 Department of Veterans Affairs		Veteran - Income Verification Response
Name of Veteran:	Income Year:	Case Number:

Before completing this form, please refer to the enclosed instructions which include examples of deductible out-of-pocket non-reimbursed expenses. Please select **one** of the **Options** below which best represents your response to our attempt to verify your income information. **An incomplete form will be returned which may delay the processing of your case.** Your gross household income including income of spouse and dependent child(ren) will assist us in determining your copay responsibilities and eligibility for VA health care benefits. Once a determination is made on your case, a decision letter will be mailed to you. **(Fill-in appropriate circle)**

Option 1. Agree

I agree with the financial information provided by IRS/SSA and agree to make the applicable copays for health care received during ~CalendarYear~. **I understand I may be billed within 60 days following the date on the decision letter regarding any unpaid health care copays.**

Option 2. Agree/Deductible Expenses

I agree with the financial information provided by IRS/SSA and have indicated the total amount of deductible out-of-pocket non-reimbursed expenses for ~Income Year~ as entered in the **Additional Requirement** section that may reduce my income below the VA National Income Threshold.

*If you select **Option 2** and do not provide the information requested below in the **Additional Requirement** section, we will complete our income verification using information provided by IRS/SSA. After our review is completed, you will receive a decision letter notifying you of your copay status and responsibilities. **You may be billed within 60 days following the date on the decision letter regarding any unpaid health care copays.***

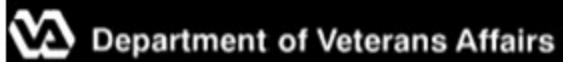
Option 3. Disagree

I disagree with the financial information provided by IRS/SSA. **I have enclosed copies of supporting documentation for any disputed IRS/SSA information.** I understand VA may use this information to determine my eligibility for health care benefits and may obtain verification from financial institutions and/or employers.

*If you select **Option 3** and do not provide the information requested below in the **Additional Requirement** section and/or do not provide copies of supporting documentation for the disputed IRS/SSA information, we will complete our income verification using information provided by IRS/SSA and you will receive a decision letter notifying you of your copay status and responsibilities. **You may be billed within 60 days following the date on the decision letter regarding any unpaid health care copays.***

Additional Requirement: (Fill in appropriate circle and complete, where applicable)

I attest that the **household** deductible out-of-pocket non-reimbursed expenses paid in ~IncomeYear~ are as follows:



Veteran - Income Verification Response

Name of Veteran:	Income Year:	Case Number:
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Medical: \$ _____ (Total) Medical Mileage: _____ miles (Total) Burial: \$ _____ (Spouse, Dependent Child(ren))

Educational: \$ _____ (Veteran only) Gambling Losses: \$ _____ (Deducted from gambling winnings only)

I attest that the listed sale of real estate was my primary residence.

I attest that I have been separated from my spouse since _____.
(MM/DD/YYYY of separation)

I declare to the best of my knowledge and belief that the information stated is true and correct and I understand that I may be required to provide supporting documentation as proof which may be used to determine the final decision regarding my health care benefits during ~CalendarYear~.

Signature:	Date:
Sign and date this form. Return the form and any copies of your supporting documentation to: VA Health Eligibility Center, Income Verification Division, 2957 Clairmont Road, Atlanta, GA 30329-1647	

If you sign with an "X", two people you know must witness your signature as you sign. They must print their names and sign and date the form below.

_____	_____	_____
Witness' Name (Please Print)	Signature	Date
_____	_____	_____
Witness' Name (Please Print)	Signature	Date

For more information about VA health care eligibility and enrollment, visit VA's website at www.va.gov/healthbenefits.

Document Contains Federal Tax Information



Department of Veterans Affairs

Veteran - Income Verification Response

Name of Veteran:

Income Year:

Case Number:

End of Reported Federal Tax Information

If you have additional earned or unearned income information for *~IncomeYear~* that is not listed, please provide it on a separate sheet of paper. **Be sure to write your case number on each page of correspondence you mail or fax to our office.**