



RE: Verification of Health with VDVA Form 10

To: \_\_\_\_\_

The Doctor of \_\_\_\_\_

Dear Doctor,

Your patient is requesting that you verify their condition of health in order to complete their application for assistance through the Veterans Administration.

This application is in regards to at least one of the following benefits:

1. Improved Pension Benefit
2. Home Bound
3. Aid and Attendance

In order to comply with VA titles 38 CFR 3.272 (g) and M21-1-4-16.31 Medical Expenses: Authorization Procedures, please provide verification concerning the health status of \_\_\_\_\_.

Please note any difficulties that the patient may have with Activities of Daily Living or circumstances in which they may need assistance due to physical or mental conditions. Please complete VDVA Form 10 in as much detail as possible. The Form should state that the person has an incapacity which requires care or assistance on a regular basis to protect the claimant from the hazards or dangers incident to their daily environment. The Veteran / Widow does not need to be helpless. They need only show that they are in need of aid and attendance of another person on a regular basis.

Thank you for helping our Veterans and their families,

U.S. Benefits Analysts, Inc.

[www.RespectTheVet.org](http://www.RespectTheVet.org)

**MEDICAL STATEMENT FOR CONSIDERATION OF AID & ATTENDANCE**

**\*\* (Please circle the appropriate answer and explain each in detail.) \*\***

**RETURN ADDRESS:**

VA FILE NO. \_\_\_\_\_

**VETERAN'S NAME:** \_\_\_\_\_  
Last First Middle

**CLAIMANT'S NAME:** \_\_\_\_\_  
Last First Middle

1. Complete Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Is the claimant able to walk unaided?    Yes            No  
Explanation (including, how far): \_\_\_\_\_  
\_\_\_\_\_

3. Is the claimant able to feed him/herself?    Yes            No  
Explanation: \_\_\_\_\_  
\_\_\_\_\_

4. Does the claimant need assistance in bathing and tending to other hygiene needs?    Yes            No  
5. Is the claimant able to care for the needs of nature?    Yes            No  
Explanation: \_\_\_\_\_  
\_\_\_\_\_

6. Is the claimant confined to bed?            Yes            No  
Explanation: \_\_\_\_\_  
\_\_\_\_\_

7. Is the claimant able to sit up?            Yes            No  
Explanation: \_\_\_\_\_  
\_\_\_\_\_

8. Is the claimant blind? Yes No

Corrected Vision: L \_\_\_\_\_ R \_\_\_\_\_

Explanation: \_\_\_\_\_  
\_\_\_\_\_

9. Is the claimant able to travel? Yes No

Explanation: \_\_\_\_\_  
\_\_\_\_\_

10. Can the claimant leave home without assistance? Yes No  
*(If yes, how far can he/she go? (List distance)*

Explanation: \_\_\_\_\_  
\_\_\_\_\_

11. Does the claimant require nursing home care? Yes No

Explanation: \_\_\_\_\_  
\_\_\_\_\_

12. In your opinion, are there other pertinent facts which would show the claimant's need for aid and attendance of another person, e.g., inability to protect oneself from the hazards of environment, properly dress oneself (buttons, zippers, socks), poor balance, memory loss, confusion, psychiatric impairment, atrophy, contractor, prosthesis, etc?

Yes No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\* If possible, please attach copies of office or hospital records concerning the claimant's recent medical history.**

**I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.**

**PHYSICIAN'S NAME & ADDRESS**

**(Please type or print)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**(Examining Physician's Signature)**

**\*\*Billing Information:**

All expenses incurred as a result of this exam are the responsibility of the veteran/claimant. Direct billing to this agency is not authorized.