

§ 58.12 VA Form 10-10EZ—Application for Health Benefits

OMB Approved No. 2900-0097
Estimated Burden Avg. 20 min

Department of Veterans Affairs		APPLICATION FOR HEALTH BENEFITS			
SECTION I - GENERAL INFORMATION					
1A. TYPE OF BENEFIT(S) APPLIED FOR (You may check more than one)					
<input type="checkbox"/> HEALTH SERVICES		<input type="checkbox"/> NURSING HOME		<input type="checkbox"/> DOMICILIARY	
				<input type="checkbox"/> DENTAL	
				<input type="checkbox"/> ENROLLMENT	
1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER					
2. VETERAN'S NAME (Last, First, MI)			3. OTHER NAMES USED		4. GENDER (Check one)
					<input type="checkbox"/> M <input type="checkbox"/> F
5. SOCIAL SECURITY NUMBER		6. CLAIM NUMBER	7. DATE OF BIRTH (mm-dd-yyyy)		8. RELIGION
9A. CURRENT MAILING ADDRESS (Street)			9B. CITY	9C. STATE	9D. ZIP
9E. COUNTY		10. HOME TELEPHONE NUMBER		11. WORK TELEPHONE NUMBER	
12. CURRENT MARITAL STATUS (Check one)					
<input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN					
13A. LAST BRANCH OF SERVICE	13B. LAST ENTRY DATE	13C. LAST DISCHARGE DATE	13D. DISCHARGE TYPE	13E. MILITARY SERVICE NUMBER	
14. CIRCLE YES OR NO					
A. ARE YOU A FORMER PRISONER OF WAR		YES	NO	H. DO YOU HAVE A MILITARY DENTAL INJURY	
				YES NO	
B. DO YOU HAVE A VA SERVICE CONNECTED RATING		YES	NO	I. DO YOU HAVE A SPINAL CORD INJURY	
				YES NO	
B1. IF YES, WHAT IS YOUR RATED PERCENTAGE			%	J. ARE YOU ELIGIBLE FOR MEDICAID	
				YES NO	
C. ARE YOU RECEIVING A VA PENSION		YES	NO	K. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A	
				YES NO	
D. ARE YOU RETIRED FROM THE MILITARY		YES	NO	K1. EFFECTIVE DATE	
D1. WAS YOUR RETIREMENT THE RESULT OF A DISABILITY		YES	NO	L. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B	
				YES NO	
D2. WERE YOU REGULARLY RETIRED (20+ yrs.)		YES	NO	L1. EFFECTIVE DATE	
E. WERE YOU EXPOSED TO TOXINS IN THE GULF WAR		YES	NO	M. MEDICARE CLAIM NUMBER	
F. WERE YOU EXPOSED TO AGENT ORANGE		YES	NO	N. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD	
G. WERE YOU EXPOSED TO RADIATION		YES	NO		
15A. VETERAN'S EMPLOYMENT STATUS (check one)			<input type="checkbox"/> NOT EMPLOYED	15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
If employed or retired, complete item 15B			<input type="checkbox"/> EMPLOYED		
			<input type="checkbox"/> RETIRED	Date of retirement	
16A. SPOUSE'S EMPLOYMENT STATUS (check one)			<input type="checkbox"/> NOT EMPLOYED	16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
If employed or retired, complete item 16B			<input type="checkbox"/> EMPLOYED		
			<input type="checkbox"/> RETIRED	Date of retirement	
17A. VETERAN'S HEALTH INSURANCE COMPANY			18A. SPOUSE'S HEALTH INSURANCE COMPANY		
17B. NAME OF POLICY HOLDER			18B. NAME OF POLICY HOLDER		
17C. POLICY NUMBER		17D. GROUP CODE	18C. POLICY NUMBER		18D. GROUP CODE
19A. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN				19B. NEXT OF KIN'S HOME TELEPHONE NUMBER	
				()	
				19C. NEXT OF KIN'S WORK TELEPHONE NUMBER	
				()	
20A. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT				20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER	
				()	
				20C. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER	
				()	
21. I DESIGNATE THE FOLLOWING INDIVIDUAL TO RECEIVE POSSESSION OF ALL MY PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER MY DEPARTURE OR AT THE TIME OF MY DEATH. (Check one) (This does not constitute a will or transfer of title.)					
<input type="checkbox"/> EMERGENCY CONTACT <input type="checkbox"/> NEXT OF KIN					
22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY (Check one)			22B. IS NEED FOR CARE DUE TO ACCIDENT (Check one)		
<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO		

APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME	SOCIAL SECURITY NUMBER
SECTION II - FINANCIAL ASSESSMENT			
IIA - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)			
1. SPOUSE'S NAME (Last, First, MI)		2. CHILD'S NAME (Last, First, MI)	
3. SPOUSE'S SOCIAL SECURITY NUMBER	4. SPOUSE'S DATE OF BIRTH (mm/dd/yyyy)	5. CHILD'S DATE OF BIRTH (mm/dd/yyyy)	
6. SPOUSE'S ADDRESS (Street, City, State, ZIP)		7. CHILD'S SOCIAL SECURITY NUMBER	
8. SPOUSE'S TELEPHONE NUMBER		9. CHILD'S RELATIONSHIP TO YOU (Circle one) Son Daughter Stepson Stepdaughter	
10. DATE OF MARRIAGE (mm/dd/yyyy)		11. DATE CHILD BECAME YOUR DEPENDENT	
12. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE \$ CHILD \$		13. EXPENSES PAID BY YOU FOR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (tuition, books, materials, etc.) \$	
14. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO		15. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IIB - FINANCIAL DISCLOSURE			
<p>You are not required to provide the financial information in this Section. However, current law may require VA to consider your household financial situation to determine your eligibility for enrollment and/or cost-free care of your nonservice-connected (NSC) conditions. If you are 0% SC noncompensable or NSC (and are not an Ex-POW, WWI veteran or VA pensioner) and your annual household income (or combined income and net worth) exceeds the established threshold, you must agree to pay VA co-payments for care of your NSC conditions to be eligible for enrollment. See Section III - Consent and Signature.</p> <p><input type="checkbox"/> YES, I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO HAVE ELIGIBILITY FOR CARE DETERMINED. Complete all sections below that apply to you with last calendar year's information. Sign and date the application.</p> <p><input type="checkbox"/> NO, I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. I understand I will be assigned the appropriate enrollment priority based on nondisclosure of my financial information. By checking NO and signing below, I am agreeing to pay the applicable VA co-payment. Sign and date the application.</p>			
IIC - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN			
	VETERAN	SPOUSE	CHILDREN
1. WHAT WAS YOUR GROSS ANNUAL INCOME FROM EMPLOYMENT (wages, bonuses, tips, etc.), AS WELL AS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	\$	\$
2. LIST OTHER INCOME AMOUNTS (Social Security, compensation, pension, interest, dividends). Exclude welfare	\$	\$	\$
3. WAS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS (if yes, refer to page 2, Section IIC of the instructions) <input type="checkbox"/> YES <input type="checkbox"/> NO			
IID - DEDUCTIBLE EXPENSES			
1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (payments for doctors, dentists, drugs, Medicare, health insurance, hospital and nursing home)		\$	
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (Also enter spouse or child's information in Section IIA)		\$	
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES (tuition, books, fees, materials, etc.) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.		\$	
IIE - NET WORTH			
	VETERAN	SPOUSE	
1. CASH, AMOUNT IN BANK ACCOUNTS (Checking and savings accounts, certificates of deposit, individual retirement accounts, etc.)	\$	\$	
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. Do not count your primary home. Include value of farm, ranch, or business assets.	\$	\$	
3. STOCKS AND BONDS AND VALUE OF OTHER PROPERTY OR ASSETS (art, rare coins, etc.) MINUS THE AMOUNT YOU OWE ON THESE ITEMS. Exclude household effects and family vehicles.	\$	\$	
SECTION III - CONSENT AND SIGNATURE			
<p>CO-PAYMENT NOTICE: If you are a 0% service-connected noncompensable or a nonservice-connected veteran (and are not an Ex-POW, WWI veteran or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, you may be eligible for enrollment only if you agree to pay VA co-payments for treatment of your NSC conditions. By signing this application you are agreeing to pay the applicable VA co-payment if required by law.</p>			
I CERTIFY THE FOREGOING STATEMENT(S) ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.			DATE (mm/dd/yyyy)
SIGN HERE			
(Signature of applicant or applicant's representative)			
THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION.			