IN THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

In the matter of HERBERT N. HASKELL, II, Appellant,	)	
vs.	)	Vet. App. No. 22-1018
DENIS MCDONOUGH, Secretary of Veterans Affairs, Appellee.	)	

RESPONSE TO THE COURT'S AUGUST 14 ORDER

On August 14, 2023, the Court ordered Margaret Laska, the movant for substitution in this case, to submit a copy of the veteran Herbert Haskell's death certificate and indicate the actions she has taken before VA.

Ms. Laska hereby responds to the Court's Order:

- Mr. Haskell's death certificate is attached to this Response as Exhibit 1.
- On September 13, 2023, Ms. Laska submitted the following documents to VA, which are attached to this Response as Exhibit 2:
    - A completed VA Form 21P-534, Application for Dependency and Indemnity Compensation, Survivors Pension and Accrued Benefits by a Surviving Spouse or Child, and
    - A completed VA Form 21P-0847, Request for Substitution of Claimant Upon Death of Claimant.

Respectfully submitted,

/s/ *April Donahower*
April Donahower
Chisholm Chisholm & Kilpatrick Ltd
321 S Main St #200
Providence, RI 02903
(401) 331-6300
(401) 421-3185
Counsel for Appellant

EXHIBIT 1

STATE OF FLORIDA

THIS DOCUMENT HAS A LIGHT BACKGROUND ON TRUE WATERMARKED PAPER. HOLD TO LIGHT TO VERIFY FLORIDA WATERMARK.

BUREAU of VITAL STATISTICS

CERTIFICATION OF DEATH

STATE FILE NUMBER: 2023140287

DATE ISSUED: AUGUST 15, 2023

DATE FILED: AUGUST 14, 2023

DECEDENT INFORMATION

NAME: HERBERT N HASKELL

DATE OF DEATH: AUGUST 14, 2023
SEX: MALE SSN: [redacted] AGE: 077 YEARS
DATE OF BIRTH: [redacted]1946
BIRTHPLACE: NORTHAMPTON, MASSACHUSETTS, UNITED STATES
PLACE OF DEATH: HOSPICE
FACILITY NAME OR STREET ADDRESS: EDWARD M POE CARE CENTER
LOCATION OF DEATH: TITUSVILLE, BREVARD COUNTY, 32780
RESIDENCE [redacted] TITUSVILLE, FLORIDA 32780, UNITED STATES
COUNTY: BREVARD
OCCUPATION, INDUSTRY: OWNER, BED AND BREAKFAST
EDUCATION: MASTERS DEGREE
EVER IN U.S. ARMED FORCES? YES
HISPANIC OR HAITIAN ORIGIN? NO, NOT OF HISPANIC/HAITIAN ORIGIN
RACE: WHITE

SURVIVING SPOUSE / PARENT NAME INFORMATION

(NAME PRIOR TO FIRST MARRIAGE, IF APPLICABLE)

MARITAL STATUS: MARRIED
SURVIVING SPOUSE NAME: MARGARET A LASKA
FATHER'S/PARENT'S NAME: HERBERT N HASKELL
MOTHER'S/PARENT'S NAME: RUTH M CROSBY

INFORMANT, FUNERAL FACILITY AND PLACE OF DISPOSITION INFORMATION

INFORMANT'S NAME: MARGARET A LASKA
RELATIONSHIP TO DECEDENT: WIFE
INFORMANT'S ADDRESS [redacted] TITUSVILLE, FLORIDA 32780, UNITED STATES
FUNERAL DIRECTOR/LICENSE NUMBER: DAVID FERGUSON, F045264
FUNERAL FACILITY: NORTH BREVARD FUNERAL HOME F041101
1450 NORWOOD AVENUE, TITUSVILLE, FLORIDA 32796
METHOD OF DISPOSITION: CREMATION
PLACE OF DISPOSITION: BREVARD COUNTY CREMATORY
TITUSVILLE, FLORIDA

CERTIFIER INFORMATION

TYPE OF CERTIFIER: CERTIFYING PHYSICIAN
MEDICAL EXAMINER CASE NUMBER: NOT APPLICABLE
TIME OF DEATH (24 HOUR): 0532
DATE CERTIFIED: AUGUST 14, 2023
CERTIFIER'S NAME: MINA MAMDOUH ZEINI
CERTIFIER'S LICENSE NUMBER: ME86118
NAME OF ATTENDING PRACTITIONER (IF OTHER THAN CERTIFIER): NOT APPLICABLE

CAUSE OF DEATH AND INJURY INFORMATION

MANNER OF DEATH: NATURAL
CAUSE OF DEATH - PART I - AND APPROXIMATE INTERVAL: ONSET TO DEATH

a.	METASTATIC MELANOMA, LUNG MASS, BONE METASTASIS TO RIGHT HIP	ONE MONTH
b.	MELANOMA	2 YEARS
c.		
d.		

PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I:

AUTOPSY PERFORMED? NO
AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH?
DATE OF SURGERY:
DID TOBACCO USE CONTRIBUTE TO DEATH? NO
REASON FOR SURGERY:
PREGNANCY INFORMATION: NOT APPLICABLE
DATE OF INJURY: NOT APPLICABLE
TIME OF INJURY (24 HOUR):
INJURY AT WORK?
LOCATION OF INJURY:
DESCRIBE HOW INJURY OCCURRED:

PLACE OF INJURY:
IF TRANSPORTATION INJURY, STATUS OF DECEDENT:
TYPE OF VEHICLE:

Ken Jones ,STATE REGISTRAR

REQ: 2025588127

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE.

WARNING: THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH WATERMARKS OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARKS. THE DOCUMENT FACE CONTAINS A MULTICOLORED BACKGROUND, GOLD EMBOSSED SEAL, AND THERMOCHROMIC FL. THE BACK CONTAINS SPECIAL LINES WITH TEXT. THIS DOCUMENT WILL NOT PRODUCE A COLOR COPY.

61037475

DH FORM 1947 (03-13)

CERTIFICATION OF VITAL RECORD

Florida HEALTH

VOID IF ALTERED OR ERASED

EXHIBIT 2

OMB Approved No. 2900-0004
Respondent Burden: 1 hour 15 minutes
Expiration Date: 07/31/2025

Department of Veterans Affairs

APPLICATION FOR DEPENDENCY AND INDEMNITY COMPENSATION, SURVIVORS PENSION AND ACCRUED BENEFITS BY A SURVIVING SPOUSE OR CHILD (Including Death Compensation if Applicable)

IMPORTANT - Read the attached "General Instructions" before you fill out this form.

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

PART I - CLAIM INFORMATION *(Tell us what you are applying for and what you and the deceased veteran have applied for)*

1. DID THE VETERAN EVER FILE A CLAIM WITH VA ? ☒ YES ☐ NO *(If "Yes," answer Item 2)*

2. WHAT IS THE VA FILE NUMBER? *(If known)* [redacted]

3. HAS THE SURVIVING SPOUSE OR CHILD EVER FILED A CLAIM WITH VA? ☐ YES ☒ NO *(If "Yes," answer Items 4 through 6)*

4. WHAT IS THE VA FILE NUMBER? *(If known)*

5. WHAT IS THE NAME OF THE PERSON ON WHOSE SERVICE THE CLAIM WAS FILED? *(First, Middle, Last Name of Veteran)*

6. WHAT IS YOUR RELATIONSHIP TO THAT PERSON?

7. ARE YOU CLAIMING SERVICE CONNECTION FOR CAUSE OF DEATH? ☒ YES ☐ NO

PART II - IDENTIFYING INFORMATION *(Provide information about you and the deceased veteran)*

8. WHAT IS THE VETERAN'S NAME? *(First, Middle, Last Name of Veteran) (Suffix - if applicable)*
Herbert N Haskell

9. VETERAN'S SOCIAL SECURITY NO. [redacted]

10A. DID THE VETERAN SERVE UNDER ANOTHER NAME? ☒ YES ☐ NO *(If "Yes," answer Item 10B)*

10B. LIST THE OTHER NAME(S) THE VETERAN SERVED UNDER
Herbert N Haskell II

11. WHAT IS THE VETERAN'S DATE OF BIRTH *(Month, Day, Year)*
[redacted]1946

12. WHAT IS THE VETERAN'S DATE OF DEATH *(Month, Day, Year)*
08/14/2023
*(**NOTE:** Attach a copy of the death certificate unless the veteran died in active service of the Army, Navy, Air Force, Marine Corps, or Coast Guard, or in a U.S. government institution)*

13. WAS THE VETERAN A FORMER PRISONER OF WAR? ☐ YES ☒ NO

14. WHAT IS YOUR NAME? *(First, Middle, Last Name of Veteran's Spouse or Child)*
Margaret Laska

15. WHAT IS YOUR RELATIONSHIP TO THE VETERAN? *(Check one)*
☒ SURVIVING SPOUSE
☐ CHILD

16. WHAT IS YOUR ADDRESS *(Number and street or rural route, city or P.O., State, ZIP Code and Country)*
[redacted]Titusville, FL 32780

17. WHAT ARE YOUR TELEPHONE NUMBERS? *(Include Area Code)*

DAYTIME	EVENING	CELL PHONE
[redacted]		

18. WHAT IS YOUR E-MAIL ADDRESS?

19. WHAT IS YOUR SOCIAL SECURITY NUMBER?
[redacted]

20. WHAT IS THE YOUR DATE OF BIRTH *(Month, Day, Year)*
[redacted]1951

PART III - VETERAN'S ACTIVE DUTY SERVICE

IMPORTANT: Enter complete information for all periods of service. If more space is needed use Item 49 "Remarks". If the veteran never filed a claim with VA, attach the original DD214 or a certified copy for each period of service listed. We will return original documents to you.

21A. ENTERED ACTIVE SERVICE - First Period *(Month, Day, Year)*	21B. PLACE ENTERED ACTIVE SERVICE - First Period	21C. SERVICE NUMBER	21D. DATE LEFT ACTIVE SERVICE - First Period *(Month, Day, Year)*
03/08/1966	Hartford, CT	[redacted]	12/12/1967

21E. PLACE LEFT ACTIVE SERVICE - First Period	21F. BRANCH OF SERVICE	21G. GRADE, RANK, OR RATING
Boston, MA	USMC	Cp1

21H. ENTERED ACTIVE SERVICE - Second Period *(Month, Day, Year)*	21I. PLACE ENTERED ACTIVE SERVICE - First Period	21J. SERVICE NUMBER	21K. DATE LEFT ACTIVE SERVICE - Second Period *(Month, Day, Year)*

21L. PLACE LEFT ACTIVE SERVICE - Second Period	21M. BRANCH OF SERVICE	21N. GRADE, RANK, OR RATING

PART IV - MARITAL INFORMATION

(Attach a copy of your marriage certificate showing your marriage to the veteran)

NOTE: You must furnish complete information about ***all*** marriages of the surviving spouse and the veteran. If you need additional space, please attach a separate VA Form 21-686c, *Declaration of Status of Dependents*, providing the requested information.

If you are claiming benefits as the surviving spouse of the veteran you should complete Items 22A through 28. If you are not the surviving spouse, skip to Section V.

TELL US ABOUT THE VETERAN'S MARRIAGES

22A. HOW MANY TIMES WAS THE VETERAN MARRIED? (Include marriage to you)

3

22B. DATE (month, day, year) and PLACE OF MARRIAGE (city, state or country)	22C. TO WHOM MARRIED (first, middle, last name)	22D. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	22E. HOW MARRIAGE TERMINATED (death, divorce)	22F. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)
11/20/2000 Salt Lake City, Utah	Debra Hall	ceremonial	Divorce	Approx. 2010 San Marcos, TX
Do not have the information	Carla Haskell	ceremonial	Divorce	08/18/1983 Northampton, MA

22G. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 22D, PLEASE EXPLAIN:

3

TELL US ABOUT YOUR MARRIAGES

23A. HOW MANY TIMES HAVE YOU BEEN MARRIED? (Include your marriage to the veteran)

Provide information in Items 23c through 23G for all of your marriages)

23B. HAVE YOU REMARRIED SINCE THE DEATH OF THE VETERAN?

☐ YES ☒ NO

23C. DATE (month, day, year) and PLACE OF MARRIAGE (city/state or country)	23D. TO WHOM MARRIED (first, middle, last name)	23E. TYPE OF MARRIAGE (ceremonial, common-law, proxy, tribal, or other)	23F. HOW MARRIAGE TERMINATED (death, divorce, marriage has not been terminated)	23G. DATE (month, day, year) and PLACE MARRIAGE TERMINATED (city/state or country)
06/28/1987 Roslyn, NY	Howard Levy	ceremonial	Divorce	12/07/2011 Mineola, NY
08/11/1975 Greenwich, CT	Frederick Drummond	ceremonial	Divorce	12/08/1981 Mineola, NY

23H. IF YOU INDICATED "OTHER" AS TYPE OF MARRIAGE IN ITEM 23E, PLEASE EXPLAIN:

24. WAS A CHILD BORN TO YOU AND THE VETERAN DURING YOUR MARRIAGE OR PRIOR TO YOUR MARRIAGE?

☐ YES ☒ NO *(Answer Item 24 only if you were married to the veteran less than one year)*

25. ARE YOU EXPECTING THE BIRTH OF THE VETERAN'S CHILD?

☐ YES ☒ NO

26. DID YOU LIVE CONTINUOUSLY WITH THE VETERAN FROM THE DATE OF MARRIAGE TO THE DATE OF HIS/HER DEATH?

☒ YES ☐ NO *(If "No," complete Item 27)*

27. WHAT WAS THE CAUSE OF SEPARATION? GIVE THE REASON, DATE(S) AND DURATION OF THE SEPARATION *(IF THE SEPARATION WAS BY COURT ORDER, ATTACH A COPY OF THE ORDER)*

28. AT THE TIME OF YOUR MARRIAGE TO THE VETERAN, WERE YOU AWARE OF ANY REASON THE MARRIAGE MIGHT NOT BE LEGALLY VALID?

☐ YES ☒ NO *(If "Yes," provide explanation):*_____

PART V - DEPENDENT CHILDREN *(Complete ONLY if claiming benefits for a child(ren) of the veteran)*

*(Skip to Section VI if you are **NOT** claiming benefits for a child(ren) of the veteran)*

TELL US ABOUT THE UNMARRIED CHILDREN OF THE VETERAN

NOTE: You should provide a copy of the public record of birth or a copy of the court record of adoption for each child listed in Item 29A ***unless*** the veteran was receiving additional VA benefits for the child.

If you need additional space, please attach a separate VA Form 21-686c, *Declaration of Status of Dependents*, providing the requested information about each child.

IMPORTANT: **Skip to Part VI if you are not claiming benefits for any children that meet the following criteria.**

VA recognizes the veteran's biological children, adopted children, and stepchildren as dependents. These children must be unmarried and:

- under age 18, or
- at least 18 but under 23 and pursuing an approved course of education, or
- of any age if they became permanently unable to support themselves before reaching at 18.

"Seriously disabled" (Item 29H) means that the child became permanently unable to support himself/herself before reaching age 18. Furnish a statement from an attending physician or other medical evidence which shows the nature and extent of the physical or mental impairment.

Note to surviving spouse: If entitlement to DIC is established, a "seriously disabled" child over age 18 is entitled to receive DIC benefits in his or her own right. A veteran's child who is seriously disabled and over age 18 must submit a separate VA Form 21-534 to apply for benefits.

PART V - DEPENDENT CHILDREN *(Complete ONLY if claiming benefits for a child(ren) of the veteran)*

*(Skip to Section VI if you are **NOT** claiming benefits for a child(ren) of the veteran)* **(Continued)**

29A. NAME OF CHILD (First, middle initial, last name)	29B. DATE (month, day, year) and PLACE OF BIRTH (city/state or country)	29C. SOCIAL SECURITY NUMBER	(Check all that apply)						
			29D. BIOLOGICAL	29E. ADOPTED	29F. STEPCHILD	29G. 18-23 YEARS OLD (in school)	29H. SERIOUSLY DISABLED	29I. CHILD MARRIED	29J. CHILD PREVIOUSLY MARRIED
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

Tell us about the child(ren) listed in Item 29A that ***do not*** live with you in Items 30A through 30D.

30A. NAME OF CHILD (First, middle initial, last name)	30B. CHILD'S COMPLETE ADDRESS (Number and street or rural route, city or P.O., city, State, ZIP Code and country)	30C. NAME OF PERSON THE CHILD LIVES WITH (If applicable)	30D. MONTHLY AMOUNT YOU CONTRIBUTE TO THE CHILD'S SUPPORT
			$
			$
			$

PART VI - HOUSEBOUND, IN A NURSING HOME OR REQUIRE AID AND ATTENDANCE

NOTE: If you are claiming aid and attendance allowance and/or housebound benefits because you need the regular assistance of another person, are having severe visual problems, or are housebound and not in a nursing home, submit a statement from your doctor showing the extent of your disabilities. If you are in a nursing home, attach a statement signed by an official of the nursing home showing the date you were admitted, the level of care you receive, the amount you pay out-of-pocket for your care, and whether Medicaid covers all or part of your nursing home costs.

31. ARE YOU CLAIMING SPECIAL MONTHLY PENSION BECAUSE YOU NEED THE REGULAR ASSISTANCE OF ANOTHER PERSON, HAVE SEVERE VISUAL PROBLEMS, OR ARE CONFINED TO YOUR IMMEDIATE PREMISES?

☐ YES ☒ NO *(If "Yes," please complete and attach with this application VA Form 21-2680, Exam for Housebound Status or Permanent Need for Regular Aid and Attendance. Please make sure every box is complete and signed by a Physician, Physician Assistance (PA), Certified Nurse Practitioner (CNP), or Clinical Nurse Specialist (CNS))*

32A. ARE YOU NOW IN A NURSING HOME?

☐ YES ☒ NO *(If "Yes," answer Items 32B and 32C and submit a statement from an official of the nursing home that tells us that you are a patient in the nursing home because of a physical or mental disability. The statement should include the monthly charge you are paying out-of-pocket for your care)*

32B. PROVIDE THE NAME AND COMPLETE MAILING ADDRESS OF THE FACILITY

32C. DOES MEDICAID COVER ALL OR PART OF YOUR NURSING HOME COSTS?

☐ YES ☒ NO *(If "No," answer Item 32D)*

32D. HAVE YOU APPLIED FOR MEDICAID?

☐ YES ☒ NO

PART VII - INCOME AND ASSETS

33A. HAVE YOU CLAIMED OR ARE YOU RECEIVING BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION ON YOUR OWN BEHALF OR ON BEHALF OF A CHILD OR CHILDREN IN YOUR CUSTODY?

☐ YES ☒ NO *(If "Yes," answer Item 40B)*

33B. IS SOCIAL SECURITY BASED ON YOUR OWN EMPLOYMENT?

☐ YES ☒ NO

34. HAS A SURVIVING SPOUSE OR CHILD FILED A CLAIM FOR COMPENSATION FROM THE *OFFICE OF WORKER'S COMPENSATION PROGRAMS* BASED ON THE DEATH OF THE VETERAN?

☐ YES ☒ NO

35. HAS A COURT AWARDED DAMAGES BASED ON THE DEATH OF THE VETERAN OR IS A CLAIM OR LEGAL ACTION FOR DAMAGES PENDING?

☐ YES ☒ NO

36. HAVE YOU CLAIMED OR ARE YOU RECEIVING *SURVIVOR BENEFIT PLAN (SBP) ANNUITY* FROM A SERVICE DEPARTMENT BASED ON THE DEATH OF THE VETERAN?

☐ YES ☒ NO

PART VIII - INCOME AND ASSETS

IMPORTANT: Tell us about the income and assets of you and your dependents.

37A. DO YOU OR YOUR DEPENDENTS RECEIVE SOCIAL SECURITY BENEFITS?

☐ YES ☐ NO *(If "Yes," complete Item 37B) (If "No," skip to Item 38)*

37B. GROSS MONTHLY INCOME (Attach a separate sheet if necessary)

SOCIAL SECURITY RECIPIENT	GROSS MONTHLY AMOUNT
	$
	$
	$
	$
	$
	$
	$
	$
	$

38. DO YOU OWN YOUR PRIMARY RESIDENCE?

☐ YES ☐ NO *(If "No," skip to Item 40)*

39A. WHAT IS THE SIZE OF THE LOT ON WHICH YOUR PRIMARY RESIDENCE SITS? (Square Feet)

Square Feet:_____

39B. COULD PART OF YOUR LOT BE SOLD *WITHOUT SELLING YOUR RESIDENCE?*

☐ YES ☐ NO (If "YES," complete and attach VA Form, 21P-0969, *Income and Asset Statement*)

IMPORTANT: VA matches income information reported with Federal tax information. Report ALL income you and your dependents receive on the appropriate sections of this form and VA Form 21P-0969, Income and Asset Statement, if appropriate.

40A. **OTHER THAN SOCIAL SECURITY**, DO YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME?

☐ YES ☐ NO

40B. **OTHER THAN SOCIAL SECURITY**, DID YOU OR YOUR DEPENDENTS RECEIVE ANY INCOME LAST YEAR?

☐ YES ☐ NO

40C. DO YOU OR YOUR DEPENDENTS HAVE MORE THAN $10,000 IN ASSETS? (NOTE: Assets are all the money and property you or your dependents own. Assets ***do not*** include your primary residence or personal effects such as appliances and vehicles you or your dependents need for transportation)

☐ YES ☐ NO

40D. IN THE THREE CALENDAR YEARS BEFORE THIS YEAR, DID YOU OR YOUR DEPENDENTS TRANSFER ANY ASSETS? (Examples of asset transfers include giving them away, selling them, purchasing an annuity, or using them to establish a trust)

☐ YES ☐ NO

40E. DID YOU ANSWER "YES," TO ***ANY*** OF THE QUESTIONS IN ITEMS 40A THRU 40D?

☐ YES ☐ NO (If "Yes," you ***must*** also complete VA Form 21P-0969, *Income and Asset Statement*)

PART IX - DIRECT DEPOSIT INFORMATION

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, ***and*** attach either a voided personal check ***or*** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

41. ACCOUNT NUMBER (Check the appropriate box and provide the account number, or simply write "Established" if you have a direct deposit with VA.)

☒ CHECKING ☐ SAVINGS ☐ I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT

Account No [redacted] Account No.:_____

42. NAME OF FINANCIAL INSTITUTION (Please provide the name of the bank where you want your direct deposit)

Vystar Credit Union

43. ROUTING OR TRANSIT NUMBER (The first nine numbers located at the bottom left of your check)

[redacted]

PART X - MEDICAL, LAST ILLNESS, BURIAL OR OTHER UNREIMBURSED EXPENSES

IMPORTANT: Tell us about medical, last illness, burial or other unreimbursed expenses.

Family medical expenses and certain other expenses actually paid by you may be deductible from your income. Show the amount of any unreimbursed medical expenses, including the Medicare deduction, you paid over the last year (or expect to pay and continue indefinitely) for yourself or relatives who are members of your household.

Also, show unreimbursed last illness and burial expenses and educational or vocational rehabilitation expenses you paid. Last illness and burial expenses are unreimbursed amounts paid by you for the veteran's or his/her child's last illness and burial and the veteran's just debts. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials. **Do not** include any expenses for which you were reimbursed. If you receive reimbursement after you have filed this claim, promptly advise the VA office handling your claim. If more space is needed attach a separate VA Form 21P-8416, Medical Expense Report.

IMPORTANT: If you are claiming expenses for in-home care or assisted living, adult day care, or similar facility, you must complete the applicable worksheet(s) on pages 10 and 11.

44. ARE YOU CLAIMING UNREIMBURSED MEDICAL EXPENSES?

☒ YES ☐ NO *(If "No," skip to Section XI)*

45A. WHOSE MEDICAL, BURIAL, OR OTHER EXPENSES WERE PAID?	45B. PAID TO (Name of provider, Insurance company, nursing home, etc.)	45C. PURPOSE (Medicare premiums, nursing home, etc.)	45D. DATE PAID (mm/dd/yyyy)	45E. HOURLY RATE/HOURS (In-home Provider only)	45F. AMOUNT YOU PAY
Burial	North Brevard Funeral Home	Burial	08/21/2023		$ 3314
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$

PART XI - CERTIFICATION AND SIGNATURE

I CERTIFY AND AUTHORIZE the release of information:

I CERTIFY that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me, and I waive any privilege which makes the information confidential.

46A. SIGNATURE (Provide your signature in the box, **DO NOT PRINT**) (If you sign with an "X," then you must have 2 people you know witness as you sign. They must then sign the form and print their names and addresses)

Margaret Laska

46B. TODAY'S DATE (MM,DD,YYYY)

09/12/2023

47A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	47B. PRINTED NAME AND ADDRESS OF WITNESS
48A. SIGNATURE OF WITNESS (If claimant signed above using an "X")	48B. PRINTED NAME AND ADDRESS OF WITNESS

PART XII - REMARKS

49. REMARKS *(Use this space for any additional information or statements that you would like to make concerning your application)*

I cannot recall all of the previous marriage information for my husband. I provided the information to the best of my knowledge.

PART XII - REMARKS (Continued)

49. REMARKS *(Continued) (Use this space for any additional information or statements that you would like to make concerning your application)*

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment which you are not entitled to.

WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR A SIMILAR FACILITY

NOTE: Only complete this worksheet if you are claiming expenses for an assisted living facility, adult day care or similar facility.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

INSTRUCTIONS: Use this worksheet if you are claiming a disabled person's care in an assisted living facility, adult day care, or similar facility as unreimbursed medical expenses. Follow the steps below to determine whether VA may deduct all or some of your out-of-pocket payments to the facility.

STEP 1. Are the expenses you wish to claim due to the disabled person's treatment in a hospital, inpatient treatment center, nursing home, or VA approved medical foster home?

☐ YES ☐ NO (If "NO," continue to Step 2)
(If "YES," ***all*** payments to the facility qualify as medical expenses in Items 45A thru 45F. You are finished completing this worksheet)

STEP 2. Do ***all*** of the following apply to the facility?
- The facility is licensed (if the State or Country requires it)
- The facility's staff (or the facility's contracted staff) provides the disabled person with health care or custodial care or both.
- If the facility is residential, it is staffed 24 hours per day with caregivers.

☐ YES ☐ NO (If "NO," payments to the facility ***do not*** qualify as medical expenses. You are finished completing this worksheet)

STEP 3. Are you (the claimant) the disabled person, a surviving spouse, or a Parents' DIC claimant?

☐ YES ☐ NO (If "NO," skip to Step 6)

STEP 4. Did you claim special monthly pension in Item 31?

☐ YES ☐ NO (If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** claim amount you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 5. If you answered "YES" in Step 2, you stated that the facility provides you with health care and/or custodial care. Is this the ***primary reason*** you live in the facility (or attend day care in the facility)?

☐ YES ☐ NO (If "YES," all payments to this facility ***may*** qualify as medical expenses in Items 45A thru 45F ***if*** VA rates you as eligible for special monthly pension or special monthly DIC. Please report separately in Items 45A - 45F applicable amounts you pay the facility for (1) ***lodging and meals***; (2) ***health care services or assistance with ADLs provided by a health care provider***; and (3) ***custodial care***. Skip to Step 8)
(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay the facility for: (1) ***health care services or assistance with ADLs provided by a health care provider*** and (2) ***custodial care***. Skip to Step 8)

STEP 6. Does the disabled person require the health care services or custodial care that the facility provides to him or her because of the disabled person's mental or physical disability?

☐ YES ☐ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the facility provides to him or her because of mental or physical disability, and (2) describes the mental or physical disability)
(If "NO," claim only amounts you pay the facility for ***health care services or assistance with ADLs provided by a health care provider*** in Items 45A thru 45F. Skip to Step 8)

STEP 7. If you answered "YES" in Step 2, you stated that the facility provides the disabled person with health care and/or custodial care. Is this the ***primary reason*** the disabled person lives in the facility (or attends day care in the facility)?

☐ YES ☐ NO (If "YES," claim all payments to this facility (to include meals and lodging) as medical expenses in Items 45A thru 45F)
(If "NO," payments to this facility for meals and lodging ***do not*** qualify as medical expenses. ***Only*** *claim amounts you pay the facility for* ***health care services or custodial care*** in Items 45A thru 45F)

STEP 8. Facility Certification (Please submit a current statement showing the fees the claimant pays to your facility and a breakdown of the care received)

I CERTIFY the information stated within this WORKSHEET FOR AN ASSISTED LIVING, ADULT DAY CARE, OR SIMILAR FACILITY is accurate and reflects the current environment pertaining to _____
(Name of individual staying at your facility)
and his/her care at this facility (_____).
(Name and address of facility)

_____ _____
(Name, Signature, Title at Facility) (Date)

WORKSHEET FOR IN-HOME ATTENDANT EXPENSES

NOTE: Only complete this worksheet if you are claiming expenses for in-home care.

IMPORTANT: VA recognizes the following five activities as Activities of Daily Living (ADLs) for medical expense purposes:

(1) Eating

(2) Bathing/Showering

(3) Dressing

(4) Transferring (for example, from bed to chair)

(5) Using the toilet

Custodial Care is regular -
- assistance with two or more ADLs, ***or***
- supervision because a person with a mental disorder is unsafe if left alone due to the mental disorder.

IMPORTANT: The following activities are examples of Instrumental Activities of Daily Living (IADLs) for VA purposes. VA generally ***does not*** recognize assistance with these activities as medical expenses: (1) Shopping; (2) Food Preparation; (3) Housekeeping; (4) Laundering; (5) Handling medications; (6) Using the telephone; (7) Transportation (except for medical purposes such as transportation to a doctor's appointment).

INSTRUCTIONS: Use this worksheet if you are claiming payments to a disabled person's in-home attendant as an unreimbursed medical expense.

Follow the steps below to determine whether or not:

- the attendant must be a health care provider for VA purposes ***and***
- VA may deduct payment for assistance with IADLs as well as assistance with ADLs and custodial care.

STEP 1. Are you (the claimant) the disabled person, a surviving spouse, or Parents' DIC claimant?

☐ YES ☐ NO (If "NO," skip to Step 4)

STEP 2. Did you claim special monthly pension on Item 31?

☐ YES ☐ NO (If "NO," the in-home attendant ***must be a health care provider*** and payments for assistance with IADLs ***do not*** qualify as medical expenses. Payments for ***health care services or custodial care*** qualify as medical expenses. You may claim these expenses in Items 45A thru 45F. Skip to Step 6)

STEP 3. Is the ***primary responsibility*** of the in-home attendant to provide you with health care or custodial care?

☐ YES ☐ NO (If "YES," payments to this in-home attendant ***may*** qualify as medical expenses ***if*** VA rates you as eligible for special monthly pension. Please report separately in Items 45A - 45F amounts you pay an in-home attendant for: (1) health-care services or assistance with ADLs provided by a health care provider; (2) assistance with IADLs, and (3) custodial care. Skip to Step 6)

(If "NO," payments to this in-home attendant for assistance with IADLs ***do not*** qualify as medical expenses. Please report separately in Items 45A thru 45F applicable amounts you pay an in-home attendant for: (1) ***health care services or assistance with ADLs provided by a health care provider***; and (2) custodial care. Skip to Step 6)

STEP 4. Does the disabled person require the health care services or custodial care that the in-home attendant provides to him or her because of the disabled person's mental or physical disability?

☐ YES ☐ NO (If "YES," you must submit a statement from a physician or physician assistant that (1) the disabled person requires the health care services or custodial care that the in-home attendant provides the disabled person because of the disabled person's mental or physical disability, and (2) describes the mental or physical disability)

(If "NO," the attendant must be a health care provider. Only report payments to the in-home attendant for health care services or assistance with ADLs provided by the health care provider as medical expenses in Items 45A thru 45F. Payments for assistance with IADLS do not qualify as medical expenses. Skip to Step 6)

STEP 5. Is the ***primary responsibility*** of the in-home attendant to provide the disabled person with health care or custodial care?

☐ YES ☐ NO (If "YES," payments to the in-home attendant qualify as medical expenses (even assistance with IADLs) and can be reported in Items 45A thru 45F)

(If "NO," report payments to this in-home attendant for ***health care and/or custodial care*** as medical expenses in Items 45A thru 45F. Payment for assistance with IADLs ***do not*** qualify as medical expense)

STEP 6. Check all activities below with which the attendant assists the disabled person:

ADLs: ☐ EATING ☐ BATHING/SHOWERING ☐ DRESSING ☐ TRANSFERRING ☐ USING THE TOILET

IADLs: ☐ SHOPPING ☐ FOOD PREPARATION ☐ HOUSEKEEPING ☐ LAUNDERING ☐ MANAGING FINANCES

☐ HANDLING MEDICATIONS ☐ USING THE TELEPHONE ☐ TRANSPORTANTION (FOR NON-MEDICAL PURPOSES)

STEP 7. **In-Home Attendant Certification** (Please submit a breakdown of the time the attendant spends assisting the disabled person with health care services, ADLs, and IADLs.)

I CERTIFY the information within this WORKSHEET FOR IN-HOME ATTENDANT EXPENSES is accurate and reflects the current environment pertaining to _____ and his/her care from (_____).

(Name of Individual Requiring Care) (Name of Attendant)

_____ _____

(Name, Signature, Title) (Date)

OMB Approved No. 2900-0740
Respondent Burden: 5 minutes
Expiration Date: 12/31/2024

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

REQUEST FOR SUBSTITUTION OF CLAIMANT UPON DEATH OF CLAIMANT

INSTRUCTIONS: Use this form if you want to request to substitute the claim of a deceased claimant.

SECTION I - VETERAN'S IDENTIFYING INFORMATION

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

1. FIRST, MIDDLE INITIAL, LAST NAME OF DECEASED CLAIMANT *(Print clearly if completing by hand)*

Herbert | N | Haskell

2. VETERAN'S FILE NUMBER *(If applicable)*

[redacted]

3. VETERAN'S SOCIAL SECURITY NUMBER

[redacted]

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*

Month Day Year

[redacted] – 1946

5. VETERAN'S DATE OF DEATH *(MM/DD/YYYY)*

Month Day Year

08 – 14 – 2023

SECTION II - SUBSTITUTE CLAIMANT INFORMATION

I have interest in the claim of the deceased and request to be substituted as the claimant. I am eligible to receive accrued benefits due the deceased claimant and I am eligible to be a substitute claimant under section 5121(a) of title 38.

6. FIRST, MIDDLE INITIAL, LAST NAME OF SUBSTITUTE CLAIMANT *(Print clearly if completing by hand)*

Margaret | | Laska

7. RELATIONSHIP TO DECEASED

Spouse

8. CLAIMANT'S SOCIAL SECURITY NUMBER

[redacted]

9. ADDRESS OF CLAIMANT *(No. and Street or rural route, City or P.O., State and ZIP Code)*

No. & Street: [redacted]

Apt./Unit Number: | City: Titusville

State/Province: FL | Country: USA | ZIP Code/Postal Code: 32780 –

10. CLAIMANT'S TELEPHONE NUMBER(S)

A. DAYTIME PHONE NUMBER: [redacted]

B. EVENING PHONE NUMBER: [redacted]

C. CELL PHONE NUMBER: [redacted]

11. E-MAIL ADDRESS *(Optional) (NOTE: By providing your E-mail address you provide consent for VA to contact you via E-mail and that those E-mails may contain personal identifiable information. However, VA will never include your SSN in E-mail correspondence.)*

[redacted]

12. FAX NUMBER *(If applicable)*

13. REMARKS

14A. SIGNATURE *(Do **NOT** print)*

Margaret Laska

14B. DATE SIGNED *(MM/DD/YYYY)*

09/12/2023

PRIVACY ACT INFORMATION: 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. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies. You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine eligibility for payment of substitution benefits under 38 U.S.C. 5121(a). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 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.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.