (Google it)
- M21-1MR, Part V, Subpart iii, Chapter 1, Section G (deductible medical expenses – Google it)
- - Annual reporting EVR/8416
  - Offer assistance to do annual reporting
  - Unreimbursed medical expenses/unreported income
- County Commissioners: Tell them what you are doing, “Bang for the Buck”