



Step 1: Before You Start . . .

What is VA Form 10-10EZ used for?

- To apply for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits.

Where can I get help filling out the form?

- Contact a National or State Veterans Service Organization.
- Ask VA to help you fill out the form by calling or visiting a VA health care facility. Before you call or go to the VA health care facility, gather the necessary materials identified in Step 2 of the instructions and complete as much of the form as you can.

How can I contact VA if I have questions?

- Look in your telephone book blue pages under "United States Government, Veterans" to locate your local VA health care facility.
- Call VA's Health Benefits Service Center toll-free at 1-877-222-VETS (8387).
- Access our website at <http://www.va.gov> and select "Contact the VA."
- If you desire a health care appointment, contact the Enrollment Coordinator at your local VA health care facility for assistance in scheduling an appointment.

Definitions of terms used on this form

- SERVICE-CONNECTED (SC):** A veteran with a VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE:** A determination by VA that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE:** A determination by VA that a service-connected disability is not severe enough to warrant monetary compensation.
- NONSERVICE-CONNECTED (NSC):** A veteran who does not have a VA determined service-related condition.

Which sections of VA Form 10-10EZ should you complete?

Look at the table below to find out which sections of VA Form 10-10EZ you should complete. The shaded sections should be completed only if you answer "Yes" to Section VI agreeing to provide income and asset information to establish eligibility for care. You may agree to copayments without providing this detailed financial information.

If you are...	Complete the sections marked with an X						
	I-IV	VI	VII	VIII	IX	X	XII
Service-connected 50% to 100%. Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for waiver of travel deductions assessed.	X	X	X	X	X		X
Service-connected 30-40%. Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications for treatment of your nonservice-connected conditions and waiver of travel deductibles assessed.	X	X	X	X	X		X
Service-connected 0% (compensable) or service-connected 10-20%. Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel for treatment of your nonservice-connected conditions assessed.	X	X	X	X	X		X
A Former POW. Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for beneficiary travel assessed. Also, complete Section X if applying for long-term care.	X	X	X	X	X		X
A veteran discharged from the military due to a disability incurred or aggravated in service or Purple Heart Medal recipient veteran. Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel assessed. Also, complete Section X if applying for long-term care.	X	X	X	X	X		X
Receiving nonservice-connected VA Pension, Aid and Attendance or Housebound benefits. Answer YES in Section VI and complete Sections VII-X to have your financial eligibility for long-term care assessed. Unmarried VA Pensioners are excluded from this requirement.	X	X	X	X	X	X	X
A recent combat veteran (e.g., OEF/OIF) with discharge from military within past 5 years or discharge from the military more than 5 years ago and applying for enrollment by Jan. 27, 2011. You are eligible for enrollment without providing your financial information. If you answer YES in Section VI and complete Sections VII-X you will have your priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of your nonservice-connected conditions assessed.	X	X	X	X	X	X	X
Service-connected 0% (noncompensable) or nonservice-connected with no special eligibilities listed above. Answer YES in Section VI and complete Sections VII-X to have your priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of your nonservice-connected conditions assessed.	X	X	X	X	X	X	X

Step 2: Completing your application ... Review the table in Step 1 to find out what sections you should complete. Answer all questions in those sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. For each question that you need more room, write "Continuation of Item" and write the section and question number.

Section II - Insurance Information. Include information for all health insurance policies that cover you. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

Section IV - Military Service Information.

If you are not currently receiving benefits from VA, you should attach a copy of your discharge or separation papers from the military (such as DD 214 or, for WWII veterans, a "WD" Form), with your signed application to expedite processing of your application.

If you indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your status as a Purple Heart Medal recipient, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating you were awarded the medal. To reduce processing time, you may submit a copy of this documentation with your signed application.

Section VI - Financial Disclosure.

The financial assessment is used to determine whether certain veterans qualify for cost-free health care services for their NSC conditions and to assign their priority for enrollment. You should review the table in Step 1 to see if your eligibility for health care benefits requires or may be based on a financial assessment. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have a special eligibility factor. **Recent combat veterans (e.g., OEF/OIF) who were discharged within the past 5 years or discharged from the military more than 5 years ago and applying for enrollment by Jan. 27, 2011 are eligible for enrollment without disclosing their financial information** but like other veterans may provide it to establish their eligibility for travel reimbursement, cost-free medication and/or medical care for services unrelated to military experience and consideration for waiver of travel deductibles. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information and agree to make copayments for treatment of your NSC conditions. If a financial assessment is used to determine your eligibility for travel assistance or waiver, and you do not disclose your financial information, you will not be eligible for these benefits. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayments as required by law.**

Section VII - Dependent Information. Use a separate sheet of paper for additional dependent children.

- You may count your spouse as your dependent even if you did not live together, as long as you contributed \$600 or more in support last calendar year.
- You may count your biological children, adopted children, and stepchildren as dependents. But these children must be unmarried and under the age of 18, or be at least 18 but under 23 and attending high school, college or vocational school on a full or part-time basis, or have become permanently unable to support themselves before reaching the age of 18.
- Count child support contributions even if not paid in regular set amounts. Contributions can include tuition payments or payments of medical bills.

Section VIII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Use a separate sheet of paper for additional dependent children.

- Report: gross annual income from employment, except for income from your farm, ranch, property or business, including information about your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses
- Report: net income from your farm, ranch, property or business.
- Report: other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities
- Do Not Report: Welfare, Supplemental Security Income (SSI) and need-based payments from a government agency, profit from the occasional sale of property, income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs), scholarships and grants for school attendance, disaster relief payment or proceeds of casualty insurance, loans, Agent Orange and Alaska Native Claim Settlement Acts Income and payments to foster parents.

Section IX - Previous Calendar Year Deductible Expenses. Report nonreimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources.

Section X - Previous Calendar Year Net Worth. Use a separate sheet of paper for additional dependent children.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

Step 3: Submitting your application ...What do I do when I have finished my application?

- Read Section V, Paperwork Reduction and Privacy Act Information, Section XI Consent to Copayments and Section XII, Assignment of Benefits.
- Make sure you sign and date VA Form 10-10EZ in Section XII. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", then you must have 2 people you know witness you as you sign. They must then sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete. This will result in a delay in processing your application.
- Attach any continuation sheets and necessary material to your application.

Where do I send my application? Mail the original application with a copy of your supporting materials to your local VA care facility. You can find the address in your local telephone book, by calling toll-free 1-877-222-VETS (8387), or on the Internet at <http://www.va.gov>.



APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME <i>(Last, First, Middle Name)</i>		2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
5. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. WHAT IS YOUR RACE? <i>(You may check more than one.) (Information is required for statistical purposes only.)</i> <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			
7. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH <i>(mm/dd/yyyy)</i>		10. RELIGION	
8. CLAIM NUMBER	9A. PLACE OF BIRTH <i>(City and State)</i>			
11. PERMANENT ADDRESS <i>(Street)</i>		11A. CITY	11B. STATE	11C. ZIP CODE <i>(9 digits)</i>
11D. COUNTY	11E. HOME TELEPHONE NUMBER <i>(Include area code)</i>		11F. E-MAIL ADDRESS	
11G. CELLULAR TELEPHONE NUMBER <i>(Include area code)</i>		11H. PAGER NUMBER <i>(Include area code)</i>		
12. TYPE OF BENEFIT(S) APPLIED FOR <i>(You may check more than one)</i> <input type="checkbox"/> HEALTH SERVICES <input type="checkbox"/> NURSING HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> DENTAL				
13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?				
14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO I am only enrolling in case I need care in the future.		15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? <input type="checkbox"/> YES, LOCATION: <input type="checkbox"/> NO		
16. CURRENT MARITAL STATUS <i>(Check one)</i> <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				
17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN		17A. NEXT OF KIN'S HOME TELEPHONE NUMBER <i>(Include area code)</i>		
		17B. NEXT OF KIN'S WORK TELEPHONE NUMBER <i>(Include area code)</i>		
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT		18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER <i>(Include area code)</i>		
		18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER <i>(Include area code)</i>		
19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE <i>(Check one)</i> <input type="checkbox"/> EMERGENCY CONTACT <input type="checkbox"/> NEXT OF KIN				

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME (<i>Last, First, Middle</i>)	SOCIAL SECURITY NUMBER
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SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ARE YOU COVERED BY HEALTH INSURANCE? (<i>Including coverage through a spouse or another person</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO	2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER				
3. NAME OF POLICY HOLDER					
4. POLICY NUMBER	5. GROUP CODE				
		YES	NO		
6. ARE YOU ELIGIBLE FOR MEDICAID?	<input type="checkbox"/>	<input type="checkbox"/>			
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	<input type="checkbox"/>	<input type="checkbox"/>	7A. EFFECTIVE DATE (<i>mm/dd/yyyy</i>)		
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	<input type="checkbox"/>	<input type="checkbox"/>	8A. EFFECTIVE DATE (<i>mm/dd/yyyy</i>)		
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			10. MEDICARE CLAIM NUMBER		
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? (<i>Check one</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO			12. IS NEED FOR CARE DUE TO ACCIDENT? (<i>Check One</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS (<i>Check one</i>) <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <i>If employed or retired, complete item 1A</i> <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <i>Date of retirement (mm/dd/yyyy)</i>	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS (<i>Check one</i>) <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED <i>If employed or retired, complete item 2A</i> <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <i>Date of retirement (mm/dd/yyyy)</i>	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER
2. CHECK YES OR NO	YES	NO		YES NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	<input type="checkbox"/>	<input type="checkbox"/>	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	<input type="checkbox"/> <input type="checkbox"/>
B. ARE YOU A FORMER PRISONER OF WAR?	<input type="checkbox"/>	<input type="checkbox"/>	F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	<input type="checkbox"/> <input type="checkbox"/>
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	<input type="checkbox"/>	<input type="checkbox"/>	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	<input type="checkbox"/> <input type="checkbox"/>
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE? %			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	<input type="checkbox"/> <input type="checkbox"/>
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	<input type="checkbox"/>	<input type="checkbox"/>	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	<input type="checkbox"/> <input type="checkbox"/>
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	<input type="checkbox"/>	<input type="checkbox"/>	J. DO YOU HAVE A SPINAL CORD INJURY?	<input type="checkbox"/> <input type="checkbox"/>

SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

